

Tuesday, 21 January 2025

(10.00 am)

**LADY HALLETT:** Mr Keith.

**MR KEITH:** Good morning, my Lady. My Lady, the first witness today is Dame Kate Bingham.

Could you be sworn, please.

**DAME CATHERINE BINGHAM (sworn)**

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

**MR KEITH:** Dame Kate, could you commence your evidence, please, by giving the Inquiry your full name.

**A.** Hello, my name is Kate Bingham, or Catherine Elizabeth Bingham.

**Q.** All right, thank you very much.

Dame Kate, thank you very much for attending and assisting the Inquiry, not least by the provision of your witness statement, INQ000474406, of October 2024.

I'd like to start, please, your evidence by asking you a few questions about your professional background, if I may. You graduated from Oxford with a first class degree in biochemistry, you worked as a management consultant, you completed an MBA at Harvard, and then you went into the world of venture capital and private equity with Schroder Ventures, and out of that, you then pursued SV Health Investors, your venture capital firm, specialising, in particular, in building and investing

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up with membership of manufacturing experts, bioindustrial specialists, vaccine scientists and a number of external professionals; is that right?

**A.** That's correct. So Patrick Vallance created that external advisory board in order to bring some specific expertise into Whitehall. So I think until that point Whitehall had been taking charge and when I think it became clear that those skills and capabilities were not there, he then brought together his group of, as you say, clinicians, industry people, manufacturing experts, regulatory, and they were there to help advise the team within BEIS, the business department, on all aspects of securing vaccines.

**Q.** Then the programme board, by contrast, comprised the Civil Service element, if you like, of the original form of the VTF. I think it was led by Alex Jones of BEIS. And in due course the external advisory group was brought to an end and the two parts were amalgamated into what became the body that you chaired, and you were formally appointed on 6 May 2020; is that right?

**A.** Yes, they didn't quite amalgamate. We -- the VTF was relaunched with a steering group which was part comprised with industry experts that I chose and part comprised, actually, with new civil servants that were brought in for specific expertise. The expert advisory

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in biotech companies. And I think you were, at the time of the pandemic, and remain, a managing partner at SV Health Investors.

**A.** Correct.

**Q.** Your role in the pandemic was, of course, centred around your position as the Chair of the Vaccine Taskforce. It is self-evident that, to a very large extent, the vaccination programme in which the VTF played such an important role was a success. It is also self-evident that there were very considerable individual successes achieved in relation to therapeutics, dexamethasone being the most obvious one, but a number of repurposed drugs were authorised for use and a number of new drugs were developed, discovered, and rolled out.

The role of the VTF, therefore, requires considerable examination because it's vital in the Inquiry's view that what worked well is embedded into the system for the future and what didn't go quite so well can be focused on and improved.

The VTF commenced its life by way of being officially launched on 17 April 2020, but there were initially two parts to it, were there not: there was an external advisory board and a programme board. What was the main feature of the external advisory board, in terms of its constitution? It appears to have been made

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group remained on the sides for a bit, and the BEIS team, I think, then was rebuilt.

**Q.** When you arrived, you say in your book that you became aware that BEIS had handed over responsibility for one part of what became the VTF group's functions, to a management consultancy firm. In the context of, and I'll ask you more about this in a moment, of the importance of bringing in external expertise, why did you take the view that using external management consultants was the wrong approach?

**A.** Well, because that seemed to be a default move within the Civil Service, and -- to bring in people supposedly with expertise, although certainly not the level of expertise that we brought through the VTF team, and what it means is you've got a Civil Service that never builds that level of expertise internally because they are always outsourcing it and relying on external experts. And the whole reason that the VTF was created was because that expertise and those relationships with industry and that understanding of how to develop, manufacture, regulate and launch a vaccine was not there in government. And the more you outsource it to major management consultancies, the more you're never going to build that capability internally.

So I am critical of not -- of the rotating seats

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1 that we see in Whitehall, and no focus or even  
 2 recognition of the need to build up that expertise.  
 3 **Q.** And we'll come back in due course to some of the general  
 4 overarching comments you make in your book about the  
 5 Civil Service approach.  
 6 It's plain from the paperwork that you demanded  
 7 a number of conditions be met prior to you taking the  
 8 role as the chair of the VTF. Just to run through them  
 9 one by one, you demanded a clear mandate with a direct  
 10 order line to the Prime Minister. Why was that?  
 11 **A.** Because I felt that if I did not have the authority of  
 12 the Prime Minister, there was clearly tensions between  
 13 the business department and the Department of Health,  
 14 and that there would be interference at a ministerial  
 15 level, and from officials if I didn't have a -- very  
 16 clear reporting to the PM. And that absolutely was the  
 17 correct decision and was worth its weight in gold.  
 18 **Q.** A second condition you demanded was that the VTF be  
 19 located in BEIS. Why was that?  
 20 **A.** Because our job was fundamentally a commercial job,  
 21 which was to work with manufacturers, industry, to  
 22 identify the best vaccines, manufacture them and secure  
 23 contracts. So this is a commercial discussion, not  
 24 a how do you actually deploy it in the health system.  
 25 **Q.** And is governmental supervision of the life sciences

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1 **A.** Essential.  
 2 **Q.** And we'll come to that in due course as well.  
 3 Of perhaps lesser importance in the general scheme  
 4 of things, but nevertheless of considerable interest,  
 5 you also demanded that you be the chair only for  
 6 six months, you said, "I want a 6-month term of office",  
 7 and you also asked that you be given the ability to sign  
 8 off on all communications in advance. Because --  
 9 **A.** I was concerned about leaks --  
 10 **Q.** -- this may reflect on your views on the Civil Service  
 11 and on the way in which government went about things.  
 12 Why did you ask for those two conditions?  
 13 **A.** So, the six months, we'd just raised a new fund, and  
 14 so -- I'm a key person in the fund and if I wasn't part  
 15 of the fund, our investors could actually suspend the  
 16 fund. So that -- it wasn't just for me, I was working  
 17 *pro bono*, but it's the entire team and the group I work  
 18 with.  
 19 So that -- I wasn't able to do more than that. And  
 20 the comms was about the worry about leaks coming out of  
 21 government.  
 22 **Q.** It's apparent from your statement and from the paperwork  
 23 that you were put through quite a robust conflict of  
 24 interest process. Is this the sum of it: your position  
 25 was examined in fact by the DHSC and by the Cabinet

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1 industry insofar as it impacts upon government --  
 2 **A.** Yes.  
 3 **Q.** -- within BEIS?  
 4 **A.** Yes.  
 5 **Q.** You demanded the ability to make rapid decisions. You  
 6 asked for rapid decision making. Again, why was that?  
 7 **A.** Because -- I hadn't worked with government before, but  
 8 the one thing you know about government is it's  
 9 incredibly slow.  
 10 **Q.** You asked for the ability to establish a dedicated  
 11 budget, with timelines. Why was that?  
 12 **A.** Because, again, my understanding was that everything in  
 13 terms of getting money signed off in government takes  
 14 a very long time and you've got to go round endless  
 15 departments and then you go back to Treasury, who say  
 16 no, and then you go round again and you do it again.  
 17 So the idea was not that we had actually -- the VTF  
 18 Steering Group, we did not have spending authority, we  
 19 made recommendations, but to the extent we could  
 20 actually have a dedicated budget from which any  
 21 contracts could be paid would then again speed up the  
 22 rate of decision making and execution of what we were  
 23 trying to do.  
 24 **Q.** And was that absolutely vital, in fact, to the proper  
 25 performance of the VTF's functions?

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1 Office. You were obliged to declare anything that might  
 2 conceivably cause a conflict of interest, and in the  
 3 interests of the government, and of what you were doing,  
 4 did you in fact step off a number of boards and  
 5 committees, and in particular, agree that no fund  
 6 managed by SV, your company, could or would invest in  
 7 any Covid-19 vaccine company?  
 8 **A.** Correct.  
 9 **Q.** And to the detriment of one of your funds, did that fund  
 10 in fact have to pause all investment and divestment for  
 11 quite a considerable period in relation to the bio  
 12 sciences industry?  
 13 **A.** Yes, correct, it was a public fund, so that it was it's  
 14 -- its performance was gauged against the index and  
 15 because the index had spiked so massively with the Covid  
 16 vaccines, not being able to participate in that was  
 17 a problem for them, yes.  
 18 **Q.** You've referred to the degree of independence that you  
 19 sought. By and large, were you afforded it?  
 20 **A.** Yes.  
 21 **Q.** You reported to the Prime Minister ultimately, but VTF  
 22 remained a formal part of BEIS and presumably the  
 23 ministerial accountability line was to Parliament  
 24 through BEIS?  
 25 **A.** Correct.

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1 **Q.** It's obvious that a very great deal of hard work was  
 2 done and a great deal of time was spent on discharging  
 3 your functions within VTF. Did that include reporting  
 4 daily in the evenings or weekends to a multitude of  
 5 ministers and officials?

6 **A.** I set up meetings at 8 o'clock in the morning, three  
 7 times a week, Monday, Wednesday, Friday. And that was  
 8 our ability within the steering group to communicate  
 9 what we were doing, and what progress we'd made. Those  
 10 meetings became a reporting mechanism as time went on  
 11 with more and more officials wanting to join. So,  
 12 I have no idea quite how many joined towards the end of  
 13 my six months, but it was a lot. We had regular  
 14 catch-ups with Alok Sharma who was the minister,  
 15 Secretary of State for BEIS, and not very regular but  
 16 nonetheless catch-ups with Number 10 and the  
 17 Prime Minister.

18 **Q.** There were in the VTF a number of external  
 19 professionals, and in order, in part, to give them  
 20 tribute for what they did, given the overarching success  
 21 of the VTF, they included Ian McCubbin, head of the BIA  
 22 bioprocessing group, Steve Bates from the BioIndustry  
 23 Association. Maddy McTernan -- was she a civil servant  
 24 or was she external?

25 **A.** Maddy is a civil servant but had come through the

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1 **Q.** So ultimately, it wasn't a question of the VTF  
 2 succeeding because it was exclusively staffed by  
 3 external professionals --

4 **A.** No.

5 **Q.** -- it was that collaborative approach from industry and  
 6 the external professions --

7 **A.** And I might say --

8 **Q.** -- as well as the Civil Service.

9 **A.** Correct, and plenty of women in the leadership team.

10 **Q.** Quite right.

11 There were three objectives set for the VTF to  
 12 secure -- very broadly, to secure vaccines for the  
 13 United Kingdom to ensure that vaccines were distributed  
 14 equitably around the world and thirdly, to make the UK  
 15 more resilient in dealing with a future pandemic. It is  
 16 obviously somewhat uncomfortable to ask for anybody to  
 17 have to mark their own homework, Dame Kate, but in  
 18 relation to goal 1 to secure vaccines for the  
 19 United Kingdom, do you feel you can say that you  
 20 succeeded?

21 **A.** Yes.

22 **Q.** That goal was to secure vaccines, but part of the VTF's  
 23 functions, it turned out, included the role of  
 24 identifying, developing, and procuring and making  
 25 available monoclonal antibodies.

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1 private sector, a lawyer.

2 **Q.** Ruth Todd, who was I think the head of your  
 3 programmes --

4 **A.** Programme manager, yeah.

5 **Q.** -- process. Civil servant or external?

6 **A.** Again, a civil servant but with a long career in the  
 7 private sector.

8 **Q.** Clive Dix, your deputy?

9 **A.** Phenomenal.

10 **Q.** And from where?

11 **A.** Private sector.

12 **Q.** And Nick Elliott, your director general?

13 **A.** Most recently from the private sector, but had a career  
 14 in the army and programme management before that.

15 **Q.** So drawing the threads together, it is obvious that the  
 16 external experience, the industrial expertise, was vital  
 17 to the proper discharge of the VTF job?

18 **A.** Completely.

19 **Q.** That's not to say, though, is it, that there isn't  
 20 a vital role for Civil Service experience? Was that  
 21 particularly in relation to contracting, obviously,  
 22 money flows, expenditure, project management, and  
 23 possibly diplomacy?

24 **A.** Correct, all those three things, I think the Civil  
 25 Service in our team did really well.

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1 **A.** Prophylactics for those who couldn't receive vaccines.  
 2 So actually, the first goal was around protecting the UK  
 3 population.

4 **Q.** And in relation to monoclonal antibodies, do you think  
 5 you succeeded on securing or making available those  
 6 monoclonal antibodies?

7 **A.** No.

8 **Q.** We'll come back to that later.

9 The second goal, to ensure vaccines were distributed  
 10 equitably around the world, why, without appearing in  
 11 any way nationalistic, does it matter, in terms of the  
 12 UK interest, that vaccines are distributed elsewhere in  
 13 the world?

14 **A.** Because, first of all, I think there's an ethical and  
 15 moral case that the UK and any wealthy countries should  
 16 be contributing to low- and middle-income countries'  
 17 health systems. The clinical argument is that for as  
 18 long as this virus continues to infect people around the  
 19 world, especially those people who are  
 20 immunocompromised, so in Africa with HIV, you will  
 21 continue to get viral mutation and so then you will get  
 22 the emergence of potentially more lethal and more  
 23 infective viruses, which is exactly what we saw. And so  
 24 the more quickly the global community can actually  
 25 vaccinate all those people who are vulnerable, the more

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1 effective we will be at stemming the impact of the  
 2 pandemic.  
 3 **Q.** And in that regard, the United Kingdom Government had  
 4 contributed and contributed during your time as chair,  
 5 a very large sum of money to the international  
 6 organisation COVAX. Was it your view that more could  
 7 have been done nevertheless?  
 8 **A.** Yes, there was the commitment, but it was very late. So  
 9 actually, I've got good data to show that we were not  
 10 even in the top ten of countries donating vaccine, you  
 11 know, in 2021 when it matters. So yes, maybe by the end  
 12 of 2022 we had started donating more, but by then it was  
 13 too late. So it really matters that we play an active  
 14 role at the time when it matters, rather than  
 15 afterwards.  
 16 **Q.** It is important, though, to note that AstraZeneca, a UK  
 17 company, of course, made the Oxford adenoviral vaccine  
 18 available at cost and was, relatively speaking, quite  
 19 a cheap vaccine, was it not?  
 20 **A.** It was cheap and it was the vaccine that will have saved  
 21 more lives than any other around the world.  
 22 **Q.** And to his credit, did the Prime Minister make plain to  
 23 you that in addition to securing vaccines for the  
 24 United Kingdom and obviously directing himself to the  
 25 direct interest of our population, he wanted the

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1 that's available for different things with no  
 2 overarching leadership, no plan of actually how can we  
 3 join up what is an incredibly effective bioprocessing  
 4 industry in particular in the UK. So this is an  
 5 industry that came together in February 2021, way before  
 6 the government is even thinking about what to do, and  
 7 they said, "We realise we're the ones" --

8 **Q.** February 2020?  
 9 **A.** Sorry, February 2020. "We're the ones who are going to  
 10 have to do the scale-up and the manufacturing of  
 11 vaccines so we might as well get going, because there's  
 12 no time to be lost."

13 Now, that is an astonishing thing, it was not based  
 14 on contracts, this was not based on money or anyone  
 15 asking them to do it, this was the industry coming  
 16 together and saying: this is how we can help. And so we  
 17 have an astonishingly collaborative, supportive generous  
 18 industry in this country, and yet we're not supporting  
 19 it with any government-led leadership which has  
 20 a coherent strategy. So the reason I think we haven't  
 21 delivered that third goal that the Prime Minister set  
 22 was not that we haven't tried, but we don't have any  
 23 ongoing leadership strategy or ability to deliver that  
 24 strategy within government, because it is not business  
 25 as usual.

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1 United Kingdom to be at the forefront of global  
 2 manufacture and supply, in order to be able to spread  
 3 the beneficial impact of vaccines globally?

4 **A.** He was explicit about that and that was really  
 5 important. And the other factor that he was explicit  
 6 about was people were dying so he wanted us to act  
 7 quickly.

8 **Q.** And throughout the six months that you were in charge of  
 9 the VTF, did the Prime Minister frequently bang that  
 10 drum?

11 **A.** Did he frequently?

12 **Q.** Bang that drum?

13 **A.** Yes.

14 **Q.** Did he constantly make that point?

15 **A.** Yes, he did.

16 **Q.** The third goal, very broadly, was to make the UK more  
 17 resilient in dealing with the future pandemic. How do  
 18 you feel you did on that?

19 **A.** Very modestly.

20 **Q.** Why?

21 **A.** Because we put lots of great plans, recommendations, and  
 22 suggestions in place, and there is no coherent  
 23 leadership to actually follow through with what we had  
 24 suggested. So we may get into this in more detail, but  
 25 there are, you know, different pots of grant money

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1 **Q.** And we'll come back to many of these areas in due  
 2 course, but broadly speaking, are you dealing there with  
 3 or are you referring to the issue of the management and  
 4 co-ordination of the funding routes, the management and  
 5 co-ordination of the clinical trials, from the vantage  
 6 point of the government, of course, and also the issue  
 7 of onshore manufacturing of both vaccines, as well as  
 8 bulk antibodies?

9 **A.** I'm talking about all of that. So we don't wait, in  
 10 defence, to have Russia invade Ukraine to then set up  
 11 a taskforce to say, "Right, what shall we be doing?  
 12 What weapons should we be using? How should we be  
 13 doing? What should we be doing? What might be coming  
 14 through in the future?" We have a standing capability  
 15 of experts who are looking at the future to say what are  
 16 the new vaccine formats, what are the new potential  
 17 threats that could be coming and how can we prepare for  
 18 that? We don't have that level of capability or  
 19 long-term thinking in government. So there's lots of  
 20 good well-meaning good strategies which are itsy bitsy,  
 21 bit of money here, bit of money here, and will be  
 22 allocated out. But there is nothing that brings  
 23 together the end-to-end manufacturing -- discovery,  
 24 development, scale-up, manufacturing, clinical,  
 25 regulatory, to get to vaccines that can get into people

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1 to protect people. And that is what is missing.

2 **Q.** Remaining for the moment with the issue of the scope of  
3 the VTF, there was quite a difficult issue to be  
4 circumnavigated concerning whether or not therapeutics,  
5 and in particular, as you said, monoclonal antibodies,  
6 should be within the remit of the Vaccine Taskforce. We  
7 understand in fact that at the first meeting on 11 May,  
8 the agenda referred to your body as the Vaccine and  
9 Therapeutics Taskforce. How was the issue as to what  
10 the remit of the VTF should be resolved?

11 **A.** Therapeutics is obviously my background, so that is the  
12 natural area for me to have included in the remit. What  
13 I did is what I would always do, which is to go and talk  
14 to the people involved, including in industry, and it  
15 was quite clear there was open warfare between BEIS and  
16 Department of Health, and the RECOVERY trial at that  
17 point had been set up. So this is the big master  
18 protocol, phase III three trial that demonstrated  
19 dexamethasone. So there was no need for me to have any  
20 involvement in that, that was being run beautifully and  
21 executed well.

22 So then the question is: well, should we have had  
23 oversight on the phase I and early phase II clinical  
24 trials testing either repurposing medicines or  
25 ultimately bringing forward new medicines, and

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1 attention? You would have been less able to focus  
2 ruthlessly on the question of identifying, procuring,  
3 and making available vaccines, which of course was your  
4 primary goal?

5 **A.** Correct.

6 **Q.** We have, in the Inquiry, a number of emails from May in  
7 which you debate with Sir Jeremy Farrar, Sir John Bell,  
8 Sir Patrick Vallance, as he then was, where this issue  
9 about the remit of the VTF would end up, and was it your  
10 position that you wanted to keep neutralising  
11 antibodies, but you were content to allow the remainder  
12 to go off to what became the Therapeutics Taskforce?

13 **A.** Yes. So I felt strongly that we should have governance  
14 over the neutralising antibodies because there are  
15 a portion of people in the UK who are immunocompromised.  
16 That means they are unable to mount a protective vaccine  
17 response if given a vaccine. So people with HIV or  
18 people going through bone marrow transplantation or  
19 anywhere where you've got basically a dysfunctional  
20 immune system, and so I felt, correctly, that that was  
21 part of our original mandate, which was to protect  
22 the UK -- the relevant UK population against SARS-CoV-2.  
23 And that wasn't just to protect those people who could  
24 respond to a vaccine, but to protect all those people,  
25 including the immunocompromised.

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1 ultimately it was quite clear that there was no need to  
2 do that, because there are already too many people  
3 probably involved. It wasn't functional, and vaccines  
4 was ultimately going to be the route out of the  
5 pandemic. So the focus for us was to actually focus  
6 solely on vaccines, not take on therapeutics.

7 **Q.** The evidence before the Inquiry appears to be that there  
8 were considerable tensions between the funders, the  
9 officials, the academics, and the industrialists in the  
10 sphere of those phase I and II trials, that there  
11 appears to have been a profusion of trials, many of them  
12 underpowered, some of them badly recruited, and quite  
13 a lot of --

14 **A.** Just to be clear, you're talking only about  
15 therapeutics --

16 **Q.** I am.

17 **A.** Yes.

18 **Q.** I am only talking about therapeutics there.

19 **A.** Yes, that was the impression I got --

20 **Q.** You mentioned the RECOVERY trial, which was  
21 a therapeutic trial.

22 **A.** Brilliant.

23 **Q.** And was this ultimately the position: that if you had  
24 brought the whole caboodle of therapeutics within the  
25 remit of the VTF, you might have ended up dividing your

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1 So, yes, that was agreed to be part of our mandate,  
2 and as part of that, you've got two different types of  
3 antibody: you've got the prophylactic antibody, to treat  
4 the people who can't mount a vaccine response, but  
5 you've also got treatment antibodies. So they --  
6 they're different only, really, in how long they last.

7 **Q.** So Evusheld, for example, could be given  
8 prophylactically --

9 **A.** Yes, Evusheld --

10 **Q.** -- also by way of treatment?

11 **A.** Yes, so Evusheld was designed to have long-acting half  
12 life, so that it would -- could dose every six months or  
13 longer. The treatment antibodies would have a normal,  
14 short half life of a month or so.

15 **Q.** All right.

16 **A.** So that was different. But if we're going to do all the  
17 due diligence on it, we should do the diligence  
18 together.

19 **Q.** But those persons who are, sadly, immunosuppressed,  
20 nevertheless would also have benefited from other  
21 therapeutics made available, not just monoclonal  
22 antibodies, they might have benefited from small  
23 molecule drugs, from anti-inflammatory drugs. If you  
24 had taken on board the other types of therapeutics, in  
25 the ultimate -- to the ultimate benefit of those persons

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1 who can't take vaccines, might you not have been able to  
2 get to a better place to have ensured that therapeutics  
3 were made more widely available?

4 **A.** I think we would have done it more quickly, and we might  
5 have been more effective but we would then need to have  
6 probably expanded our team a little bit to do that.

7 **Q.** All right. In August of 2021, so in fact after you  
8 left, because I think you left the VTF in --

9 **A.** December.

10 **Q.** -- December 2020, Charlotte Taylor, who was then the  
11 acting director of the Antivirals Taskforce, noted in an  
12 email that she had been discussing with Sir Patrick  
13 Vallance, then the Government Chief Scientific Adviser,  
14 that there appeared to be a limited enthusiasm for  
15 prophylactic use across the system, across the  
16 government system, and there was considerable debate as  
17 to whether or not the government had gone awry in terms  
18 of not focusing sufficiently on developing and making  
19 available prophylactics.

20 Did you ever get the impression, during your time in  
21 the VTF, that the issue of prophylactic development was  
22 being left behind, being made to be a second-class  
23 citizen?

24 **A.** I absolutely felt that, yes, from late October 2020.

25 **Q.** Did you have any involvement in the appointment or the  
21

1 for the access of those vaccines.

2 **Q.** And what was the disadvantage?

3 **A.** Disadvantage was the conditions that the European  
4 Commission ultimately put. So the European Commission,  
5 as soon as they discovered that the -- France, Germany  
6 had approached us -- because I think it was just three  
7 to begin with -- each one of us had a major vaccine  
8 company or drug that was being developed, if you think  
9 AZ, Sanofi, and Germany ... BioNTech, we could have done  
10 a lot, but the European Commission said: no, everybody  
11 has to be together within the European Commission. And  
12 we were still part of Europe in 2020. But the  
13 disadvantage was that they said to the UK: because  
14 you're leaving, you can't have a seat at the table to  
15 agree which vaccines we're going to have. We'll tell  
16 you which you can have and when, and by the way, you  
17 have got to stop all the work you're doing now on  
18 vaccines.

19 So it wasn't very complicated.

20 **Q.** You'd already started negotiations. Essentially you  
21 wouldn't have been able to paddle your own vaccine's  
22 canoe thereafter, and you'd have had to --

23 **A.** Sit in the back.

24 **Q.** -- sit in the back and give way to the European position  
25 in terms of which European company was then going to be  
23

1 composition of the Therapeutics Taskforce?

2 **A.** No, one of my venture partners, Ruth McKernan, was on  
3 the Antivirals Taskforce, which ultimately merged in  
4 with the Therapeutics Taskforce, but that was late 2021.

5 **Q.** All right, thank you.

6 Another topic now, and we'll come back to the detail  
7 of some of those points in due course, but just by way  
8 of headline, in your statement you raise the issue of  
9 cooperation with the European Union, and because there  
10 was a considerable amount of debate about this topic,  
11 I want to ask you some questions about it.

12 In the early stages of 2020, was there a proposal at  
13 the European level that there be, I think, a European  
14 Medicines Agency taskforce comprising France,  
15 United Kingdom and Germany?

16 **A.** Yes, they called it the E3 alliance, initially, and then  
17 they expanded it.

18 **Q.** To include Italy, the Netherlands, and Norway, so it  
19 became the E6?

20 **A.** Probably more.

21 **Q.** As far as you saw it, what was the potential benefit of  
22 joining such a European or international taskforce?

23 **A.** The benefits would have been that we could have shared  
24 expertise, shared due diligence, and then used  
25 collective bargaining power to secure attractive rights  
22

1 pursued and how they'd be negotiated with?

2 **A.** Correct.

3 **Q.** All right.

4 **A.** But just to be clear, that was not a decision for me.

5 That was a political decision. They asked me what was  
6 my views and my views was it was worth exploring the E3  
7 until that no longer became an opportunity.

8 **Q.** But it was obviously the right call?

9 **A.** Yeah, for sure, if those were the conditions.

10 **Q.** On the general topic of vaccine procurement, how likely  
11 was it, at February 2020, that you would be able to  
12 identify and assist the development of, and negotiate  
13 with -- of a vaccine, and negotiate a successful  
14 contract with a vaccine manufacturer?

15 **A.** That was a question I asked at the expert advisory  
16 meeting in -- my first one, in April 2020. And the  
17 experts there said they thought that any vaccine  
18 candidate that was in clinical trials in 2020, already  
19 in clinical trials, had a 15% chance of success, and  
20 anything that had not yet even entered clinical trials  
21 would be less than 10%.

22 And over and above that, the leading vaccine  
23 candidates were mRNA and adeno-based vaccines. They had  
24 never been approved for any products ever, in any  
25 indication. So there'd been no regulatory success with  
24

1 those formats.

2 The quickest that a vaccine had ever been developed  
3 before was 5 years, with mumps, and that was 50 years  
4 ago, when the regulatory standards were much lower than  
5 they are now. And elderly, who were the most at risk  
6 from SARS Covid 2, mount a poor response, generally, to  
7 vaccines.

8 So if you take all of that as a whole, the chances  
9 of this succeeding was very low.

10 **Q.** Can I just seek to put some human flesh on the bones.

11 You referred very quickly to mRNA and adenoviral. The  
12 mRNA, is that the messenger RNA ribonucleic acid  
13 vaccines which in fact turned out to be the Pfizer and  
14 the Moderna, the Pfizer BioNTech and Moderna vaccines,  
15 and the adenoviral, is that the Oxford vector vaccine --

16 **A.** And J&J, Janssen.

17 **Q.** Janssen, but the AstraZeneca vaccine.

18 **A.** Correct.

19 **Q.** Could we have, please, INQ000506824, please, on the  
20 screen.

21 This is a presentation, dated 7 May, your initial  
22 thoughts. If we could just have a quick look at page 3,  
23 please, we will see that you describe the challenges as  
24 being "harder than Everest." "There is no vaccine for  
25 any coronavirus", full stop.

25

1 rate due to? Was that a reference to the likelihood,  
2 the very high likelihood, of the failure of an  
3 individual vaccine pursued?

4 **A.** Yes.

5 **Q.** Right. So you needed to try to pursue as many vaccines  
6 of as many different types as you could?

7 **A.** Not quite. I don't think, because I've seen some of the  
8 witness statements that say we had to pursue everything  
9 we possibly could, that's not right. We had to pursue  
10 the best and the most likely to succeed. That doesn't  
11 mean every one. So that what we originally thought --  
12 this, I might just remark is day 2, so I was called on  
13 6 May and this is a presentation on 7 May. So what we  
14 initially thought, and we were fingers in the air, we  
15 thought we might need 10 to 12 vaccine candidates in  
16 order to assume that one would succeed, based on that,  
17 you know, 10% likelihood of success.

18 But actually, when we did the work, and the due  
19 diligence, and we really got under the skin of the  
20 candidates that were out there, we realised, actually,  
21 we did not need as many vaccines as that to really cover  
22 our bases so that we had access to all the different  
23 formats and the different characteristics that we were  
24 seeking.

25 **Q.** So you sought the most promising vaccines representing

27

1 And had there been a vaccine developed for HIV, for  
2 example?

3 **A.** No -- well, unsuccessfully. And the importance point  
4 about coronaviruses, is we first knew about them  
5 10 years before, so we had SARS 1, and then we had MERS.  
6 So in actual fact, we had had a history of failure of  
7 developing vaccines against coronaviruses, but actually  
8 that was quite helpful because it had built up  
9 a capability and a knowledge of coronaviruses so that it  
10 was much quicker to then go and develop a vaccine the  
11 next time, and with HIV, it mutates so quickly that it  
12 has been proven to be very difficult to develop a  
13 vaccine against.

14 **Q.** So there had been considerable research and development  
15 done on both mRNA vaccines and the adenoviral vector  
16 technology and funding, a lot of funding had been pumped  
17 into the system for general research and development,  
18 had it not?

19 **A.** Yes.

20 **Q.** All right. But nothing had actually been produced in  
21 terms of being developed to authorisation stage?

22 **A.** Correct.

23 **Q.** Right. You refer in the middle of the page to needing  
24 multiple different shots on goal because of the very  
25 high attrition rate. What was the very high attrition

26

1 each of the four, by and large, different formats?

2 **A.** Exactly.

3 **Q.** The second thing you did was take the decision that you  
4 had to purchase at risk. What was that and why was that  
5 so important?

6 **A.** Because there was going to be very limited supply of  
7 vaccines, and these companies, many of which were small  
8 companies, had to scale up to population-scale  
9 quantities. Every country needed a vaccine to protect  
10 their vulnerable populations, and there was going to be  
11 an adequate supply. So what we had to do, the UK, but  
12 other countries around the world, was to put money up  
13 and help fund those vaccine companies to actually invest  
14 in the manufacturing, scale-up and bulk manufacturing,  
15 and also to run the clinical trials before we knew  
16 whether or not these vaccines would work.

17 Because if we only invest in manufacturing, after we  
18 knew the vaccine would work, you then had another year.  
19 So it's highly unusual that you'd be investing in  
20 manufacturing alongside clinical but in order to get the  
21 quickest possible vaccine to people, which was the PM's  
22 instruction, we did that parallel track.

23 **Q.** Was it important, before you even began to consider  
24 identifying a particular manufacturer, let alone  
25 negotiate a contract with them, to know what sort of

28

1 planning assumption you needed to apply in terms of how  
 2 many doses we're going to need as a country?  
 3 **A.** Yes. And so we went to the JCVI, the Joint Committee on  
 4 Vaccination and Immunisation, which is a statutory body  
 5 which advises the Department of Health, and the  
 6 Secretary of State in England is obliged to take their  
 7 advice. We first met them on 25 May, and at that point  
 8 their advice to us was "You have to vaccinate the  
 9 vulnerable" and their advice to us was the range of  
 10 vulnerable people were all adults over the age of 50 and  
 11 all adults under the age of 50 with severe underlying  
 12 disease and it corresponded to basically an enhanced flu  
 13 cohort and was about 30 million people -- 30-odd. So  
 14 that is the --  
 15 **Q.** That is the broad range --  
 16 **A.** That was the range, because my job was not to decide who  
 17 should be vaccinated. I need to find out from the  
 18 experts who they want to vaccinate, and then buy  
 19 vaccines for those people.  
 20 **Q.** With that planning assumption, and bearing in mind the  
 21 number of people it entailed, you wouldn't have been --  
 22 the United Kingdom wasn't the largest country on Earth  
 23 in terms of numbers with whom the manufacturers might  
 24 care to negotiate. What did you do to make the  
 25 United Kingdom as attractive a contractual partner as

29

1 controller. So instead of waiting until you've got all  
 2 your data ready and you've got your reports and your  
 3 submissions, with the Is dotted and Ts crossed, she  
 4 said, "Bring me the data as soon as you've got it. We  
 5 will look at it, we will review it. So at the endpoint  
 6 when you finally give us your last piece of clinical  
 7 efficacy data or manufacturing quality data, we'll be  
 8 ready to vaccinate."  
 9 And that, again, was a core offer from the UK. So  
 10 manufacturing, clinical trials, and regulatory, which is  
 11 what we then presented to the potential vaccine  
 12 companies and said, "This is the reason you should work  
 13 with us, because this is what we can offer you."  
 14 **Q.** And so we're absolutely clear, this entailed the  
 15 speeding up of the process by which the paperwork: the  
 16 data and safety information, was given to the MHRA, but  
 17 there was no diminution in its safety monitoring?  
 18 **A.** No.  
 19 **Q.** Or the way in which it looked at the data?  
 20 **A.** No. And if I could just give a statistic, the largest  
 21 ever vaccine trials that had been run anywhere in the  
 22 world were for the HPV vaccines, and they were  
 23 20,000 individuals that were vaccinated. The size of  
 24 the clinical trials that we're running for Covid  
 25 vaccines were between 40 and 50,000 people. So it

31

1 possible?  
 2 **A.** So we wanted to make ourselves basically the best  
 3 possible customer, because 30 million people in the UK  
 4 versus the European Union versus the US, we were tiny.  
 5 So we took a strategy of basically leveraging the  
 6 capabilities that we had. So this is a highly  
 7 collaborative manufacturing scale-up and manufacturing  
 8 industry, with capabilities, but without a lot of bulk  
 9 manufacturing capabilities. So that was one task, was  
 10 how can we turbo-boost what's already there? You can't  
 11 build stuff *de novo* in a pandemic but you can increase  
 12 what's already there.  
 13 So that was one aspect.  
 14 The second aspect was to really leverage the fact  
 15 that we have a phenomenal national health system that is  
 16 able to run -- NIHR, to run clinical trials at  
 17 a population scale with diversity. So that was the  
 18 second aspect.  
 19 And the third aspect was that we would work  
 20 collaboratively with them and with our regulator, which  
 21 is the MHRA, so that we could actually get vaccines  
 22 approved and regulated as soon as possible.  
 23 I might just call out June Raine as being a superb  
 24 vaccine regulator because she, in her own words, moved  
 25 the MHRA from being a policeman to an air traffic

30

1 was -- these vaccine trials were much, much larger than  
 2 any vaccine trial had ever been done before. And there  
 3 was additional requirements put in place, and you can  
 4 talk to June about this afterwards, is -- where  
 5 99.9 per cent of any adverse events from a vaccine would  
 6 happen within the first few days of dosing. And so then  
 7 the regulators put on an additional 30-day time period  
 8 to say: we will not receive or consider any vaccine  
 9 submission until we've actually had that additional  
 10 30-day time period, to be doubly sure that there is --  
 11 not only have we got the largest trials ever done but  
 12 we've also got that additional safety monitoring.  
 13 So there was no question that safety was taken  
 14 extremely seriously, and more seriously than any trial  
 15 has ever been done before.  
 16 **Q.** Can we just come back to the general topic of best  
 17 possible client, and the assistance that was given to  
 18 the manufacturing process, and to the course of  
 19 identifying and developing vaccines, by the involvement  
 20 in the trial process.  
 21 Do manufacturers exclusively conduct the trials  
 22 themselves, or do they extract from trials conducted by  
 23 the biosciences industry, by government, by the NHS, by  
 24 a number of these funding bodies, the data that they  
 25 need for the purposes of verifying their vaccines?

32



1 A. No. The -- each vaccine company has to run their own  
 2 clinical trials. They cannot rely on third-party data.  
 3 So they are responsible. They are the sponsor to  
 4 develop and generate the data to show the vaccines are  
 5 both safe and effective --

6 Q. Do they get the participants or does this entire system  
 7 rest upon making members of the public making themselves  
 8 available by way of, I don't know, vaccine registries,  
 9 to participate in the trials?

10 A. Yes. So we -- that was something else we put in place,  
 11 was a national vaccine registry on the NHS website. So  
 12 anybody could sign up and say, "I consent to being  
 13 contacted about clinical trials". So there's a legal  
 14 requirement to give consent to be contacted. That's  
 15 different from enrolling in the clinical trials, but at  
 16 least they can be contacted.

17 So that was -- part of our using the national NHS  
 18 infrastructure was so we could actually provide those  
 19 patients -- sorry, not patients, volunteers -- to take  
 20 part in those trials.

21 Q. But much of the structure is funded through bodies such  
 22 as the UKRI and NIHR, a lot of the research and  
 23 development is funded, of course, by these funding  
 24 bodies, so it's not just a question of the manufacturers  
 25 taking members of the public and conducting, within

33

1 place statutory protection against liability.

2 We discussed that internally, and that was not  
 3 a starter. It was not something the government would  
 4 consider. The government would consider, however,  
 5 negotiating indemnities on a case-by-case basis.  
 6 Clearly, when I first raised it, there was disbelief  
 7 that I'd even ask the question, but it was quite clear,  
 8 because we made it clear, that if we did not offer  
 9 indemnities we would not be receiving or procuring any  
 10 vaccines. And the ultimate approach to securing the  
 11 government's worry about liabilities is not to give the  
 12 vaccine, if they were concerned about harm, but they  
 13 would have to sign indemnities if they wanted to  
 14 actually secure any vaccine at all.

15 Q. Which they then negotiated on a case-by-case basis.  
 16 They didn't provide a statutory --

17 A. Correct.

18 Q. -- immunity, which would have meant that no manufacturer  
 19 would even be liable in court for damages. And the way  
 20 the government went about it, is this right, was to  
 21 agree that manufacturers could still be sued, mainly  
 22 under the Consumer Protection Act, but in the event that  
 23 a court awarded damages against them, in certain  
 24 circumstances, the government would pick up the tab?

25 A. (No audible response)

35

1 their exclusive jurisdiction, all these trials and the  
 2 research and development, there's a very strong and  
 3 notable government input --

4 A. For sure, so the government funding for underlying  
 5 research was critical. So we would not have had  
 6 Sarah Gilbert's vaccine without the R&D funding. That  
 7 is correct. We couldn't have run the trials without the  
 8 NIHR infrastructure and their capability to do that. We  
 9 provided the volunteers, or, in many cases, provided the  
 10 volunteers through the registry. But it's not as if  
 11 you're taking data from other people. There has to be  
 12 a single sponsor of the trial that leverages all those  
 13 capabilities.

14 Q. Right. And another aspect in which the United Kingdom  
 15 endeavoured to put itself into the position of being the  
 16 best possible client was to agree a mutually acceptable  
 17 position on indemnities. Was that something that the  
 18 VTF was directly concerned with, or was that a matter  
 19 for the civil servants in government --

20 A. No, it --

21 Q. -- or ministers?

22 A. So in the US they have -- the US Government offers  
 23 statutory protection to vaccine and therapeutic  
 24 suppliers in a pandemic and it's called the US PREP Act.  
 25 So every vaccine company we spoke to asked us to put in

34

1 Q. Do you consider either that untoward pressure was put on  
 2 the United Kingdom to agree indemnities or that what was  
 3 agreed was overly generous to manufacturers?

4 A. I'm not in the detail.

5 Q. The business case. So from your witness statement and  
 6 your book, it is obvious, Dame Kate, that in the course  
 7 of the VTF's activities, the VTF was required, certainly  
 8 initially, to battle with the Treasury over the funding  
 9 for the prospective vaccine purchases. Presumably you  
 10 would agree that, as with any expenditure of public  
 11 money, a body intending to spend such vast sums of money  
 12 has to attempt to quantify what it's likely to spend and  
 13 try to measure that against the prospective benefit of  
 14 what it's trying to do?

15 A. I agree, and as a venture capitalist, of course all my  
 16 companies have to produce budgets against which I then  
 17 assess them.

18 Q. But in July 2020 particularly, from the emails that  
 19 we've seen, you were of the view that the departmental  
 20 structure and the need to battle with the iron fist of  
 21 the Treasury was slowing you down, you said -- you  
 22 raised concern about the speed of approvals across  
 23 government, and you pushed for a pot of money -- those  
 24 aren't your words, they're the words of a civil  
 25 servant -- to be delegated so the process could be sped

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1 up. Was that you endeavouring to try to get advance  
2 agreement by way of a spending envelope that you could  
3 spend up to a cap on the purchase of vaccines, without  
4 having to seek from the Treasury each time particular  
5 approval?  
6 **A.** Correct, but I might just comment that --  
7 **Q.** Please.  
8 **A.** -- I wasn't seeking to spend it myself. So the decision  
9 on spending came from ministers, but we would recommend  
10 it. But you're correct that we didn't want to have to  
11 go to the Treasury every time we wanted to make a -- put  
12 forward a business case because I think we had 30  
13 business cases.  
14 **Q.** Quite. And each time you'd have had to write it all up,  
15 and no doubt at great length, and taking time and  
16 energy, and that was obviously not a profitable way of  
17 proceeding?  
18 **A.** Well, we did the business cases for all 30 anyway. And  
19 I might just, again, so you know, we had a strategic  
20 case, an economic case, a commercial case, a financial  
21 case, a management case, all of which was repetitive.  
22 No science case, which is fundamentally the most  
23 important thing. We had to define what a minimum  
24 benefit was and in our business case our minimum benefit  
25 went between 10 and £200 billion, because it was all so

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1 Cat Little to you:  
2 "Thanks to you and your colleagues for attending the  
3 TAP [that's the Treasury Approval Panel] meeting. It  
4 was ... extremely useful ..."  
5 Got a better sense of what you are seeking, will  
6 issue formal minutes in due course.  
7 Then she identifies three broad areas: we agree we  
8 need to explore further.  
9 Then over the page, they are to do with how the bid  
10 breaks down, your resourcing and capability plans and  
11 governance and controls.  
12 If we go back to page 3 we can see your response:  
13 "Dear Cat, I am very disappointed in this response.  
14 We don't seem to have made any progress ... we requested  
15 a meeting with you at the beginning of July ..."  
16 You then refer to the fact you raised with the  
17 Prime Minister the fact that the biggest risk facing the  
18 taskforce was the government itself and they're very  
19 slow, its very slow processes, and how shocked he was.  
20 "We have not received any money even for day-to-day  
21 working, nor have we succeeded in speeding up government  
22 processes -- with the happy exception of the  
23 BioNTech/Pfizer binding term sheet."  
24 Then if we go to page 2, we can see she's  
25 disappointed that you're disappointed as to how you

39

1 subjective.  
2 So my problem was the structure was completely rigid  
3 and not fit for purpose and didn't actually address the  
4 important things that we needed to be discussing when it  
5 came to vaccines --  
6 **Q.** But you've referred there to the absence of a science  
7 case.  
8 **A.** The business, the Whitehall business case.  
9 **Q.** But in the context of having to get permission to spend  
10 vast sums of money, there would have to be of course --  
11 **A.** There has to be something.  
12 **Q.** -- a business case --  
13 **A.** But we submitted a business case to BEIS in June. We  
14 did not get an approval from the Treasury until  
15 11 September.  
16 **Q.** And was that the delay to which these emails refer in  
17 July, the absence of an answer from HMT?  
18 **A.** There was plenty of -- there was lots of responses but  
19 just endless questions.  
20 **Q.** Could we look, please, at INQ000420792, which is the  
21 exchange between yourself and Cat Little of the Treasury  
22 from whom we heard a couple of days ago.  
23 Can we start on page 3. If we just scroll back out,  
24 is that page 3 as opposed to page 4? Yes, it is. Right  
25 at the bottom of the page, we can see an email from

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1 feel. There's no decision that slowed you down. Most  
2 of our approvals mentioned have been delivered within 24  
3 to 48 hours, but they too are keen to bust through  
4 barriers.  
5 And then page 1. You say at the bottom:  
6 "The issue isn't just Treasury but Cabinet Office  
7 and commercial controls ..."  
8 And you agree subsequently to meet.  
9 By and large, strategically, the problem was  
10 resolved because a ministerial panel was set up, I think  
11 it started on 27 August 2020, and it was empowered to  
12 make decisions over any expenditure over £150 million.  
13 So the VTF had delegated authority for sums less than  
14 that, but the ministerial panel took the decision for  
15 sums over that. Did that panel work and did it address  
16 the problems which you have so pithily identified?  
17 **A.** Yes, it was fantastic.  
18 **Q.** And who was on the panel?  
19 **A.** We had four ministers. So we had the Secretaries of  
20 State for Business, Cabinet, Treasury and then Lord  
21 Agnew from the Cabinet Office. So Business, Health,  
22 Treasury and then Lord Agnew from the Cabinet Office.  
23 **Q.** So it was a combination of departmental spending  
24 ministers as well as the Treasury --  
25 **A.** Oversight.

40

- 1 **Q.** -- brought together by way of an oversight structure.  
 2 You must have often reflected as to why that couldn't be  
 3 put into place across the whole of government?  
 4 **A.** I think it should be. I mean it is manifestly a better  
 5 way to make decisions, rather than sequential, and then  
 6 keep having to go back. What I did find is there are an  
 7 awful lot of people who want to be engaged, who are  
 8 unqualified and yet feel qualified to intervene. And  
 9 the more you enable that to happen, the slower things  
 10 are going to be, whereas if you basically say, no, it's  
 11 a single business case, it goes to the ministers, and  
 12 they have to make a decision, they can't prevaricate,  
 13 they have to make a decision, yes or no, and that  
 14 worked.  
 15 **Q.** We don't, I think, need to explore the actual  
 16 negotiations with each of the manufacturers, but it was  
 17 obviously a protracted and difficult process. But it  
 18 worked. And of course, a number of contracts were  
 19 agreed, I think probably by way of binding terms or  
 20 heads of agreement being agreed and then the minutiae  
 21 and the detail of it being negotiated and then final  
 22 contracts being reached for advance purchase.  
 23 **A.** Correct. So we -- Clive would basically shape out the  
 24 scope of what we were seeking to procure from each  
 25 vaccine company, and we'd draw up a non-binding heads of

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1 So it's a very awkward relationship between  
 2 government and the industry, and there is no -- there is  
 3 just deep suspicion. And I was told this time and time  
 4 again: what are you personally going to get out of this?

5 And people are not doing things -- I was working for  
 6 free. People are not doing this in order to -- for  
 7 self-gain; they are doing this because they're in an  
 8 industry where we are trying to develop drugs for  
 9 patients who have diseases that are poorly treated.

10 And it is not -- it's not an industry where it's  
 11 knives out and winner takes all. This is an industry  
 12 which is a supportive and creative and innovative and  
 13 highly risky industry. As we talked about, 90% of all  
 14 drugs that go into clinical trials will fail. So  
 15 that -- this is not an easy industry to work in. And  
 16 yet --

17 **Q.** And AstraZeneca --

18 **A.** AstraZeneca had stepped up. They weren't a vaccine  
 19 company.

20 **Q.** And did it make its vaccine available at cost or did  
 21 they charge --

22 **A.** They made their vaccine available at cost. And also,  
 23 not only -- not only being a vaccine company, they  
 24 managed to secure licence agreements around the world.  
 25 So they had something like 15 or 20 different CDMOs

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1 terms, which we then announced in July and August. And  
 2 then Maddy and her team would then turn those heads of  
 3 terms into formal legal contracts.

4 **Q.** Just picking up some of the most notable issues that  
 5 arose in the course of the negotiations, with  
 6 AstraZeneca, obviously a UK company, which was prepared  
 7 to sell the vaccines at cost, and was probably overall  
 8 the largest single supplier of vaccines globally, once  
 9 you'd left the VTF, did you keep an eye on the nature of  
 10 the relationship between AstraZeneca and government?

11 **A.** Yes, because I'm in the industry, I talk to pharma  
 12 companies all the time.

13 **Q.** And did you gain the impression, or the view, that  
 14 despite the success of that contract and the delivery of  
 15 the AstraZeneca vaccine, the relationship between the  
 16 UK Government and AstraZeneca didn't end in a happy  
 17 place?

18 **A.** I don't think relationships stop and end, but we had the  
 19 opportunity to -- the UK had the opportunity to increase  
 20 production, both with AZ in Liverpool as well as GSK in  
 21 Barnard Castle. Neither of those discussions ended up  
 22 with any funding, collaboration, partnership. Since --  
 23 then there was a later agreement with AZ, which,  
 24 according to the papers yesterday, has now hit buffers  
 25 again.

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1 manufacturing their licence -- their vaccine, in all the  
 2 different countries around the world so that all those  
 3 people who are vulnerable could have access to vaccines.  
 4 And they did so very cheaply, at cost.

5 **Q.** In terms of building up resilience and making sure that,  
 6 in the face of the next pandemic, there is a robust and  
 7 healthy onshore manufacturing capability -- and we'll  
 8 come back to this later -- is it important that these  
 9 relationships are nurtured and protected?

10 **A.** Yes.

11 **Q.** All right. Moderna. Moderna -- is it right that since  
 12 the pandemic, the UK Government has entered into  
 13 a strategic partnership with Moderna, and I think is  
 14 investing in the construction or -- the construction of  
 15 a manufacturing site, and has a number of agreements  
 16 with it to provide for sleeping contracts for future  
 17 production of vaccines?

18 **A.** So I'm not involved so I don't know the detail of the  
 19 Moderna contract, but yes, a big Moderna relationship  
 20 has been set up.

21 **Q.** All right. In relation to Pfizer BioNTech, which is in  
 22 part a US company, did the VTF encounter significant  
 23 difficulties on account of the US Government planning to  
 24 invoke the US Defense Production Act to requisition all  
 25 US domestic supplies of that vaccine?

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1 **A.** There was a threat of that, yes, in July, just before we  
 2 were about to announce the heads of terms with  
 3 Pfizer BioNTech, and we were told by the White House  
 4 that they were going to use the US defence act to  
 5 requisition that.  
 6 We had -- we then agreed with Pfizer and BioNTech  
 7 that if we agreed to binding language on indemnities,  
 8 that they would then go back to the White House and say  
 9 that, no, the UK had already signed up and therefore  
 10 they weren't willing to comply, which is what we did.  
 11 And within 24 hours we came back with binding indemnity  
 12 language. And we then announced the contract and we  
 13 then secured, as you know, the vaccines, and we were the  
 14 first to get them approved and we were the first to  
 15 dose.  
 16 **Q.** And I think 40 million doses was the original --  
 17 **A.** Yes, which was the -- all we could get.  
 18 **Q.** But to make it absolutely plain, notwithstanding the  
 19 high stakes contractual poker play, the fact is that the  
 20 indemnities that were agreed in relation to  
 21 Pfizer BioNTech were not out of kilter with or any  
 22 different to the approach on indemnities which had been  
 23 applied to the --  
 24 **A.** No, it was -- all -- we had to offer indemnities to all  
 25 the vaccine companies, as did every other country.

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1 was part, right at the beginning. And so we initially  
 2 signed a heads of terms or a letter of intent, but  
 3 non-binding, with AZ for a million doses of their  
 4 long-acting antibody cocktail -- so this was expected to  
 5 have a six-month therapeutic effect -- right at the  
 6 beginning.  
 7 **Q.** And it needs to be injected?  
 8 **A.** No. It's an intra-muscular injection, so it's like all  
 9 the Covid vaccines, it's like all the trials --  
 10 **Q.** It is injected?  
 11 **A.** It is injected -- sorry, not intravenous.  
 12 **Q.** Right.  
 13 **A.** Sorry, that's my fault. Most antibodies would be  
 14 delivered intravenously, as in through a catheter into  
 15 the blood. This was unusual because it was both  
 16 engineered to have a 6-month half life as well as to be  
 17 delivered through -- intramuscularly.  
 18 **Q.** Was the provisional agreement to the effect that  
 19 1 million doses would be purchased because that would  
 20 provide one dose of two antibodies for what was assessed  
 21 to be the 500,000 or so immunocompromised people?  
 22 **A.** Yes. So, again, that -- the numbers of  
 23 immunocompromised people were data that had come from  
 24 the Department of Health and that was their estimate.  
 25 So our thoughts were: you either dose those

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1 **Q.** Right.  
 2 Coming now to the topic of antibody cocktails. Is  
 3 this the position: that, as you say in your book,  
 4 Clive Dix, your deputy, led the due diligence relating  
 5 to the recommendations that were made by the VTF as to  
 6 what antibody cocktails should be trialled and pursued.  
 7 And was it the result of the VTF's work on this that the  
 8 Ronapreve antibody cocktail, which I think is  
 9 casirivimab and imdevimab, was pursued.  
 10 **A.** Correct. That's the Regeneron cocktail.  
 11 **Q.** The Regeneron cocktail. And --  
 12 **A.** And for therapeutic use. So for people who have been  
 13 infected by SARS-CoV-2 and then it's used to then treat  
 14 them, to give them an additional immune response.  
 15 **Q.** And what position did the VTF reach in relation to the  
 16 alternative prophylactic candidate, which was  
 17 Project Astronaut, Evusheld? When did the VTF first  
 18 become aware of the potential of that prophylactic  
 19 candidate?  
 20 **A.** In May 2020. We knew about it immediately. Because,  
 21 again, the BIA, the BioIndustry Association, had been  
 22 working to basically try and set up standardised assays  
 23 to assess all potential Covid antibodies, no matter  
 24 where they came from: academia, industry, small, big  
 25 companies. So we were aware of that work, of which AZ

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1 immunocompromised people and you cover them for  
 2 12 months, so two 6-month doses; or, as we thought at  
 3 the time, the SARS-CoV-2 might be a winter virus, in  
 4 which case you would cover them for two winters.  
 5 We didn't know at that time, but we thought that two  
 6 doses was at least enough to secure an order until we  
 7 knew more about how the virus was going to work.  
 8 **Q.** On 26 October your director general, Nick Elliott, wrote  
 9 to the CMO, Professor Sir Chris Whitty and Clara Swinson  
 10 of the DHSC and others seeking confirmation on the exact  
 11 number of immunocompromised patients on whom Evusheld or  
 12 to whom Evusheld might be deployed?  
 13 **A.** Yes. And the reason for that was AZ had come back to us  
 14 after we had said we wanted a million doses to do our --  
 15 to cover our immunocompromised population. They then  
 16 came back and said the most they could manufacture or  
 17 have manufactured was 2.5 million doses for the world,  
 18 and therefore the UK couldn't have a million, and we  
 19 needed to be scaled back. And so our -- that letter  
 20 from Nick was to say: well, we can't get a million  
 21 because that's not reasonable. What is the minimum  
 22 amount that we would want for the UK which would be  
 23 consistent with AZ making their antibody available more  
 24 broadly globally?  
 25 **Q.** Now, after this was then debated within the Office of

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1 the Chief Medical Officer, on 11 December,  
 2 Sir Chris Whitty wrote back to Nick Elliott saying, in  
 3 essence, that he couldn't recommend buying a large  
 4 amount now because of the changed landscape, but he said  
 5 that if there was a political appetite to buy, he would  
 6 suggest around 50,000 doses only. At then in February,  
 7 as it happens, there was further advice sought from the  
 8 Office of the Chief Medical Officer, and Professor Sir  
 9 Jonathan Van-Tam emailed saying that the steer from the  
 10 CMO remains 50,000 doses, and ultimately the decision  
 11 was made that there wouldn't be an advance purchase of  
 12 the prophylactic Evusheld.

13 By the time you left in December 2020, were you  
 14 aware of the way in which the wind was blowing in terms  
 15 of whether the government would pursue Evusheld?

16 **A.** Yes, I was. And I felt very strongly that we were  
 17 conducting a strategy that was not following the  
 18 Prime Minister's goals. So we were following or we, the  
 19 government, was following a very clear two-tiered  
 20 strategy where the clinically vulnerable  
 21 immunocompromised patients were being deprioritised in  
 22 favour of those who were able to receive vaccines, and  
 23 I felt that was manifestly wrong, both ethically and  
 24 morally, but also, it did not follow the goals that we'd  
 25 been set, which was to protect the entire population.

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1 are developing a new drug you don't have the data to  
 2 show an 18-month shelf life because you haven't been  
 3 developing it long enough to have that stability data.

4 So there was a catalogue of reasons which I don't  
 5 think, I'm afraid, any are sound in reasons for why the  
 6 clinically vulnerable immunocompromised patients in the  
 7 UK were deprioritised versus those who could receive  
 8 vaccine.

9 **Q.** I think it's important that I put to you that the letter  
 10 from Professor Sir Chris Whitty of 11 December, which  
 11 I know you've been provided a copy of, didn't make any  
 12 reference to cost and I think Sir Chris Whitty would  
 13 say, if we were to ask him this question directly, that  
 14 that was within the reach of the Office of the Chief  
 15 Medical Officer. Cost wasn't for him. And he makes no  
 16 reference to cost. What he says is there's a different  
 17 context now because of the vaccine rollout. By  
 18 December 2020, there is the prospect of the vaccine  
 19 programme succeeding, and therefore the context had  
 20 changed, and it remained difficult to assess against  
 21 that context what the ultimate benefit of Evusheld  
 22 would be.

23 So it wasn't, from the Office of the Chief Medical  
 24 Officer a costs issue. They were relying upon other  
 25 epidemiological and clinical issues.

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1 And you've kindly shared witness statements that  
 2 I have read, and I'm afraid to say the witness  
 3 statements clearly show that there was zero appetite in  
 4 the Department of Health to actually consider how these  
 5 patients would be treated. So the evidence is that it  
 6 was cheaper to let these clinically vulnerable  
 7 individuals, who were already shielding, to stay  
 8 shielding at home, and then if they were to be infected,  
 9 then they would be treated with drugs, but there was no  
 10 appetite, because of cost, to actually buy vaccine --  
 11 buy the therapeutics now.

12 Now, again, that is at odds with the way we did our  
 13 commercial contracts with vaccines. So in the case of  
 14 vaccines, we, of course, didn't know which, if any, of  
 15 these vaccines would work. So we provided some money  
 16 upfront to help with the manufacturing scale-up, and  
 17 with the clinical development. Then, if the vaccine  
 18 actually showed it was effective, then that was another  
 19 milestone and we made another milestone payment. Then,  
 20 when, you know, whatever doses had been agreed, was  
 21 delivered, we made another milestone payment. So you  
 22 don't have to pay all the money upfront.

23 There was a comment in one of the statements about  
 24 shelf life, and they couldn't accommodate the shelf  
 25 life. Well, that is wrong, because of course, when you

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1 **A.** Well, I'm reading one of the statements that says,  
 2 "I consider costs, including cost effectiveness and  
 3 practicality considerations, to be entirely rational  
 4 factors when making decisions on neutralising antibody  
 5 procurement."

6 **Q.** And whose statement is that?

7 **A.** JVT's.

8 **Q.** That's JVT's, right. So that's --

9 **A.** So cost clearly played a role.

10 **Q.** Right.

11 **A.** No question on that. And the fact that the vaccine  
 12 rollout had been effective doesn't stop people without  
 13 an immune system getting infected. And the idea that  
 14 you take your most clinically vulnerable and say, well,  
 15 don't worry, you're going in for a bone marrow  
 16 transplant to treat your leukaemia but, you know, coming  
 17 into hospital, if you get infected with Covid, don't  
 18 worry, we'll treat you, rather than saying: you know  
 19 what, you're in a very clinically vulnerable time of  
 20 your life, let's give you all the help we can before you  
 21 go in for this traumatic procedure.

22 **Q.** The issue of whether or not to pursue monoclonal  
 23 antibodies was, as you've said, a matter for the VTF.  
 24 It was within your reach. Ultimately, the decision on  
 25 not to pursue an advance purchase was therefore one that

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1 would have been subject of a recommendation from the  
 2 VTF. You rightly pointed out earlier that, ultimately,  
 3 decisions are for ministers.  
 4 Before you left in December 2020, were you aware of  
 5 what the VTF itself would recommend?  
 6 **A.** Yes, and of the VTF was strongly supportive.  
 7 **Q.** Of purchasing Evusheld in advance?  
 8 **A.** As a tool to manage those individuals that otherwise we  
 9 were not managing.  
 10 **Q.** Did you happen to see, or was it brought to your  
 11 attention, that Professor Sir Chris Whitty had written  
 12 expressing the views of the Office of the Chief Medical  
 13 Officer --  
 14 **A.** I hadn't seen the letter but I understood -- and I spoke  
 15 to Chris and I understood the arguments. Well, I heard  
 16 the arguments. I didn't agree with them.  
 17 **Q.** And no doubt, in your inimitable way, you would have  
 18 pushed back against those arguments?  
 19 **A.** So my job was not to tell the Chief Medical Officer how  
 20 to manage public health in the UK. My job was to make  
 21 vaccines and prophylactic treatments available for use  
 22 and for deployment. If they choose not to deploy, that  
 23 is not for me to influence; I just think it was the  
 24 wrong decision. And I think it is symptomatic of  
 25 business as usual in Whitehall, as opposed to what the  
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1 with the government. And I think it's probably  
 2 important that I emphasise through you that of course  
 3 a great deal of what government does is extremely good  
 4 and very effective. However, the first recommendation  
 5 that you make is this:  
 6 "Reward outcome not process."  
 7 And you talk about the need to ensure that Whitehall  
 8 is refocused on outcomes not procedures, that  
 9 outperformers need to be promoted and underperformers  
 10 released, stop rapid rotation of staff, promote  
 11 specialist science skills, mandate training for  
 12 ministers, seek robust references on past performance,  
 13 and recalibrate, in essence, the thinking of government  
 14 officials.  
 15 **A.** Completely agree that those are critical for Whitehall.  
 16 So I faced working with, not my -- my steering group was  
 17 excellent and they were hand picked and they did a great  
 18 job, but I spent so much time basically battling incoming  
 19 questions, enquiries, having to educate officials. It  
 20 was obstructive, in many cases. And I might say that  
 21 the National Audit Office doing a 5-month audit during  
 22 my 6-month tenure is completely ridiculous, but it is --  
 23 **Q.** We can't go there --  
 24 **A.** I know, but it's all the mentality --  
 25 **Q.** -- for reasons of parliamentary privilege --  
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1 Vaccine Taskforce was, which was to deliver some very  
 2 clear goals.  
 3 **MR KEITH:** My Lady, is that a convenient moment? There is  
 4 only one topic to go.  
 5 **LADY HALLETT:** We take regular breaks for everyone's sake  
 6 but also the stenographer's sake, so I shall return  
 7 at 11.30. Thank you.  
 8 **THE WITNESS:** Thank you.  
 9 (11.44 am)  
 10 (A short break)  
 11 (11.30 am)  
 12 **LADY HALLETT:** Mr Keith.  
 13 **MR KEITH:** Dame Kate, in part deference to the assistance  
 14 you've given the tribunal, we're now going to plug your  
 15 book, *The Long Shot*, and have a look at it.  
 16 It's INQ000474735.  
 17 You take the opportunity in your book, this is  
 18 page 21, to make recommendations for improvements in the  
 19 future. And this section of your book focuses on the  
 20 recommendations you make in respect of government, about  
 21 which you've said a few things already.  
 22 And I want to, please, spend a little time, not too  
 23 much, on these five recommendations, on account of your  
 24 almost unique position as the chair of the Vaccine  
 25 Taskforce, and engaging, of course, very, very closely  
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1 **A.** It's going to -- it's in my book and it's in my witness  
 2 statement, and everybody should read the letter.  
 3 But it reinforces this whole box-checking view of  
 4 the world, which is: we can't be criticised if we follow  
 5 all these boxes.  
 6 So I'll give you an example. Patrick Vallance had  
 7 to stop Whitehall from investing in a chicken egg  
 8 manufacturing plant, because that is the way that  
 9 vaccines always used to be made: with lots and lots of  
 10 people injecting chicken eggs and that's how you get  
 11 vaccines. And he had to say: well, have you actually  
 12 heard about recombinant techniques? Which is the modern  
 13 day of making vaccines.  
 14 And so what happens is you've basically got this  
 15 groupthink, and we saw it with mRNA, and it's: at last  
 16 we've got a vaccine, we now can basically ignore  
 17 everything else we've done! We ignore the fact that we  
 18 need a breadth of vaccine formats. And in fact even the  
 19 JCVI now has had to formally put it in their  
 20 recommendations that they want to have a protein-based  
 21 vaccine because government, at the moment, is going down  
 22 a very narrow, "We've got mRNA, and this is all we ever  
 23 need forever". And that is not true.  
 24 And this is the problem: you've just got people that  
 25 don't understand what it is we're doing, they have  
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1 hostile relationships with industry, they distrust them.  
2 And again, read my witness statement and the book to see  
3 how they behaved with Valneva and Novavax --

4 **Q.** I don't want to go into any of the detail of any  
5 individual --

6 **A.** I'm not going to go into the detail, I'm just  
7 encouraging everybody, if they want to see a good story,  
8 look at the SEC filings, because that will tell how our  
9 government has behaved.

10 **Q.** No, Dame Kate, I'm afraid you're in danger of doing what  
11 some of your predecessors have done, of a more political  
12 hue; you have to answer the questions, please, not go  
13 off in other directions.

14 Much of what you say under this heading, "Reward  
15 outcome not process" appears to focus on performance,  
16 because you refer to ridding the system of  
17 underperformers and promoting outperformers and stop  
18 rapid rotation and reward the skillful.

19 Do you think there is a general problem in terms of  
20 there not being any absence of good faith, but because  
21 many of the politicians and officials you dealt with  
22 were generalists rather than specialists, in particular  
23 STEM graduates or STEM trained.

24 **A.** You are quite right. So this was an observation I made  
25 immediately having joined BEIS, and actually, I spoke to

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1 Service --

2 **Q.** Do more and write less?

3 **A.** Do what Whitehall calls "delivery". So get out into the  
4 front line, spend some time in industry, do something  
5 that is not what they regard as the most important part,  
6 which is policy writing, and do something that is  
7 achieving something that is for the common good.

8 And it's not that they're not good natured and it's  
9 not that they're not hardworking and well meaning,  
10 because I think they are all of those things; they're  
11 just ill-equipped for the 21st century  
12 technologically-driven society in which we operate.

13 **Q.** Is that why, in essence, if we look at page 23, you  
14 refer to the need to embed scientific thinking and  
15 science in policy making, just like economics, and you  
16 refer to the need for scientific thinking to be at the  
17 forefront of what, in particular, BEIS does. And then  
18 at the time --

19 **A.** Not just BEIS! Across government!

20 **Q.** Then at the bottom of the page, you go as far as  
21 suggesting a complete overhaul of the recruitment,  
22 professional development and incentives for civil  
23 servants.

24 And by that, if we go over the page, did you have in  
25 mind, or do you express views on turnover, having

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1 the head of recruiting or HR at BEIS pretty quickly and  
2 said, "You don't have -- this the business department  
3 and industrial strategy. You have nobody with any  
4 business skills and you've got nobody with any  
5 understanding of the industry in which we're operating.  
6 And how does that work?" And they've all got humanities  
7 degrees with an economics masters and none of them have  
8 any relevant expertise.

9 So -- and if you look at the stats, 90% of Whitehall  
10 have humanities backgrounds so only 10% are STEM, and if  
11 you have a PhD in the Civil Service, you hide it under  
12 a bushel, because as soon as you're discovered to be  
13 a scientist, then you're a wonk and you're put in the  
14 corner and never allowed to do anything.

15 And more importantly, no one has ever done anything,  
16 so they're all busy writing policy papers and sending  
17 each other, you know, stuff to review and all that.

18 None of that actually gets to the heart of what it is  
19 they're trying to do. What are they trying to achieve,  
20 and are they measured against the delivery of their  
21 goals? And the answer is no. In the private sector,  
22 you don't deliver your goals, you're out of a job and  
23 you have to move on. And in the private sector you get  
24 referenced, and if you don't perform people know about  
25 that. That is not the way it works in the Civil

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1 a slower turnover and less rotation. You say something  
2 quite pithy, I think, about firing people dealing with  
3 communications --

4 **A.** All of them!

5 **Q.** -- engagement.

6 Well, I don't think we can go, probably, that far,  
7 Dame Kate, but you express some pretty trenchant views  
8 on the need to ensure that government officials have  
9 a better trained, a better analytical, a better  
10 statistical and science-based approach to what they do.

11 **A.** And what it is that they're trying to achieve. So when  
12 I'm getting emails from BEIS communications saying,  
13 "We've approved you to do a speech to GAVI", which had  
14 already been pre-recorded and delivered two days  
15 earlier, you're kind of thinking, what world are you on?  
16 Because this has already been done. They're just not  
17 thinking. They're not engaged in what are you trying to  
18 achieve. And --

19 **Q.** And --

20 **A.** Yes.

21 **Q.** Sorry, please go on. And at page 24, and at perhaps  
22 a more granular level you suggest -- and this is in fact  
23 something which is one of my Lady's recommendations in  
24 the Module 1 report, so I think we might have beaten you  
25 to it from today's vantage point, "Appoint a senior and

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1 permanent pandemic security capability", and then on  
2 page 25, "Agree a strong international approach to  
3 vaccine research and development", we've already  
4 discussed.

5 **A.** Can I just make a point on that, please?

6 **Q.** Please.

7 **A.** The whole idea of manufacturing and capability in the  
8 UK, the government's view, it's all about, you know,  
9 have we made investments and are we doing the right  
10 thing? And they're the missing the point that factories  
11 are basically people who know what they're doing, they  
12 are doing it, they're doing it repeatedly at scale.  
13 It's not about the building; it's about the people and  
14 what it is they are doing and delivering. And we cannot  
15 be in a position where we can say, well, look we've got  
16 all these shiny new buildings but without somebody with  
17 a plan and somebody saying, "This is what we want you to  
18 do, and this is how we're going to assess you and  
19 measure you." And there is no capability in government  
20 doing that.

21 And again, I heard the witnesses on -- from UKHSA,  
22 it is business as usual, procurement, government  
23 bureaucracy. It is not strategic planning to make sure  
24 that we are better set up for the future.

25 **Q.** On that topic, there was in December 2020

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1 very effective at controlling serious disease and death  
2 but they don't block transmission. They're not durable.  
3 They're expensive. You've got cold chains. You've got  
4 endless -- they are specific, they're not broad. So  
5 there's lots of things that we need to do to improve and  
6 there's no coherence in how we are actually going to  
7 delivery those improved provides.

8 And yes, you need to have somebody with an external  
9 viewpoint, not a bureaucratic mindset, to say what does  
10 the contract say and now let's enforce you. This is  
11 not, you know, buying generics, it is being innovative,  
12 creative and collaborative.

13 **LADY HALLETT:** Forgive my interrupting, Mr Keith.

14 Supposing you had a government that was reluctant to  
15 set up another body, like an independent vaccine agency,  
16 what arguments would you put forward to persuade the  
17 government that it was absolutely essential?

18 **A.** If you were able to recruit the right people into UKHSA  
19 it's possible that might work but then you lose all the  
20 commercial capability. So the problem is you've got  
21 this conflict between the commercial side and the  
22 clinical side, and we've seen it in the testimony. The  
23 clinical side is all about: how do we not generate  
24 precedent, we don't want to spend money and, you know,  
25 what's the path of least resistance? It's the sort of

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1 a recommendations document produced by the VTF, authored  
2 by yourself and Clive Dix. I presume, or we presume,  
3 that it's dated December 2020 because it was approaching  
4 the end of your time at the VTF. You recommend the  
5 creation of a new executive agency within BEIS as  
6 a central body responsible for co-ordination of  
7 industrial and public sector assets and maintaining the  
8 relationship between the UK's vaccine industrial base  
9 and government.

10 Did you have in mind an agency or a body, it doesn't  
11 have to be a statutory body, of course, that would deal  
12 with vaccine-related issues on an end-to-end basis, so  
13 dealing with clinical development as well as the  
14 research and development, and going through to the  
15 scale-up and the manufacturing end of the process?

16 **A.** Correct.

17 **Q.** So not just procurement, but a wider remit?

18 **A.** Absolutely that is what we were recommending. It wasn't  
19 published at the time because it was deemed that if they  
20 published it, it would be government policy, when it  
21 wasn't, it was recommendations from the Vaccine  
22 Taskforce. But what we were trying to recommend was how  
23 can you ensure that this capability and this drive and  
24 this partnership relationship continues with industry  
25 and with the innovators? Because our vaccines have been

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1 "Yes, Minister" view. And the commercial side wants to  
2 get on with it.

3 So the reason to have a separate agency is they  
4 would have the authority, like we did at the VTF, to  
5 actually make recommendations that deliver an outcome.  
6 If you put it into an existing government department,  
7 you're going to end up with the same business as usual,  
8 and you're going to be bogged down in bureaucracy, and  
9 actually, in one of these -- your sessions yesterday  
10 with Chris Whitty, where you talked about how many  
11 different bodies were assessing Evusheld --

12 **MR KEITH:** Prophylactics -- (overspeaking) --

13 **A.** Yes, something like six or eight different bodies, all  
14 of which had to give their views on things. Now, if  
15 you're embedded in government you're going to get lots  
16 of that. The real success that we had was we were  
17 slightly outside government. So even though we reported  
18 into BEIS, we were not part of government. And that was  
19 what caused friction; people didn't like it.

20 **Q.** But that's -- the word is slightly, isn't it? Because  
21 you were a body within BEIS. However, you had a very  
22 strong external input and you that the independence and  
23 the authority to be able to report directly to the  
24 Prime Minister, which you negotiated successfully in  
25 advance, so you were a government body with bells on,

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1 external bells. That was the key.

2 **A.** I think that is critical. And again, if you continue  
3 with the defence analogy, defence isn't being split  
4 between different departments with lots of people  
5 putting their oars in. They have a very clear goal:  
6 protect the UK, support your allies, all of those  
7 things. It's very similar. We're much more likely to  
8 have another pandemic than we are to be invaded. We've  
9 had seven pandemics since 2020. That's a lot.

10 **Q.** I think you must have read my Lady's forward to the  
11 Module 1 report where precisely that point is made in  
12 the second paragraph.

13 **A.** Excellent. I'm delighted. Thank you.

14 **Q.** So do we take it -- I just want to ask you one or two  
15 questions about a second recommendation that you make.  
16 You have spoken in the past about the need for a vaccine  
17 registry. Without going into the detail of it, the  
18 vaccine registry was the process by which I think around  
19 about, in total, 500,000 people volunteered by mid-2021  
20 to participate in vaccine trials, and of course the  
21 process itself was also used to generate data for other  
22 public health policy decisions.

23 Would you like to see that vaccine registry put on  
24 a permanent and perhaps surer footing?

25 **A.** Thank you for raising this. This is one of the good

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1 was a legacy of something else. That is not the case.  
2 This is a completely *de novo* vaccine registry that we  
3 stood up in July 2020.

4 **Q.** And did you and Clive Dix, in particular, also secure  
5 approval for another type of capability but broadly on  
6 the same lines, namely the Human Challenge Programme,  
7 which is a trial in which healthy young adults receive  
8 a vaccine before then being given the virus to test the  
9 efficacy of the vaccine?

10 **A.** Yes, we did. And so I asked my friend and colleague,  
11 Garth Rapeport, who used to run respiratory medicine --  
12 respiratory at GSK, and I've backed him twice as CEO and  
13 I've backed him to do human challenge studies in his  
14 respiratory companies successfully and I called him and  
15 said, you know, "What do I do?" Because again, I'm not  
16 a vaccine expert. I work with lots of brilliant people.  
17 I am a mouthpiece compared with all these fantastic  
18 people. And Garth then said what you need to do is a  
19 human challenge because you will be able to understand  
20 how the virus is infecting and therefore you can start  
21 thinking about development of vaccines and therapeutics  
22 and diagnostics. And, actually, those papers that have  
23 been published both in the New England Journal and in  
24 The Lancet have shown that exactly. And it did alter  
25 the course of government policy. So it showed that

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1 news responses. So the registry, you're correct, we  
2 have 542,000 people that are signed up on the NHS  
3 registry. In middle of 2022 -- I'm obviously one of  
4 them -- in the middle of 2022, I received an email  
5 saying, "We are shutting down the registry, and if you  
6 want to re-register into our new registry, please go  
7 ahead." So of course I was not very thrilled with that  
8 email, and said so, and shook the trees quite hard. And  
9 the outcome was that this registry has not been shut  
10 down, and has in fact been enlarged and embedded within  
11 NIHR's larger registry. It now has over 42% over the  
12 age of 60. So exactly the sorts of people who will need  
13 to be tested for every kind of drug. It's not just for  
14 vaccines; it's for any therapeutic, and it's been linked  
15 with a database where you can search for clinical  
16 trials.

17 So this is starting to deliver the strategy that we  
18 set out, which was "We'll do something very specific for  
19 vaccines because we need to and we've got to get bodies  
20 into the trials quickly but we need to leave something  
21 with a legacy so that we are broader, not just for  
22 pandemic preparedness but for the UK."

23 So this is definitely a plus that I am very pleased  
24 about.

25 One of your witness statements suggested that that

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1 lateral flow tests were able to pick up live virus  
2 before PCR and in fact when PCR was still registering  
3 positive, a lateral flow showed that you could -- it  
4 didn't register dead virus, basically. So it was a more  
5 effective test.

6 So there are some clearly useful things that came  
7 out of it. But it's a difficult test, because as  
8 viruses mutate, you have to then mutate -- you have to  
9 remanufacture. So I think it was a useful experience  
10 but it hasn't continued.

11 **Q.** Drawing some of the threads from what you said earlier  
12 about the manufacturing base for vaccines and also  
13 therapeutics, together, in very short terms, do you call  
14 as loudly as you are capable, for the manufacturing of  
15 vaccines and antibodies to be nurtured and secured as  
16 far as is possible and for the manufacturing and  
17 industrial base, the sites, the factories, to be  
18 maintained or reconstructed or certainly grown?

19 **A.** Yeah, I mean, that's a very large question. We need to  
20 have a strategy, and that -- and the plan of how we're  
21 going to secure, grow and expand our manufacturing base  
22 has to be led by somebody who comes from the  
23 manufacturing industry. We were blessed to have  
24 Ian McCubbin in our team, and everybody knows Ian and  
25 everybody loves him so when Ian would call up and say,

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1 "I need you to do me a favour, I need you to help",  
 2 everybody would. If somebody from UKHSA calls up these  
 3 manufacturers and says, "I need you to help", they  
 4 won't, because they don't have that warmth,  
 5 collaborative relationship.

6 So what we need, it's not just about buildings; it's  
 7 about a plan and a coordinated plan to bring together  
 8 the public sector, the private sector, government, all  
 9 of which -- we've got all the bits in place, and we've  
 10 shown we can do it in 2020, but that is not being  
 11 nurtured, and it is not being coordinated effectively  
 12 and we don't have the people to do it. And that is  
 13 what's missing and that is what needs to get put in  
 14 place.

15 **Q.** Because it always fundamentally comes back to people,  
 16 doesn't it?

17 **A.** Completely.

18 **MR KEITH:** Thank you very much.

19 **A.** Thank you.

20 **LADY HALLETT:** Thank you, Mr Keith.

21 I think there are some questions from Mr Thomas, who  
 22 is over there, Dame Kate.

23 **THE WITNESS:** Excellent.

24 **Questions from PROFESSOR THOMAS KC**

25 **PROFESSOR THOMAS:** Good morning, Dame Kate, can you hear me?  
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1 And you go on to say:

2 "I still do not know how or why this happened. This  
 3 ban further complicated our work, as it meant that the  
 4 VTF had to try to deliver a national message without the  
 5 benefit of any targeted advertising support."

6 Question: have you since become aware why the  
 7 Cabinet Office made this decision to block expenditure?

8 **A.** No, I think it's just -- goes back to my box-checking  
 9 process point, which is, in order to recruit advertisers  
 10 or companies, they had to go through a formal government  
 11 procurement process, which was too slow and we  
 12 wouldn't -- you know, by the time that had happened, the  
 13 vaccine would have been -- the registry had been and  
 14 gone.

15 So it was astonishingly irritating, and it  
 16 significantly hindered our ability to deliver that  
 17 vaccine registry.

18 **Q.** Right. Let me ask you the next question, which is this:  
 19 what impact, if any, do you think this had on ethnic  
 20 minority recruitment to the NHS registry?

21 **A.** (Laughs). I mean, I think the impact was that we had  
 22 fewer minority and ethnic individuals that signed up.  
 23 We ended up with about 8% in the registry, and it's --  
 24 there's a public-facing dashboard, so you can actually  
 25 go in and have a look at it. But we -- and we did work  
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1 **A.** Yes, just.

2 **Q.** Okay, just bear with me one moment.

3 My name is Leslie Thomas, and I'm representing  
 4 FEMHO, the Federation of Ethnic Minority Healthcare  
 5 Organisations. I've only got a small handful of  
 6 questions for you. You state, and note at  
 7 paragraph 41.10 of your statement, that the VTF had  
 8 planned a paid advertisement campaign to support  
 9 a large-scale push to drive people to sign up to the NHS  
 10 registry, and that the costs for this had been approved  
 11 by the VTF business case. And you go on to say and let  
 12 me just quote:

13 "We were particularly keen that our targeted  
 14 campaign should reach those most at risk from infection,  
 15 including the elderly, those with severe underlying  
 16 diseases and frontline workers. We also especially  
 17 wanted to attract people from black, Asian and minority  
 18 and ethnic backgrounds who were disproportionately  
 19 affected by [Covid] and who the evidence suggested might  
 20 be among the more vaccine-hesitant to sign up."

21 You also note at paragraph 41.12 that:

22 "... the Cabinet Office then [suddenly] blocked  
 23 expenditure from our budget for advertising the NHS  
 24 Registry, even though these costs had already been  
 25 approved."  
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1 with NIHR to do -- and we worked with the Behavioural  
 2 Insights unit. We tried lots of different things to try  
 3 to figure out how to address vaccine hesitancy.

4 And, Mr Thomas, if I can just touch on it, I have  
 5 spent over 30 years working in drug discovery and  
 6 development's. That is my -- I live, eat, sleep,  
 7 thinking about it. I have never been part of a clinical  
 8 trial. And if I've never been part of a clinical trial,  
 9 how are we going to get members of the public to do it?

10 So the first thing I did, obviously, was to sign up  
 11 into a clinical trial. But I was very clear that unless  
 12 you tell people why it's important, what it involves,  
 13 what the risks are, and what the opportunities are of  
 14 being involved, people aren't going to sign up. So it  
 15 was really important to get that information out in  
 16 order to get people to sign up.

17 **Q.** Hence the advertising strategy?

18 **A.** Everything. So because that was blocked, we ended up  
 19 having to go -- we went onto local radio. Divya, who  
 20 was our wonderful person leading clinical trials, went  
 21 onto Asian radio. We worked with a fantastic physician  
 22 in Bradford, Dinesh Saralaya, who basically was a sort  
 23 of community champion who addressed more of the Muslim  
 24 community. But it wasn't helped -- because trying to do  
 25 things piecemeal, you know, I'd have interviews with,  
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1 you know, breakfast TV doctors to try to say why we  
2 should do that. But it was -- it definitely harmed us.  
3 **Q.** Let me move on to my last question. I want to be  
4 forward thinking and looking. What recommendations  
5 would you make to increase the participation of ethnic  
6 minority groups in vaccine clinical trials in the  
7 future?  
8 **A.** I mean, we can start now. We have a registry on the NHS  
9 website which anybody can sign up to. Once they're  
10 signed up, they can go in and search clinical trials  
11 that they may be eligible for.

12 If you think about it, most diseases are not cured.  
13 So anybody with a diagnosis of a disease that isn't well  
14 managed would be well advised to go and look to see  
15 whether or not there's a clinical trial they can take  
16 part in. So what I would do is absolutely promote the  
17 opportunity for people to have a better potential  
18 healthcare outcome by taking part in clinical trials, to  
19 then see are there new drugs that would actually suit  
20 and treat that particular condition that people might  
21 have.

22 And then you'll need to get community champions,  
23 you'll need to get local, trusted individuals, whether  
24 they're physicians, teachers, religious leaders, to  
25 encourage people to do it. Because this is a highly,

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1 **(The witness withdrew)**  
2 **MS STEPHENSON:** My Lady, the next witness is Dr Mary Ramsay.  
3 **LADY HALLETT:** Thank you.

4 **DR MARY RAMSAY (sworn)**

5 **Questions from COUNSEL TO THE INQUIRY**

6 **MS STEPHENSON:** Thank you, please sit down.  
7 Please can you say your full name.  
8 **A.** Yeah, Mary Ramsay.  
9 **Q.** Thank you for attending today to assist the Inquiry,  
10 Dr Ramsay.  
11 A few preliminary matters. Could I ask you to keep  
12 your voice nice and loud, and speak slowly, please.  
13 You have produced a witness statement, that's  
14 INQ000496177, dated 26 July 2024. It runs to 70 pages  
15 and 102 exhibits. Have you had the opportunity to  
16 familiarise yourself with that statement recently?  
17 **A.** I have, thank you.  
18 **Q.** And are you satisfied that its contents are true to the  
19 best of your knowledge?  
20 **A.** I am, thank you.  
21 **Q.** Thank you. I'm just going to touch first on your  
22 professional background. You're currently Director of  
23 Public Health Programmes at UKHSA, and prior to that,  
24 you were Head of Immunisation and Deputy Director of the  
25 Immunisations and Vaccine Preventable Diseases Division

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1 highly regulated industry. Safety is paramount in  
2 any -- and it's by law that we have to take -- do a lot  
3 of work before you even start to put drugs into people.  
4 And you need to tell people that it's available and what  
5 the opportunities are and what the risks are.

6 **Q.** Trust is important, isn't it?  
7 **A.** Trust is critical. And so by trying to hide information  
8 or not give people access to full and fair information,  
9 it's just going to -- doesn't address the trust issue.

10 **Q.** Bureaucratic blockages don't help, do they?  
11 **A.** They certainly don't. You can imagine how thrilled  
12 I was when I got that response.

13 **PROFESSOR THOMAS:** My Lady, those are my questions.

14 **LADY HALLETT:** Thank you very much, Mr Thomas.

15 I think that completes the questions for you,  
16 Dame Kate.

17 **THE WITNESS:** Excellent.

18 **LADY HALLETT:** I don't know, you said -- you've obviously  
19 been following some of the evidence. Your appointment  
20 as the chair of the Vaccine Taskforce was described  
21 yesterday as a stroke of genius, and I think we can see  
22 why. Thank you so much for everything you and your  
23 colleagues did, it was an extraordinary achievement.

24 **THE WITNESS:** Excellent. Thank you very much for having me.

25 **LADY HALLETT:** Thank you.

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1 within the National Infection Service in PHE, as it then  
2 was, from March 2018 until the establishment of UKHSA in  
3 October 2021? Is that all correct?

4 **A.** That's correct.

5 **Q.** And before that, you held roles as Head of Immunisation,  
6 Hepatitis and Blood Safety within PHE, and indeed in its  
7 predecessor organisation, the Health Protection Agency,  
8 from as far as back as 2009.

9 You have extensive clinical expertise, which I won't  
10 attempt to summarise in full here, but is it right that  
11 you hold a medical degree, you have extensive research  
12 experience in epidemiology of vaccine-preventable and  
13 blood-borne diseases, 30 years of that kind of expertise  
14 and research?

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

16 **Q.** You have acted as an adviser to the World Health  
17 Organisation, including as a member of the Covid-19  
18 vaccination subgroup, and finally, and importantly for  
19 the evidence you'll give today, you are also the editor  
20 of the "Immunisation against ... disease", known as the  
21 "Green Book"?

22 **A.** That's right.

23 **Q.** And have been since 2006?

24 **A.** That's correct.

25 **Q.** Thank you. Just remind ourselves of that with which we

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1 may be well familiar, the transition of PHE to UKHSA.  
 2 That was -- UKHSA was established on 1 April 2021 but  
 3 became operational on 1 October 2021. But of course,  
 4 when we are referring to matters pre that date, we're  
 5 talking about PHE?  
 6 **A.** That's correct.  
 7 **Q.** The role of PHE, its key responsibilities in terms of  
 8 infectious diseases, was one of a duty to protect the  
 9 public from infectious diseases, and also, was it not,  
 10 to evaluate the effectiveness of immunisation programmes  
 11 and procure and supply of vaccines, and improve  
 12 population health by supporting health and care  
 13 services. Is that a fair summary of the duties?  
 14 **A.** Some of the duties, I should say.  
 15 **Q.** Some of.  
 16 It's worth reiterating, however, that Public Health  
 17 England wasn't mandated or, indeed, funded to be ready  
 18 to respond to a pandemic of the scale that was  
 19 encountered with Covid-19; is that right?  
 20 **A.** I think that's fair.  
 21 **Q.** Moving, then, to touch on the work undertaken by Public  
 22 Health England, as it was then, on vaccinations when  
 23 moving towards the rollout of Covid-19 vaccines.  
 24 Were there two divisions within PHE: the  
 25 Immunisation and Vaccine Preventable Diseases Division

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1 **Q.** So, in England, the decision was made that the NHS and  
 2 NHSE would take the lead on deployment --  
 3 **A.** That's right.  
 4 **Q.** -- for vaccinations, as opposed to PHE?  
 5 In the context of this pandemic, was PHE of the view  
 6 at the time that that was appropriate, that division of  
 7 responsibility?  
 8 **A.** Yes, I think so. I mean, I think the -- we were  
 9 a relatively small team within PHE, a much smaller  
 10 organisation, so it made sense for NHS to take on some  
 11 of the huge scale. But obviously we wanted to be, and  
 12 we were, embedded within that work and leading on the  
 13 areas that we had the expertise on.  
 14 **Q.** Perhaps just before we get into the detail of the  
 15 matters covered in your statement, by way of overview of  
 16 what the responsibilities were, as opposed to what they  
 17 were not, PHE took responsibility, importantly, for  
 18 storage and distribution, taking on the enormous task of  
 19 building the national infrastructure to enable the  
 20 storage and distribution of vaccines across the UK,  
 21 importantly, whilst maintaining the required temperature  
 22 regimes; is that correct?  
 23 **A.** Yes, although because again it was a very different  
 24 product from previous products, there was an element  
 25 which, whereas we deliver for normal vaccines, we

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1 (IVPD), which is probably the one you may refer to the  
 2 most in your evidence today?  
 3 **A.** Exactly, yes.  
 4 **Q.** And there was another division, the Vaccines and  
 5 Countermeasures Response Division. Was there also  
 6 a board, a vaccination -- a Covid-19 vaccination  
 7 programme board set up in May 2020?  
 8 **A.** Yes, so we ran boards at -- the IVPD ran boards with VCR  
 9 for the introduction of all new vaccines or any changes  
 10 to the vaccine programme. So in May 2020 we decided to  
 11 set up one in anticipation that there would be a Covid  
 12 vaccine at some point to support some of the workstreams  
 13 that we would need to deliver in preparation for that.  
 14 **Q.** And when preparations started for the commencement of  
 15 the deployment of vaccines, is it right that that board  
 16 was dissolved in September 2020, but effectively because  
 17 NHSE were going to take on the vaccine deployment  
 18 programme through their Vaccine Deployment Delivery  
 19 Group?  
 20 **A.** Yes, I mean, I think they took over a lot of our, sort  
 21 of, project management stuff, but obviously there was  
 22 a much greater need to scale up the actual delivery, so  
 23 it became a -- DHSC decided it made more sense for them  
 24 to lead that because there was so much additional  
 25 delivery capacity needed.

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1 deliver to the end user, the doctor and nurse who are  
 2 giving the vaccines, in this we delivered to, sort of, a  
 3 series of hubs, and then the NHS commissioned onward  
 4 delivery at that point. So it was a joint piece of  
 5 work, but we did substantial amounts of work in getting  
 6 the infrastructure in terms of freezers, et cetera, set  
 7 up to receive the vaccines.  
 8 **Q.** And the IVPD, the division, mainly dealing with this  
 9 work, did it, in overview, have the following functions:  
 10 that it provided scientific advice and secretariat  
 11 support to the JCVI?  
 12 **A.** That's correct.  
 13 **Q.** It provided clinical and technical input for NHS England  
 14 to support the design of that deployment that we have  
 15 just been discussing?  
 16 **A.** **(Witness nodded).**  
 17 **Q.** Of course the Green Book was also a responsibility that  
 18 we've mentioned. And then responsibility, too, for the  
 19 clinical documentation, the supporting guidance, the  
 20 toolkits, as we've sometimes heard them referred to,  
 21 training materials, Q&A materials that would be used or  
 22 would be the basis of NHS health professionals'  
 23 documentation for the immunisation programme?  
 24 **A.** That's correct.  
 25 **Q.** So focusing, then, on the first main topic that I'd like

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1 to ask you about, which is vaccine safety, and PHE and  
 2 the UKHSA's involvement on vaccine safety issues, could  
 3 you first help us to get an idea of where PHE sat  
 4 alongside the other bodies involved in safety? So  
 5 first, MHRA. What work did the relevant division do in  
 6 assisting MHRA in its safety investigations and  
 7 surveillance?  
 8 **A.** Well, the MHRA has primary responsibility for safety of  
 9 all therapeutics and vaccines, but we've had  
 10 a longstanding relationship with them, in particular in  
 11 relation to -- first of all, we -- because we're the  
 12 group that monitors how effective the vaccine is, that's  
 13 part of that risk/benefit, you know, how much benefit  
 14 you're getting versus any safety concerns. And we've  
 15 been working with them for many years on developing  
 16 their methods. We have -- the PHE had privileged  
 17 access, I guess, to a lot of clinical data systems that  
 18 allowed us to do some of the investigations of potential  
 19 safety concerns, and over many years we had done that  
 20 for MMR and other vaccines in the past, and we worked,  
 21 as I said, we worked very closely and actually, during  
 22 the pandemic we embedded people, we had, you know, joint  
 23 staff embedded within MHRA to try to support them in  
 24 their role.

I think the other thing we have is we have a much

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1 does that mean?  
 2 **A.** Well, most people are familiar with the concept of the  
 3 Yellow Card system which is the reporting system that is  
 4 basically a passive system which means that people have  
 5 to report it. There is no active -- we don't go and ask  
 6 people, it is what comes in through this passive system.  
 7 So that's the backbone of most safety surveillance. I'm  
 8 sure the MHRA can explain this better and there are some  
 9 expert reports explaining it, so that's the, sort of,  
 10 backbone. But it also includes other sources of  
 11 intelligence, exactly those things I was talking about  
 12 earlier. Clinical networks may approach us and say,  
 13 "We're seeing something unusual", so that sort of  
 14 passive reporting, which is where people out in the  
 15 health service report to us without us going out seeking  
 16 advice.  
 17 **Q.** You talk about active surveillance in specific cohorts.  
 18 What does that --  
 19 **A.** That is something that the MHRA established, which is  
 20 where they set up a system where a group of people are  
 21 recruited to report any symptoms they got after  
 22 vaccination, so that's an active reporting system  
 23 because they are asked, "How are you after your  
 24 vaccine?" in an active way, so they were recruited to  
 25 this enhanced surveillance.

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1 stronger sort of clinical network, intelligence role  
 2 with -- so we have -- we tend to get things reported  
 3 from clinical networks through our clinical colleagues  
 4 that we work with because we work with frontline health  
 5 protection, our frontline teams in health protection  
 6 work with local providers. So we get a lot of soft  
 7 intelligence that we feed in jointly with the MHRA.  
 8 **Q.** And in terms of NHSE, was it the role of the UKHSA when  
 9 it came to safety, to inform the clinical advice and  
 10 information about safety that NHSE would be using?  
 11 **A.** Well, again, we worked jointly on that but we were the,  
 12 sort of, work stream lead for surveillance which  
 13 included safety and so we were the people representing,  
 14 I guess, some of MHRA interests with the NHS. So we  
 15 worked very closely with them on the development of  
 16 those protocols.  
 17 **Q.** If we could move on now, then, to that surveillance  
 18 strategy and the specifics on it. You explain in your  
 19 statement that there were four main components to the  
 20 surveillance strategy which PHE, MHRA and NHSE  
 21 collaborated on, as you describe it, to monitor the  
 22 implementation of the programme and the safety of it,  
 23 once vaccines had begun to be deployed. The first of  
 24 those four elements you describe as enhanced passive  
 25 surveillance. Could you translate that, please? What

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1 **Q.** Also formal epidemiological investigations; really, in  
 2 summary form, what does that mean?  
 3 **A.** Yes, so where you have a potential signal like, say,  
 4 vaccine X is associated with condition Y, then what we  
 5 would normally do, and that's where PHE has a really big  
 6 role, is do a formal investigation where we may collect  
 7 data especially or we may use an existing dataset and  
 8 formally look at whether there is an increased risk of  
 9 that condition in a certain time period following  
 10 vaccination, for example. So it's an analytical study  
 11 to test a hypothesis.  
 12 **Q.** And the fourth branch, the near realtime monitoring for  
 13 a set of events of interest. What does that mean?  
 14 **A.** So in advance of a vaccine being approved, you may have,  
 15 from the basis of the trials or from previous  
 16 experience, a series of conditions that you think may  
 17 well be potential side effects of the vaccine, and so  
 18 what you put in place in advance is some process of  
 19 actively collecting information on those conditions,  
 20 a list of conditions, in realtime as the vaccine  
 21 programme is rolled out, and constantly looking at that  
 22 to see whether you're getting more than you might expect  
 23 based on the background, background rate.  
 24 **Q.** Could we have on screen, please, document INQ000477132.  
 25 This is the Covid-19 vaccine surveillance strategy

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1 dated January 2020. If we could go to, please, page 7.

2 **A.** 2021, I think it probably was, was it?

3 January 2021, that's all, sorry.

4 **Q.** Thank you very much, I apologise. Thank you.

5 If we could go, please, to page 7, at paragraph 4.1  
6 there we see the heading "Signal detection". So this is  
7 the policy of the strategy of PHE setting out how signal  
8 detection would work:

9 "A signal of potential adverse events may come from  
10 a range of sources such as the pre-licensure clinical  
11 trials, MHRA assessments of Yellow Cards reports [and]  
12 active follow-up ..."

13 And also:

14 "... from other countries or specialist healthcare  
15 professionals seeing increases in consultations for  
16 specific conditions."

17 So does this capture what you were referring to  
18 earlier about the network of reporting back to PHE being  
19 relied upon, not just the Yellow Card system --

20 **A.** Exactly.

21 **Q.** -- and waiting for people to report, but this web of  
22 routes of feedback?

23 **A.** Exactly, yes.

24 **Q.** And then if we just for completeness look at 4.2,  
25 please, on the same page.

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1 at the time to make sure, one, that they were being  
2 managed appropriately and reported to the MHRA, and also  
3 that my colleagues who work at local level, as well as  
4 ourselves, can provide advice on the implications of  
5 that for the programme, particularly where there were  
6 potential concerns about, you know, denting confidence  
7 in the programme where people hear about a condition  
8 that occurs after vaccination.

9 **Q.** So this was an operating procedure for any clinical  
10 incident that arose in the delivery --

11 **A.** Exactly.

12 **Q.** -- of vaccines which might include things like storage  
13 being an issue --

14 **A.** Yeah.

15 **Q.** -- administration errors --

16 **A.** Yes, exactly.

17 **Q.** -- (overspeaking) -- incidents that may cause worry and  
18 may need further investigation?

19 **A.** Yeah.

20 **Q.** Could we have a look, please, at INQ000421370, which we  
21 see there is the standard operating procedure, and this  
22 particular version is dated 9 December 2020.

23 Could we go to page 9, please, of that document.

24 This is something that's described as the Clinical  
25 Case Escalation Framework. We -- certainly I do not

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1 "Rapid assessment

2 "To assess any signal coming from these sources,  
3 a more detailed investigation is needed before a full  
4 epidemiological study is performed."

5 What does that relate to, please?

6 **A.** So that relates to these conditions -- so, for example,  
7 if the trial had suggested there was a case of  
8 condition X and that was in our pre-defined list of  
9 conditions, then we would actively look at datasets that  
10 collect information on how many cases of disease X are  
11 occurring, and comparing that to how many people have  
12 been vaccinated to work out whether or not there was any  
13 signal of a higher rate in people who are vaccinated.

14 **Q.** Thank you. We can take that document down now.

15 Was there also in place a standard operating  
16 procedure when it came to surveillance and safety issues  
17 that had been agreed with NHS England?

18 **A.** Yes, it was a surveillance and response, actually. It  
19 was in order to manage -- so one of the difficulties  
20 with the programme, we were starting to roll it out in  
21 old, older people, many of whom were frail and had  
22 underlying medical conditions, and so it was not  
23 surprising that we would expect to see people being  
24 taken ill after vaccination, and we wanted to be sure  
25 that that was being captured properly and also assessed

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1 intend to ask you questions explaining every element of  
2 this diagram but perhaps just to get an overview of  
3 those systems of reporting that you described earlier,  
4 we see on the left-hand side there that if an incident  
5 is identified, that -- on the left-hand side a route is  
6 to report to the MHRA by the Yellow Card system, but  
7 there is also another route, and just pausing there  
8 before we get to it, this document is intended for  
9 clinicians delivering vaccines in mass vaccination  
10 centres, GPs delivering, the range of routes of  
11 delivery, it's intended for them to read if there is  
12 a clinical incident at the point of the vaccine being  
13 given; is that correct?

14 **A.** Yes, and also for the wider NHS. At the time the  
15 programme in the NHS was being managed as part of the  
16 emergency response procedures, because that was what was  
17 set up for the whole pandemic, so the NHS, as you  
18 realise, was under immense pressure and so was managing  
19 things as an emergency, so they had this regional and  
20 national escalation system.

21 **Q.** Just looking at this diagram, is that what we see here?

22 **A.** In the middle.

23 **Q.** There are regional points of contact which then feed  
24 into the National Incident Co-ordination Centre?

25 **A.** Exactly.

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1 **Q.** And that eventually that can be escalated right up to  
 2 DHSC once it has gone through that route of escalation,  
 3 if it is a matter of concern, in terms of potential side  
 4 effects?  
 5 **A.** Exactly. And I think this was bringing together that  
 6 incident structure with the technical support from MHRA  
 7 and from PHE at the time.  
 8 **Q.** Thank you. We can take that down.  
 9 So again, I don't want to labour the point but this  
 10 is in addition to MHRA's own Yellow Card surveillance  
 11 system, although obviously you're working closely  
 12 together.  
 13 **A.** Absolutely, yes.  
 14 **Q.** Is it also right that within that standard operating  
 15 procedure there was available a seven-day-a week,  
 16 I think 12 hours a day phone line, which clinicians  
 17 could contact with any concerns?  
 18 **A.** So, I mean, MHRA already have, I think, a phone line.  
 19 I think what we put in place as well was an expert  
 20 vaccine, kind of, capacity, through my own team, really.  
 21 So that was, as you say, seven days a week, mainly,  
 22 actually, probably email, but it was available on the  
 23 phone using our duty doctor system.  
 24 **Q.** I want to move on now from those systems of surveillance  
 25 to ask you about what information was provided to people

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1 people?  
 2 **A.** So it's all about -- I mean, it went up online as soon  
 3 as we produced it and it's obviously cascaded, the NHS  
 4 providers themselves would be aware of it so they could  
 5 use it, but actually, certainly in the stages where we  
 6 were inviting people in through the national programme,  
 7 the leaflet was designed to go out with the letter  
 8 inviting people to make an appointment or, in the  
 9 initial stages perhaps giving them appointments, to come  
 10 forward for vaccination for that first cohort. So we  
 11 actually worked with the NHS, printed the leaflet so  
 12 that it went out with the letters.  
 13 **Q.** And what about after the point of vaccination? What  
 14 input did you have into making people aware of  
 15 conditions that they may need to look out for, symptoms  
 16 they may need to look out for?  
 17 **A.** So we also produce a leaflet and, again, it's our normal  
 18 approach, it's called "What to expect after  
 19 vaccination", and it's something that can be handed out  
 20 at the time someone gets the vaccine, that perhaps tells  
 21 them what to do if they get symptoms, to take  
 22 paracetamol, or whatever, and also how to report  
 23 symptoms, and if there is a particular concern about  
 24 a safety signal, we might put specific things to look  
 25 out for, for example, headache, for example, chest pain,

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1 receiving the vaccine, or considering receiving the  
 2 vaccine, about safety. Please could you explain what  
 3 input PHE and then UKHSA had into the information about  
 4 safety which people received.  
 5 **A.** Okay. Well, I mean, I think again, a bit like the  
 6 safety monitoring, it's not just one thing, but our  
 7 responsibility, my own team's responsibility in PHE is  
 8 on providing the sort of information resources that are  
 9 used by healthcare professionals to help with consent of  
 10 individuals for vaccination. That's our kind of normal  
 11 role outside of the pandemic as well. So when a new  
 12 vaccine is introduced, we will develop a patient-facing  
 13 resource, leaflet, which explains why people need the  
 14 vaccine, what the side effects are, a broad range of  
 15 things. And we did that, as well, in the pandemic,  
 16 and -- in the programme, sorry, I should say, and we  
 17 produced that in a range of formats, a range of  
 18 languages. We print it so that it's available for  
 19 people to actually read as a piece of paper as well as  
 20 online, and we produce other kind of formats for people,  
 21 BSL, braille, other ways, videos for people who don't  
 22 have high literacy, Easy Read, and all those sorts of  
 23 different approaches.  
 24 **Q.** So that information about what the vaccine is and what  
 25 the risks and benefits are, how was that delivered to

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1 those sorts of things, if there is something that we are  
 2 particularly concerned as being related to that  
 3 particular vaccine.  
 4 **Q.** Within the Green Book, there was, throughout the  
 5 vaccination programme and still is, guidance on the  
 6 principle of consent, which includes the requirement for  
 7 people to be informed about the process of vaccination,  
 8 the benefits, the risks, including extremely rare  
 9 potential side effects or, indeed, common and not so  
 10 serious side effects. Are you confident that the  
 11 information provided by PHE and UKHSA to patients, taken  
 12 in conjunction with some of the legally-required  
 13 documentation that the MHRA were responsible for, that  
 14 they satisfied that requirement that people were  
 15 receiving the vaccine having been informed properly and  
 16 able to consent to what they were receiving?  
 17 **A.** Well, I would hope so, but that's not the -- I mean, the  
 18 leaflet isn't the only thing. Obviously it's the  
 19 process and everybody was supposed to see a healthcare  
 20 professional so that they could discuss either any  
 21 specific issues about their individual health that might  
 22 affect the safety of the vaccine, which is really  
 23 important, as well as asking any questions about things  
 24 that are there. I mean, the extent of literature that  
 25 there is about safety, there's a lot of it, and some

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1 people may not be able to manage to read that as well or  
2 take it in as well. So obviously that potential for  
3 a conversation is a really important element, and  
4 I think ensuring that healthcare workers are also able  
5 to answer questions of the public is another element of  
6 that.

7 So as I think we always say, consent is a process,  
8 not a one-off event, and there's a range of things. But  
9 I think the leaflets are one way that we help to ensure  
10 that they after consist -- that people are getting  
11 consistent advice and that advice is aligned with the  
12 clinical information as well.

13 **Q.** I want to move on now to ask you about a very particular  
14 issue that arose within the safety of vaccines in  
15 respect of blood clots and updates on information  
16 available to the public about possible safety signals  
17 and about blood clots.

18 We looked at this yesterday with Professor Dame  
19 Jenny Harries so I don't want to spend too much time on  
20 it, having already looked at this document, but just to  
21 get your view on it and to understand what it might tell  
22 us about the systems that were in place at the time to  
23 inform the public about safety issues.

24 If we could have up on screen INQ000528432, please.

25 This is an email chain between you and others in  
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1 with the parties that you've mentioned there about how  
2 to update the information that was going to go out to  
3 the public. Can you remember how your concerns on this  
4 occasion were responded to, how this was resolved?

5 **A.** Well, in the end the DHSC, deputy director made  
6 a decision to put the question to Secretary of State,  
7 and described my concerns and the Secretary of State  
8 decided to -- that it was okay to wait until after the  
9 Bank Holiday weekend and for everything to go out in  
10 a single suite. My proposal had been -- I mean, I knew  
11 there was going to be a lot of information going out  
12 immediately after the Bank Holiday but I was keen to  
13 change the NHS website in particular because of that  
14 slightly confusing advice about days of headache, so  
15 that people could get appropriate treatment as early as  
16 possible. That was my concern. So that was how it was  
17 resolved.

18 **LADY HALLETT:** Dr Ramsay, I'm sorry to interrupt, I don't  
19 follow why a decision of this kind, if there's wrong  
20 advice on the website, why it has to go to the Secretary  
21 of State? Why did you have to get your concern dealt  
22 with at that level?

23 **A.** Well, because I had tried to make an appeal to the DHSC  
24 comms, but they were very clear that they wanted  
25 everything to go out in a coordinated way and didn't

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1 April 2021. It's addressed from you to this -- the  
2 particular email we're looking at, is from you to  
3 Professor Dame Jenny Harries to be aware, you say:

4 "... I have requested clearance to change NHS  
5 website which is currently out of date for information  
6 on clots -- sort of me against the DHSC comms, CMO in  
7 between -- sub going to [Secretary of State]."

8 And you explain that it wasn't updated after the  
9 last MHRA press release because you were waiting for  
10 updated advice, it dragged on, and your concern was that  
11 the current content linked to out of date MHRA story  
12 with bad advice about presenting and it implied,  
13 incorrectly, you had to have had four days of a headache  
14 rather than a headache starting more than four days  
15 after the vaccine.

16 Thank you, we can take that down and go to the next  
17 page, please.

18 This is another email in the chain where you say:

19 "FYI -- this sub follows my request to update  
20 information on the NHS website ..."

21 And you go on to say:

22 "All against me but I feel obliged to push."

23 We can take that document down entirely now. Thank  
24 you.

25 There was also a meeting on, I think, 2 April 2021

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1 want this to be changed.

2 **LADY HALLETT:** So you had to go to the top?

3 **A.** So basically that was the decision, yes.

4 **MS STEPHENSON:** Was this is an isolated incident or were  
5 there any other incidents where you had concerns about  
6 public information on safety being accurate?

7 **A.** I think this was the -- there were others where perhaps  
8 it took a while to, you know, but generally they were  
9 resolved. I think this was a particularly difficult one  
10 because it was just before the Bank Holiday so therefore  
11 there was this concern that -- we had four days, it was  
12 a four-day Bank Holiday, which was quite unusual, so we  
13 had a slightly longer delay but yeah, I mean, obviously  
14 I was always trying to make sure that everything got out  
15 as soon as possible and there was always that balance  
16 with the communications professionals wanting to make  
17 sure everything was aligned so that we were able to  
18 a completely clear message, which of course is very  
19 important. So I appreciate there's a balance, but  
20 I think this was the only one where I was so  
21 significantly concerned that we took it upwards, yes.

22 **Q.** You spoke earlier about the advantages of cooperation  
23 and co-ordination when it came to safety surveillance.  
24 But on messaging, does this chain of emails or this  
25 incident highlight that potentially there were too many

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1 entities, organisations, involved in public messaging on  
2 safety and not one with a definitive say, or conversely,  
3 actually, was it a good thing that there were lots of  
4 eyes on what was happening?

- 5 **A.** Well, I mean, I think a decision was made that the  
6 messaging would be managed, sort of, centrally in the  
7 Cabinet Office/DHSC. So that was fine, having one  
8 message, because it's very important not to have  
9 inconsistent messaging because that confuses people  
10 more. So I think I have no problem with that, and  
11 I think what is good is that there is clinical input  
12 into that, and that the clinical expertise is reflected,  
13 which it was, even though at the end of the day,  
14 subsequently, my opinion was, sort of, overruled in  
15 terms of the timing, but certainly when the messaging  
16 went out, the tone of the messaging was completely --  
17 you know, I was completely behind making sure that the  
18 balance of risks and benefits were going to be reflected  
19 hopefully as accurately as possible.
- 20 **Q.** What about from a patient or member of the public  
21 perspective? We've heard about these different sources  
22 of information about the risks and benefit of vaccines,  
23 the process of vaccination. Do you think, on  
24 reflection, it might have been good to have a central  
25 source for the public to access information, so they're

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1 yes, our secretariat also, who work in my team, were  
2 also invariably there.

- 3 **Q.** And an active advisory role, including producing  
4 reports, for example citing scientific or surveillance  
5 data?
- 6 **A.** Exactly, yes.
- 7 **Q.** Risk of mortality, for example, PHE produced information  
8 about that prior to prioritisation decisions being made  
9 in order to inform --
- 10 **A.** Absolutely.
- 11 **Q.** -- the --
- 12 **A.** Yeah, our job would be try to source as much information  
13 as possible to support the JCVI decision making.
- 14 **Q.** The Inquiry has heard about one particular part of the  
15 prioritisation process, and that is the system for  
16 deciding who falls into which cohort.
- 17 Cohort 6 in particular appears to have been a tricky  
18 area in terms of definitions and who was going to be  
19 included. I just want to ask you for your perspective  
20 on this, particularly as the person responsible for the  
21 Green Book.

22 In February 2021 there was an issue about unpaid  
23 carers, and a point of discussion between DHSC, OCMO,  
24 and you as the person holding the pen, if you like, on  
25 the Green Book. Effectively, at the end of December,

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1 not going between the NHSE website, the PHE website,  
2 a letter they might have received in the post? Might  
3 that be something to reflect on for the future?

- 4 **A.** Yeah, I mean, I feel -- I actually personally think  
5 a single, sort of, website or a single authoritative  
6 source of information on immunisation would be helpful.  
7 We did used to have one prior to 2010 but now it's  
8 devolved into either the NHS website or the DHSC  
9 website. But of course, I do want to remind you it's  
10 not just about websites, it's about the whole process  
11 where people talk to their health professionals. So  
12 having a consistent message is the key thing there, and  
13 I do think we managed to achieve that, but I do think it  
14 would be easier if people could find everything in one  
15 place. So I think it would facilitate that people are  
16 accessing information that is aligned and authoritative.
- 17 **Q.** I want to move on now to a different topic entirely,  
18 that of prioritisation, and PHE and UKHSA's role in  
19 that. You've already confirmed that there was the  
20 provision of secretariat support for JCVI. Did PHE, in  
21 the -- at least in the early stages -- always -- sorry,  
22 often attend JCVI committee and subcommittee meetings as  
23 observers? Was that a role that --
- 24 **A.** Yes. I mean, there was always a number of us. Myself,  
25 as the medical adviser, invariably would be there, and

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1 JCVI had included within cohort 6 those who were in  
2 receipt of Carer's Allowance or the main carer of an  
3 elderly or disabled person whose welfare may be at risk  
4 if the carer falls ill, and then in February 2021 that  
5 definition was changed to include those who are the sole  
6 or primary carer for an elderly or disabled person who  
7 is at increased risk of Covid-19 mortality and therefore  
8 clinically vulnerable, in addition to those who are in  
9 receipt of Carer's Allowance.

10 So we may not need to get into the minutiae of what  
11 happened but I provide it for context because it's an  
12 example of an interaction between the advice coming from  
13 the JCVI about who should be included in a cohort, and  
14 then that definition being refined because it's  
15 a definition which requires reference to the Green Book,  
16 and the Green Book definition being ironed out, if you  
17 like, between a number of bodies.

- 18 What was the procedure, please, for changing or  
19 deciding on definitions in the Green Book which might  
20 directly impact who was going to be included in  
21 a particular priority cohort, such as unpaid carers?
- 22 **A.** Well, I mean, the Green Book already -- the Green Book  
23 really is a sort of clinical document. It's designed  
24 for the clinicians. But obviously it reflects policy  
25 decisions that have been made on the basis of JCVI

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1 recommendations. So it's a difficult balance as to how  
2 much detail is in the Green Book. But, primarily, the  
3 Green Book I see as about the principle behind the  
4 prioritisation, to explain that without necessarily  
5 operationalising every single detail. And obviously, in  
6 terms of the number of people eligible and whether  
7 there's enough vaccines to vaccinate them and where  
8 they, you know -- and those sorts of decisions are  
9 really policy decisions, which are made by government or  
10 by ministers.

11 So, for example, the definition that we had of  
12 carers in that chapter was exactly the same as had been  
13 in the flu chapter for the last ten or fifteen years,  
14 probably. So I wasn't expecting it to need to be  
15 changed. It has to be generic enough to cover the four  
16 different devolved administrations, who may have  
17 different legislation, different mechanisms for  
18 identifying and even understanding who their carers are.  
19 And DH took the responsibility of defining what  
20 a healthcare worker was for England, including other  
21 elements link -- like caring, but I was asked, actually,  
22 by the NHS, in particular, to further clarify  
23 particularly the clinical aspects of who was being cared  
24 for, in order to avoid introducing unnecessary  
25 inequalities and also to be so that people could

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1 to do everyone in one go. So if we had taken -- if we  
2 had given more vaccines to more carers, we could  
3 potentially have had less vaccine to give to the  
4 patients themselves, who were at high risk of mortality.  
5 So it was part of the prioritisation, I think, just to  
6 clarify and make it more consistent across the four  
7 countries.

8 **Q.** I want to deal now with data, with monitoring uptake.  
9 So monitoring, by which I don't mean surveillance of  
10 safety issues, but how many people are taking up the  
11 vaccine offer --

12 **A.** Yeah.

13 **Q.** -- and who are they. That type of monitoring was the  
14 responsibility of PHE and UKHSA, was it not?

15 **A.** Well, yes, but again, in collaboration, and our main  
16 data source was the national immunisation monitoring  
17 system, which was established by NHS Digital,  
18 subsequently NHS England, but we worked very closely  
19 with them and we primarily are the agency that takes the  
20 role at a national level for producing these kind of  
21 statistics, and publishing them. That's our normal  
22 role.

23 **Q.** If we may just look again at the vaccine surveillance  
24 strategy briefly.

25 It's INQ000477132, thank you. Page 6, please.

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1 self-declare, so that if they came forward to  
2 self-declare, that could be tested against the  
3 definition of the person they were caring for.

4 So that's why that additional information was added.  
5 It wouldn't normally be required in most of our  
6 programmes because there is a clinician initiating the  
7 activity, but obviously with a centrally managed thing  
8 like the Covid programme they wanted more consistency,  
9 I think.

10 **Q.** Was it the case -- and it's a concern that is held by  
11 some disabled people's organisations -- was it a concern  
12 that operational considerations crept into the  
13 definitions within the Green Book, by which I mean there  
14 was a desire to make that particular cohort smaller so  
15 that it wasn't unmanageable, and that might have been  
16 why the definition of unpaid carers in particular was  
17 narrowed?

18 **A.** No, I mean, I don't really see it particularly as being  
19 narrowed, actually, I see it as being -- the main  
20 concern was about equity -- equity and consistency so  
21 that we could make the offer equal and consistent. And  
22 also, really importantly, that we wouldn't be taking  
23 vaccine away from individuals who themselves were at  
24 very high risk of dying from Covid.

25 So at the early stages we didn't have enough vaccine

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1 Which sets out the models for reporting.

2 At 3.1 -- if we could zoom in, thank you -- this is  
3 the existing systems of reporting. It is pointed out  
4 there:

5 "Most vaccines are delivered via primary care and  
6 uptake data are extracted automatically from [the]  
7 GP ... record systems ..."

8 But if we could then go to the next paragraph, 3.2.  
9 We have here that -- as you've just mentioned, the  
10 National Immunisation Management System (NIMS), which  
11 captures demographic data, GP data and employee data --  
12 or, rather, that is what feeds into NIMS, to identify  
13 vaccine-eligible groups.

14 Thank you, we can take that down.

15 There was an evaluation, was there not, a UKHSA-led  
16 paper published in December of 2022, which recognised  
17 some points for improvement with that system, including  
18 better cross-organisational sharing of data, easing of  
19 the data entry burden on immunisation sites. Can you  
20 tell us a little more about that, please, how that was  
21 hoped to be improved.

22 **A.** Well, I think there has been a lot of improvement since,  
23 but it was a new system at the time. It was a game  
24 changer, a really good overall intervention, so we  
25 shouldn't miss that. But yes, I think there was

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1 a rather clumsy way of the data getting in and we  
2 wanted, obviously, people to be able to enter data --  
3 not -- for the people who were giving the vaccines to be  
4 able to get the data into the system with relatively  
5 little overhead in terms of data entry capacity.

6 So point of care apps were produced by the NHS and  
7 they've been rolled out since and there are more of  
8 them, and I think that has reduced that burden. But  
9 that was an initial concern, that there was a need,  
10 potentially, for more data entry than would be required.

11 **Q.** Was there also emerging from that report the identified  
12 issue of individuals who didn't have NHS numbers or  
13 didn't have GP registration not being sufficiently  
14 monitored?

15 **A.** Yes. I mean, we were aware that they wouldn't -- that,  
16 by definition, if you were making your database from the  
17 GP system, you were going to miss out people who weren't  
18 in the GP system.

19 But, again, that was flagged, and I believe over the  
20 first few months of the programme various interventions  
21 were introduced to allow people to get vaccinated  
22 without an NHS number or also -- or to have an NHS  
23 number at the point they came for a vaccine rather than  
24 having to have it in advance. But obviously they would  
25 have missed out on the invitation, for example, if they

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1 immunisation as we had, and so that was why we flagged  
2 those potential issues, to make sure that that was  
3 considered in the implementation and rollout.

4 **Q.** And was there also an important paper in January of  
5 2021, "*Covid vaccination in Inclusion Health*  
6 *Populations*", which focused specifically on those groups  
7 who, it was emerging, had lower uptake, or certainly had  
8 reason to think would have lower uptake: so ethnic  
9 minority groups, vulnerable groups such as migrant  
10 groups, Gypsy, Roma, Traveller groups, homeless people,  
11 to use just a few examples.

12 Did that report make clear that one of the key  
13 considerations is that healthcare has to be taken in  
14 some circumstances to people, that it isn't enough to  
15 simply set up mass vaccination centres, expect people to  
16 walk into their local GP and wait for them to come, that  
17 that kind of model isn't going to engage those  
18 vulnerable groups?

19 **A.** Yes, and I think, again, we were aware of that from our  
20 routine programmes. But there were some additional  
21 barriers with this particular programme that made that  
22 more challenging, one of the issues being the product  
23 itself: coming in multi-dose vials, not being able to be  
24 moved -- the Pfizer product initially wasn't able to  
25 physically be moved and then used. And so, in theory,

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1 weren't on the system.

2 So that is an ongoing issue, I think, for the whole  
3 health service, really, about how we access people who  
4 aren't registered.

5 **Q.** Turning, then, to that issue of monitoring and unequal  
6 uptake and identifying those gaps in coverage, did PHE  
7 produce papers, before even vaccines began to be  
8 delivered to people, highlighting -- and I'm talking  
9 here in particular about a November 2020 paper on  
10 vaccine and health inequalities, considerations for  
11 prioritisation and implementation -- pre rollout  
12 identified the need for identification of vulnerable  
13 groups, the importance of recognising that there are  
14 gaps where the most vulnerable groups may not be  
15 registered with a GP, and not have an NHS number.

16 It appears from what was recognised in that report  
17 that this was a foreseeable difficulty, would you agree?

18 **A.** Yes.

19 **Q.** And was it quite a longstanding problem?

20 **A.** Very longstanding, yes. I mean, I think -- and I think  
21 the NHS were well aware of it as well, but it's not  
22 a trivial thing to correct, obviously, and, yes, we just  
23 felt it was important to flag that, because there were  
24 a lot of people, both JCVI and people working in the  
25 programme, who maybe hadn't been as embedded in

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1 you could go to an outreach clinic with a box of  
2 176 doses, and only use 50 of them. And potentially,  
3 therefore, wasting the rest because it couldn't be moved  
4 and used again.

5 So there were very real barriers very early on, and  
6 therefore it took some time for those outreach models to  
7 start to get implemented, particularly the advent of the  
8 AZ vaccine, which was more flexible in its storage  
9 requirements.

10 **Q.** Once that ability was there to deliver more flexibly,  
11 can you explain in overview what UKHSA did and PHE did  
12 to try to reach those communities identified in these  
13 important papers?

14 **A.** So most of that work was really led by the NHS, I would  
15 say. PHE are obviously very important in pointing out  
16 and helping, hopefully, to monitor it at a national  
17 level, but also at that time we had local teams,  
18 screening and immunisation leads, who were embedded in  
19 the NHS. Now, they would be people who would be  
20 normally working on immunisation programmes with other  
21 stakeholders at a local level, directors of public  
22 health, you know, community groups, et cetera. And they  
23 would be working with the local NHS to work out what  
24 delivery models might be suitable for people, for  
25 example, in homelessness, in the justice system, which

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1 would require things like taking the vaccine to those  
2 individuals.  
3 **Q.** Can I just touch on the issue of local collaboration, by  
4 which I mean collaborating from the centre with local  
5 authorities, who are best placed, potentially, to  
6 identify gaps in coverage locally and to reach those  
7 communities.

8 Were you aware of concerns set out by the -- on  
9 behalf of the local government associations that data,  
10 which would prove important in identifying where gaps in  
11 coverage were locally, was not reaching local  
12 authorities in the early days of the pandemic as quickly  
13 as it should have been or could have been, and that,  
14 when it came, it wasn't sufficiently detailed? Were you  
15 aware of those concerns at the time?

16 **A.** Well, we were aware of their requests for data. I think  
17 the level -- I mean, I think there's a level of  
18 expectation, I guess, as to what was realistic in terms  
19 of what could be provided. As I said, the system was  
20 being established at the time, and there are very strict  
21 governance issues around name data, for example. So  
22 I think we made a lot of efforts to provide data to them  
23 through our platform, secure platforms we developed for  
24 Covid, actually, for sharing data on Covid disease, but  
25 I think the NHS was primarily responsible for managing

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1 I think we had a much less central role to it because  
2 the policy decisions were being made in different  
3 groups. We weren't part of that decision-making  
4 process. So we were providing evidence to support that  
5 decision-making process. And some of that work involved  
6 laboratory work, some of it involved that monitoring  
7 work I was talking about earlier, looking at different  
8 variants and what their implications may be.

9 So I think we did a lot of work on variants, that's  
10 very well noted. I think there is some concern in some  
11 of the witness statements about a delay in some of our  
12 laboratory testing. I would just point out, as my  
13 understanding, that work was commissioned by the  
14 manufacturer, not by government or any of the committees  
15 making those decisions, and I don't think -- our  
16 understanding is that we provided the data relatively  
17 rapidly after we were asked for it, noting that it's  
18 kind of an evolving situation, there were different  
19 variants emerging and we were having to do additional  
20 testing over the period of when some of those products  
21 were being considered by those expert groups, et cetera.

22 **MS STEPHENSON:** Dr Ramsay, thank you very much, those are  
23 all the questions I have for you.

24 **LADY HALLETT:** Thank you, just a few more questions for you,  
25 Dr Ramsay.

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1 that data, and their -- I think it would be through  
2 their local networks that they would be sharing with the  
3 directors of public health, that would be the  
4 appropriate mechanism. And I think there's quite a lot  
5 of this discussed in the NHS evidence statement.

6 **Q.** I just have one final topic to cover with you, and it is  
7 a brief one, and that's the issue of therapeutics. Was  
8 UKHSA's remit in respect of therapeutics to monitor for  
9 evidence of emerging resistance, to produce reports on  
10 the effectiveness, in particular effectiveness against  
11 new strains of Covid?

12 **A.** So I think we had a role in monitoring variants, and  
13 part of that role would be looking at the genetic  
14 changes in the virus that might affect therapeutics. So  
15 we would be flagging issues that might be of concern in  
16 terms of theoretical concerns about whether or not  
17 a product would work. So that was one of our roles, and  
18 we did produce reports on that, looking at potential  
19 resistance to antivirals, for example.

20 **Q.** From your perspective in that area of work, were  
21 therapeutics, and the work you were doing on them, was  
22 it sufficiently prioritised in comparison to work that  
23 was being done on vaccines, and were there any delays in  
24 that work which were problematic?

25 **A.** So I think it was prioritised in terms of our role.

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1 Ms Naik usually hides over that way. There she is.

#### 2 **Questions from MS NAIK KC**

3 **MS NAIK:** Thank you very much, I hope you can hear me.

4 Thank you very much, Dr Ramsay. I represent the  
5 Migrant Primary Care Access Group, and there is a Public  
6 Health England briefing note that's exhibited to your  
7 witness statement from the Behavioural Science and  
8 Insight Unit, and that's entitled "Barriers and  
9 facilitators to Covid-19 vaccination uptake."

10 It's INQ000477091, and it's dated September 2021,  
11 and you refer to it in your witness statement under the  
12 section in relation to unequal uptake of vaccine and  
13 understanding of disparities to uptake, and also in the  
14 section relating to vaccine hesitancy and countering  
15 misinformation.

16 So at page 17 of that document, specifically  
17 referring to barriers to Covid-19 vaccination for adults  
18 from ethnic minority groups and following a number of  
19 other issues there relating to lack of reliable  
20 information, misinformation, language and trust, it then  
21 goes on specifically and expressly to identify that fear  
22 of immigration enforcement and data sharing between  
23 healthcare bodies and Home Office deterred migrant  
24 uptake of the vaccine, and there's a specific section  
25 under a subheading "Fear of persecution", that's how

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1 it's expressed there, that this has been reported by  
2 undocumented migrants and refugees who are either not  
3 aware of this information regarding the absence of  
4 documentation checks at vaccine sites or who do not know  
5 whether to trust this information.

6 And so I just wanted to ask you, what, if any,  
7 specific and tailored interventions were made in  
8 response to this evidence aimed at migrants?  
9 **A.** So that report, as you've said, it has a lot of  
10 information, and that's just one element of it. That  
11 was produced by our behavioural surveillance insight  
12 unit, I think it's called, and that was really mainly to  
13 support local collaborations, so through local directors  
14 of public health and our local screening and  
15 immunisation teams. So I would have expected that --  
16 I mean, that briefing note went out to those local teams  
17 to hopefully support them in understanding what the  
18 barriers might be in their area, and how to address  
19 that. That is to say however -- that's not a new  
20 phenomenon, I think it's something we had found  
21 previously looking at Eastern European migrants of, you  
22 know, people's perception of what might happen if they  
23 came forward for vaccination and whether or not they  
24 could register has always been a potential barrier.

25 So it's something we've been aware of for a while  
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1 He is at the back there.

2 **THE WITNESS:** I can, yes.

3 **Questions from MR JACOBS**

4 **MR JACOBS:** Hello, Dr Ramsay, good afternoon, I act for the  
5 Gypsy and Traveller community and my client is the  
6 Traveller Movement which represents the three Roma,  
7 Gypsy and Traveller communities in the United Kingdom,  
8 and I'll call them the GRT for the sake of convenience.  
9 Did you hear the evidence of Yvonne MacNamara, who  
10 is the CEO of the Traveller Movement, on 16 January,  
11 that was last Thursday?

12 **A.** I didn't hear it but I have looked at the document very  
13 briefly, yes.

14 **Q.** I'm grateful. She highlighted that there's been  
15 a historic problem that the GRT Traveller community  
16 ethnicity is not recorded by institutions. For example,  
17 GRT are not recorded in the NHS Data Dictionary, and you  
18 refer to this issue at paragraph 7.3 of your statement,  
19 no need to turn it up, and you refer to a November 2020  
20 PHE-authorized paper which noted, pre-rollout, that  
21 membership of certain groups is often not recorded in  
22 routine healthcare record systems. And I think  
23 Ms Stephenson took you to this issue at about 12.45, so  
24 about a quarter of an hour ago.

25 And you also refer to GRT, at paragraph 7.5 of your  
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1 and been working with migrant groups, I'm not sure if  
2 we've worked with the people you're representing  
3 yourselves, but I'm sure people within the agency have  
4 at some point touched on those areas.

5 **Q.** So you say you would have hoped -- so was it -- were you  
6 able to say whether it was effective and successful?

7 **A.** I mean, I think not because I think we've already  
8 touched on some of the issues about data. I mean, if  
9 those teams are not -- I mean, apart from, sort of, soft  
10 intelligence on the ground that people were coming  
11 forward, which I think there is some of that in the NHS  
12 witness statements, I don't think there's any formalised  
13 data because, by definition, those groups may not be on  
14 our data system.

15 So that's one of the weaknesses and one of the  
16 ongoing things, I think we really need to continue to  
17 address in the future.

18 **Q.** Thank you. Just to confirm, you said in your statement  
19 that it was shared with a range of local and national  
20 government stakeholders in order to inform efforts to  
21 improve its uptake in specific communities.

22 **A.** Exactly.

23 **MS NAIK:** Thank you.

24 **LADY HALLETT:** Thank you, Ms Naik.

25 Mr Jacobs, I don't know -- can you see Mr Jacobs?  
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1 statement, as being one of the inclusion health groups  
2 which is an umbrella term for people who are socially  
3 excluded, tend to have very poor health outcomes and who  
4 are considered to be at high risk of missing out on  
5 vaccination, and I think Ms Stephenson took you to that  
6 around about 12.50.

7 So I have three questions for you. Firstly, did you  
8 recognise, during the pandemic, how this lack of data  
9 capture relating to the GRT communities could  
10 potentially impact on their vaccine uptake?

11 **A.** Well, I think we did recognise it because that was  
12 partly why that paper was written, prior to the  
13 programme, and I believe we held a workshop with the  
14 Gypsy, Roma, Traveller community with about 150 people  
15 and worked with your organisations to produce some  
16 guidance to try to facilitate that.

17 That didn't solve the data problem but hopefully  
18 would have helped to improve the actual delivery by  
19 making it clear that people were eligible for  
20 vaccination and that Travellers could be registered with  
21 GPs, advice was produced for GPs, advice was produced  
22 for the community itself and advice was produced for  
23 various other elements of the health service to try to  
24 facilitate that.

25 I wouldn't -- we still don't, as far as I know, have  
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1 good data to show how effective that might be and that  
 2 is something long-term we would very much appreciate.  
 3 As you say, then, we've been aware that that community  
 4 in particular, misses out on other vaccines in the past.  
 5 **Q.** Really what I wanted to sort of follow up on there, was  
 6 there was an awareness that the lack of data capture was  
 7 an issue in relation to vaccine uptake in this group,  
 8 for example, if a group is statistically invisible, then  
 9 they can't be looked after and planned for by the  
 10 medical institutions? Was that something that was at  
 11 the forefront of your thinking at the time?  
 12 **A.** I don't know whether it was at the forefront of  
 13 everyone's thinking, I think it's very much part of our  
 14 overall view of the inequalities picture and the  
 15 inclusion groups picture, that this was one group where  
 16 we know not only were they less likely to access  
 17 vaccines, they were also potentially at higher risk  
 18 because of underlying comorbidities, underlying  
 19 sociodemographic issues, so I think we were very well  
 20 aware of that as an organisation, and again, it comes  
 21 back to how we would try and influence that, it would be  
 22 mainly at a local level because it's obviously at  
 23 a local level that people will be aware of where their  
 24 Traveller sites are, et cetera, and what facilities and  
 25 services there are for those Traveller sites and how

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1 not just Covid.  
 2 **Q.** Well, that leads me to my final question. In respect of  
 3 this data desert, if you like, that was raised by  
 4 Ms MacNamara and others in this Inquiry, what actions to  
 5 address that will be made that you're aware of in future  
 6 pandemics?  
 7 **A.** Well, I don't -- again, I don't think this is just an  
 8 issue for the pandemic; I think it's an issue for all  
 9 time, and I do think we do need sustainable solutions  
 10 to -- reaching out to that community in order to ensure  
 11 that they are getting access to vaccination and to other  
 12 healthcare interventions and other prevention measures,  
 13 and obviously engagement to improve trust in that  
 14 community so that they are more able to come forward.  
 15 Vaccines are a medical intervention. I think it's  
 16 very important that people are engaged with the health  
 17 service in order to receive those, that it isn't just  
 18 given as a separate thing. So I do think that, as part  
 19 of the overall reach-out of the whole health service to  
 20 that community, that would be my kind of advice. I have  
 21 relatively limited leverage across the whole system, of  
 22 course.  
 23 **MR JACOBS:** Of course.  
 24 Just on one --  
 25 **LADY HALLETT:** Thank you very much, Mr Jacobs.

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1 those have been funded and maintained over a long period  
 2 of time.  
 3 **Q.** That's helpful. I just have two other questions.  
 4 We've seen examples, in the evidence, of limited  
 5 local initiatives to engage the GRT community, for  
 6 example at Appleby Horse Fair, but we haven't seen in  
 7 the evidence any concerted effort at a national level to  
 8 ensure the inclusion of GRT in a systematic manner. And  
 9 my question for you is, notwithstanding what you've  
 10 said, but given this lack of data recognition of GRT and  
 11 the knowledge that GRT faced health inequalities and  
 12 social exclusion, what specific efforts were made at  
 13 national level, not locally, but at a national level, to  
 14 ensure the targeting of GRT communities in the  
 15 vaccination programmes?  
 16 **A.** I'm personally not aware of specific -- but other than  
 17 holding that national workshop -- which wasn't about  
 18 data, that was about trying to make sure the guidance  
 19 was as facilitative as possible -- I'm not aware of  
 20 anything specifically at a national level. And I'm not  
 21 entirely sure of the technical issues that stopped that  
 22 data collection, but I'm very happy to take that  
 23 forward, and I'm very happy that we would look to a more  
 24 sustainable solution to ensuring that this community in  
 25 particular is able to access vaccinations of all types,

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1 I'm sorry, the stenographer has had the toughest of  
 2 tough mornings, so we'll have to leave it there.  
 3 **MR JACOBS:** Of course, I understand. Thank you.  
 4 **LADY HALLETT:** Thank you very much indeed for your help,  
 5 Dr Ramsay, extremely grateful to you.  
 6 And we will take a break now and I will come back  
 7 at 2.05 pm.  
 8 (The witness withdrew)  
 9 (1.05 pm)  
 10 (The Short Adjournment)  
 11 (2.05 pm)  
 12 **LADY HALLETT:** Mr Keith.  
 13 **MR KEITH:** My Lady, the next witness is Susannah Storey, the  
 14 Permanent Secretary at the Department for Culture, Media  
 15 and Sport. Could you be --  
 16 **LADY HALLETT:** I hope you were warned we wouldn't get to you  
 17 until this afternoon.  
 18 **THE WITNESS:** I was, thank you.  
 19 **MR KEITH:** Could you be sworn, please.  
 20 **MS SUSANNAH STOREY (affirmed)**  
 21 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4**  
 22 **MR KEITH:** Could you please commence your evidence by giving  
 23 us your full name.  
 24 **A.** Susannah Jemima Storey.  
 25 **Q.** Thank you very much, Ms Storey. Thank you for attending

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1 today and for the provision of your witness statement  
2 dated 2 August 2024, some 29 pages, and for the  
3 44 exhibits that you also supplied.

4 You are now the Permanent Secretary at the DCMS, but  
5 from August 2019 to February 2023, were you the Director  
6 General of what is known as the Digital and Media group  
7 in the DCMS?

8 **A.** I was.

9 **Q.** And within the many directorates for which you were no  
10 doubt responsible, was there a directorate called the  
11 Security and Online Harms Directorate?

12 **A.** Yes.

13 **Q.** And within that directorate was there something known as  
14 the Counter Disinformation Unit?

15 **A.** There was. Originally Counter Disinformation Cell.

16 **Q.** What are, as far as the government sees it,  
17 disinformation and misinformation?

18 **A.** Yes, I put the government's definition in my statement.  
19 Disinformation is defined as the deliberate creation and  
20 dissemination of false information which is intended to  
21 deceive and mislead. And misinformation is the same but  
22 without the deliberate intent.

23 **Q.** In terms of the government understandably seeking to  
24 monitor falsities, or what is being said in the public  
25 domain that is untrue and trying to do something about

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1 worried about mis- or disinformation, because they could  
2 contribute to real-world problems.

3 And as I said in my statement -- if it's helpful for  
4 me to briefly elaborate -- actually at the start of the  
5 pandemic there was vandalism and fires on telephone  
6 aerials and infrastructure, and that was causing us real  
7 concern at the time.

8 So I think there's lots of different examples why  
9 governments might be interested in this at all sorts of  
10 different times, but particularly in the context of  
11 a global pandemic.

12 **Q.** Just to try to delineate the particular types of harm or  
13 harmful consequences from not countering, in  
14 a proportionate and reasonable way, dis- and  
15 misinformation, firstly, presumably, if obvious  
16 falsehoods are not countered, are not dealt with, there  
17 can be a heightened distrust in government and health  
18 services generally, would you agree?

19 **A.** I would.

20 **Q.** There could also be a heightened distrust in medicine,  
21 in particular vaccines?

22 **A.** Potentially.

23 **Q.** Thirdly, it can have an impact, can it not, on rates of  
24 uptake of vaccines?

25 **A.** Potentially.

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1 it, does it matter whether the false information is  
2 being deliberately disseminated and is therefore  
3 disinformation as opposed to misinformation?

4 **A.** I mean, I think it can be context-specific, but in the  
5 case of this piece of work and this team at the time of  
6 Covid, we were interested in either, because what we  
7 were trying to do was look at mis- or disinformation  
8 that might be causing harm and might cause harm to  
9 public safety or public health or national security.

10 **Q.** So the intent behind the dissemination perhaps matters  
11 a little less?

12 **A.** It might do.

13 **Q.** You've just referred to it, but if you could just build  
14 on your answer, please. Why, in the context of the  
15 extreme public health demands of a pandemic, is mis- and  
16 disinformation a matter for government?

17 **A.** Well, as I said in my statement, there had been a sort  
18 of growing focus, in policy terms, on mis- and  
19 disinformation for a number of years before the  
20 pandemic, and we'd been asked to set up, been asked to  
21 set up a formal team on this, actually in 2019.

22 And the reasons I think the government was focused  
23 on it is situational awareness. It helps you understand  
24 a situation if you know what is going on online in open  
25 fora. And in particular, in some circumstances, you are

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1 **Q.** And I suppose, is there a link also to routine  
2 immunisation? So falsity perpetrated in a public domain  
3 or propagated in a public domain about vaccines in the  
4 context of Covid can have an indirect effect on routine  
5 immunisation take-up?

6 **A.** Yeah, I think -- before I was even in post I know that  
7 the Health Department had talked to the DCMS team about  
8 vaccine hesitancy, so it had been -- which could be  
9 caused by lots of different things.

10 **Q.** Sure.

11 **A.** But that had been a concern.

12 But just the one thing I want to point out at this  
13 point, if it's okay, is that whilst mis- or  
14 disinformation could contribute to a lot of those things  
15 you've just described and many more, real-world harms,  
16 there was always a very, very acute focus in this team  
17 on freedom of expression. So it wasn't that just  
18 because something caused a harm, that was a problem.  
19 There was a balance between the assessment of that harm  
20 and, of course, the need for freedom of expression.

21 **Q.** We'll come back to that. I was only asking you in very  
22 general terms what conceptually the harms are.

23 **A.** Yes.

24 **Q.** And why government is interested in this issue.

25 **A.** Yeah.

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1 Q. In very general terms, again, Ms Storey, if the  
2 government corporately comes across a piece of mis- and  
3 disinformation, or rather, if there is a piece of mis-  
4 or disinformation in the public domain, is there  
5 a distinct limit in fact on what the government can do  
6 about it beyond monitoring, simply acknowledging that it  
7 is there, looking at it, reaching a view as to the  
8 potential harm, and then bringing it to the attention  
9 of, in particular, social media companies and saying,  
10 "Well, it's a matter for you"?

11 A. Well, broadly I agree with that. So the -- the, sort  
12 of -- the remit of this team was very clearly defined,  
13 and didn't include everything. So there were specific  
14 parameters set out, it was only looking at open source  
15 online information. If, in the particular searches it  
16 was doing, all of which would have been agreed with  
17 ministers in terms of those parameters, if, in the  
18 course of that, certain mis- or disinformation was  
19 captured, then if the team believed that that mis- or  
20 disinformation was false, and also potentially breached  
21 the terms and conditions of the social media platforms,  
22 then they would flag it to them, but then, to your  
23 point, it was a matter for the platforms what they did  
24 about it. They might decide to do nothing.

25 So this team was analysing those narratives and  
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1 A. Yeah.

2 Q. -- telling ministers what's out there, and taking a view  
3 on reporting individual instances of mis- and  
4 disinformation to the social platforms for them to deal  
5 with?

6 A. Reporting narratives and trends, not always individual  
7 instances.

8 Q. All right. Reporting trends as well. And did the unit  
9 have any function in or any role in relation to, or do  
10 anything remotely connected with surveying people?  
11 Carrying out surveillance of people?

12 A. No, and in fact you can see in the compliance policy  
13 that I've included as one of the exhibits, it was very  
14 explicit that it should not be doing that.

15 Q. We'll look at that.

16 A. So there was monitoring within certain parameters but  
17 not surveillance under the law.

18 Q. Did it, in law, have the ability or in practice did it  
19 take to itself the ability to look at private material?

20 A. So it was looking for narratives and trends in open  
21 source public material, so things that people or  
22 entities had posted, not private communications. There  
23 was, from time to time, in the search for information  
24 against specific parameters, sometimes as a kind of  
25 byproduct, some personal information might be captured.

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1 trends and taking action in relation to some of them,  
2 but the team itself had no power to require the  
3 platforms to do something about it.

4 Q. We'll look at that in a minute or two in more detail.

5 So just to deal, again at quite a high level with  
6 the Counter Disinformation Unit's or cell's role in the  
7 general scheme of things, it was not a body that was  
8 concerned with putting out into the public domain the  
9 government's general public health messages?

10 A. Absolutely not.

11 Q. It wasn't to do -- in fact, it had nothing to do with  
12 the provision of public health information about -- from  
13 the DHSC or the NHS?

14 A. No.

15 Q. It had nothing to do with the Cabinet Office or the  
16 DCMS's usual communication systems by which they deal  
17 with the public and deal with the press and deal with  
18 public health messages?

19 A. No. That's right. The cell was inputting some  
20 information into some of those teams, but it itself was  
21 not an output in those communication terms that you  
22 describe.

23 Q. It was monitoring what was going on in the public  
24 domain, and we'll look at in a moment in detail at  
25 what's meant by public domain --

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1 So, for example, a Twitter handle or some other way of  
2 identifying the post. But the team then took careful  
3 steps to anonymise that data before onward transmission  
4 within the government system, and obviously, if they  
5 were flagging this information because it had met the  
6 parameters to be flagged to the social media companies,  
7 they would also be making clear, you know, just for  
8 identification purposes only. So the team were very  
9 mindful of their obligations under the Data Protection  
10 Act.

11 Q. So to summarise that, the unit only looked at material  
12 in the public domain. So a social media post, for  
13 example?

14 A. Yes.

15 Q. When somebody posts a post on social media, there is an  
16 element of that post which is personal, namely the user  
17 name, the person who put it there?

18 A. Yes, it could be an anonymised name or some other name  
19 but it -- (overspeaking) --

20 Q. But a piece of data?

21 A. Yes, that's right. It could be their personal data.

22 Q. But that piece of personal data, such as it is, but it's  
23 probably anonymised is put into the public domain  
24 alongside the post by the person who posts it?

25 A. That's right.

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- 1 Q. So when the unit says, well, there is a bit of data here  
2 that's personal, they're only monitoring or responding  
3 to data which has already been put into the public  
4 domain by the user?
- 5 A. That's right.
- 6 Q. Right.
- 7 A. And as I said, the primary objective of the unit is  
8 actually the narrative or trend in the information, not  
9 the personal data. So for example, if the post said  
10 something about Covid being connected to 5G, that's the  
11 issue the unit is looking for.
- 12 Q. So you don't really care who posts it; what you're  
13 concerned about is the impact on the general message of  
14 the contents of the post?
- 15 A. That's right.
- 16 Q. Right.
- 17 A. The narrative and the trend.
- 18 Q. And if you don't care about who is posting it, does it  
19 follow from that that the unit had no interest in, and  
20 no business in, following individuals, whether they be  
21 members of the public, journalists, academics,  
22 Parliamentarians -- I'll come back to the question of  
23 journalists and Parliamentarians specifically in  
24 a moment, but did you care who was posting?
- 25 A. The primary objective was those narrative and trends.

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- 1 And:  
2 "The ... vaccine is a means used by governments or  
3 the elites to modify/control the population ..."  
4 Microchips will be injected. Vaccines are being  
5 deliberately trialled on those from BAME backgrounds or  
6 frontline workers.  
7 There's a reference there to the number of deaths,  
8 I suppose, of the participants. So one narrative is  
9 that there were disproportionate or highly significant  
10 levels of death.  
11 Bill Gates gets a note up there.  
12 Vaccines aren't necessary.  
13 Covid is harmless. Vaccines are harming health.  
14 In relation to the harming health element and  
15 vaccines, did the unit proceed on the obvious and  
16 self-evident basis that all medicines, including  
17 vaccines, may have side effects, some of them quite  
18 serious or very serious? What was -- the concern,  
19 however, held here was that there was a general  
20 narrative that the vaccine had had significant side  
21 effects on those involved in the trials.
- 22 A. Yes, so this is just -- this is a summary in the advice  
23 to ministers, which was for their information.
- 24 Q. Right.
- 25 A. And this was in the summer of 2020 and I think it's

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- 1 It was the substance of the post, it was not the private  
2 individual's information. And as I'm sure you're going  
3 to say in a minute, there were some specific carve-outs  
4 to ensure Parliamentarians and journalists were not  
5 captured.
- 6 Q. Yes. Can we just look at the sorts of disinformation  
7 that the CDU had to deal with, and have up INQ000361167.  
8 So this is a note to ministers, dated 22 July 2020.  
9 It's a submission, and it comes from the security and  
10 online harms directorate. We can see that in the top  
11 right-hand corner, can't we?
- 12 A. Yes.
- 13 Q. And this isn't actually a -- it's not actually one of  
14 the weekly reports, it's a general submission, isn't it,  
15 on the work that the unit is doing?
- 16 A. That's right.
- 17 Q. If you could turn over, please, to pages 6 to 8.  
18 "Since late April 2020, a range of anti-vaccination  
19 narratives have been observed by the ... Counter  
20 Disinformation Cell ..."  
21 That's the CDU, isn't it?
- 22 A. It is.
- 23 Q. "Vaccines as a form of population control ...  
24 "The UK Government will introduce mandatory vaccines  
25 ..."

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- 1 giving an illustration of the sorts of themes and  
2 narratives --
- 3 Q. That were out there?
- 4 A. -- that were out there.
- 5 Q. So this wouldn't necessarily trigger any sort of  
6 reaction on the part of the CDU; this is just  
7 identification of the narratives that are in the public  
8 domain?
- 9 A. That's right, yeah.
- 10 Q. So if we then look at INQ000361175, we can see an  
11 example of a particular report. Was this a weekly  
12 report?
- 13 A. Yes.
- 14 Q. "Over the past week the Cell has observed 57 pieces of  
15 content and made 16 escalations to platforms."  
16 Is that a reference to telling the platforms that  
17 these pieces have brought themselves to your attention,  
18 and you inviting the platforms to apply their policies  
19 as they see fit and do whatever they want to do?
- 20 A. Yes, so the unit had this status called "trusted flagger  
21 status" which the government and some NGOs and academics  
22 and other bodies had. And it meant that if, in this  
23 instance, the unit was seeing mis- or disinformation  
24 that it believed was harmful to public health or public  
25 safety and it believed was in breach of that particular

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1 or multiple platforms' terms of service, then it would  
2 flag them to them.  
3 So what this is saying is there had been 57 pieces  
4 of content that meet those criteria, but only 16 have  
5 met the criteria to be escalated to platforms, and then,  
6 as we were discussing before, it may well be -- and this  
7 document, I think, goes on to show what happened -- not  
8 all of the 16 would have had necessarily the same  
9 treatment by the platform because it was their  
10 prerogative to decide what to do.

11 **Q.** Right. And we can see that there were a number of  
12 instances in which the cell had brought to its attention  
13 or saw online in public, documents, posts or videos  
14 dealing with the extent of the impact of the vaccines  
15 and their supposed high levels of side effects, health  
16 misinformation about the genetic alteration of cells,  
17 that the vaccines are biologically manipulated  
18 bio-weapon, if you could scroll back out, over the page,  
19 "Hoax material, no pandemic, Covid-19 is a bioweapon."

20 And in some of these instances, not necessarily all  
21 of them, the social media platforms responded by taking  
22 them down or not taking them down, as they saw fit.

23 **A.** Yeah, each social media platform would have their own  
24 policies and it would be their prerogative to decide  
25 what to do.

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1 platforms, that was the way it was searched for, but any  
2 information posted by journalists or elected Members of  
3 Parliament would not be included. So that was  
4 a specific carve-out to ensure, you know, free and open  
5 debate and freedom of expression.

6 **Q.** You mentioned earlier the compliance policy. Let's  
7 perhaps have a look at that. INQ000361185.

8 If we go to the top -- thank you very much -- now of  
9 page 4., we can see there the reference to human rights  
10 laws, data protection legislation, surveillance laws,  
11 RIPA, and of course there's an extremely tight, rigorous  
12 process within RIPA providing for warrants for active  
13 interventions such as surveillance and so on; and none  
14 of that had any application at all to the unit?

15 Page 6, paragraph 3.8, we can see something of the  
16 general obligations set out: the analysis and conduct  
17 must meet the permitted purpose, must be necessary and  
18 proportionate, doesn't amount to surveillance.

19 And there's a checklist.

20 Page 7, paragraph 4.1, is this right, there is  
21 detail there set out of the flagging process, that's the  
22 process you've just described --

23 **A.** Yeah.

24 **Q.** -- whereby if something appears to fall within the remit  
25 of the unit, it's public, it could lead to significant

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1 **Q.** Right. Very briefly and just by way of overview, were  
2 the officials in the unit subject to a significant  
3 degree of oversight and legal obligation?

4 **A.** Yes, yes. So I was responsible for those teams.  
5 There'd be all sorts of the usual parameters in place,  
6 and they would be aware of their obligation and  
7 ultimately, we all reported to the ministers and at the  
8 time it was Oliver Dowden.

9 **Q.** Ministerial oversight, subject to the GTPA, that's the  
10 General Data Protection Regulation and Data Protection  
11 Act, Human Rights Act, Civil Service Code, obligations  
12 of integrity, and so on, and political neutrality?

13 **A.** Yes.

14 **Q.** And, of course, subject to the common law obligation to  
15 ensure that all data, monitoring and analysis was  
16 lawful, necessary, and proportionate.

17 Was there also an express ban on the reference or  
18 the referral of content posted by Parliamentarians and  
19 journalists?

20 **A.** Yes, there was.

21 **Q.** How did that work?

22 **A.** Well, if the content that met the criteria that I've  
23 described in terms of being mis- or disinformation, and  
24 potentially risking public health and public safety, and  
25 potentially breaching the terms and conditions of the

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1 harm, then the officials have to put the material  
2 through a kind of escalating process of deciding whether  
3 or not it gets referred to the social media platform?

4 **A.** That's right.

5 **Q.** Page 9, dos and don'ts. Lots of hedging around the  
6 functions and the role of the unit. And in borderline  
7 cases, did in fact officials have to seek sign-off from  
8 more senior officials before matters could be referred  
9 to the social media platform?

10 **A.** They did.

11 **Q.** All right. By comparison to the number of documents,  
12 posts, videos, whatever, referred to social media  
13 platforms by the CDU during the course of the pandemic,  
14 how many documents are you aware, posts or videos, did  
15 the social media platforms themselves remove without any  
16 kind of prodding from the CDU?

17 **A.** So I don't have --

18 **Q.** Roughly.

19 **A.** Yeah, I don't have a scientific assessment. In my  
20 statement I've included, you know, thousands and  
21 sometimes millions of documents that the social media  
22 platforms themselves dealt with, and I think I'd say  
23 that we looked at something like 3,500 pieces of  
24 information flagged, of which around 55% related to  
25 vaccine issues. So it was a tiny, tiny proportion.

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1 But, as I say, this was really about an input into  
2 a wider process.  
3 But the platforms themselves I think over the course  
4 of the pandemic also evolved their own processes, and  
5 you would want to talk to them about those specifics.  
6 **Q.** Of course. I think in your statement you say that --  
7 you've obviously done some research on this:  
8 "Meta ... displayed warnings on Facebook on more  
9 than 190 million [pages] ... [as being, at least in  
10 part] false, partly false, altered or missing context.  
11 In September 2021, Meta reported that it had removed  
12 more than 20 million pieces of false Covid-19 and  
13 vaccine [related] content."  
14 I'm very sorry to observe that, but that rather puts  
15 the unit and your department's work in the shade.  
16 **A.** Absolutely. And I think that's important to be clear  
17 about, which is the scale of the responsibility of the  
18 platforms in these situations and also, as I said there,  
19 it wasn't just that they would remove information. You  
20 know, a really important thing during Covid was to be  
21 the signpost and the flag to trusted health information,  
22 and that was something that the team worked closely with  
23 them on.  
24 **Q.** Just for a moment on that, so I didn't ask you  
25 deliberately at the beginning, but one of the major ways

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1 **A.** That is not my view.  
2 **Q.** Do you believe that the genuine experiences of the  
3 vaccine injured and bereaved were wrongly swept up in  
4 this monitoring process and wrongly brought to the  
5 attention of social media platforms?  
6 **A.** No, I mean, as I say, the purpose of the unit was very  
7 specifically trying to minimise the public health or  
8 public safety impact of this mis- or disinformation.  
9 Obviously you're doing general searches, so it is  
10 possible that some information could be captured and  
11 ultimately flagged, if it hit those criteria I said,  
12 that might not be mis- or disinformation, and then it's  
13 for the platforms to assess whether it meets their terms  
14 of service or not and then for them to decide what do.  
15 **Q.** Did the flagging system that you've described, and the  
16 trusted status which the CDU have, in any way lead to  
17 pressure being applied to social media companies to  
18 remove content wrongly?  
19 **A.** No, I don't think so. I mean, I think at the beginning  
20 of the pandemic, the Secretary of State and I think the  
21 Health Secretary were very keen to work with the  
22 platforms, and there was a number of roundtables later  
23 in the pandemic, after the vaccine we had this Counter  
24 Disinformation Policy Forum, so there was lots of  
25 proactive work with them, but that was more about this

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1 in which a government may respond to dis- or  
2 misinformation is to keep on repeating its own message?  
3 **A.** Yes.  
4 **Q.** And obviously it was important that social media  
5 platforms, along with all other organisations which  
6 disseminate material into the public domain, they were  
7 encouraged to keep on printing, repeating,  
8 disseminating --  
9 **A.** Yeah.  
10 **Q.** -- the public health lines?  
11 **A.** Absolutely. Absolutely.  
12 **Q.** All right.  
13 X, you say, had removed over 65,000 pieces of  
14 content and suspended over 3,000 accounts for violations  
15 of its Covid-19 guidance.  
16 YouTube removed over 130,000 videos, and TikTok  
17 introduced a Covid-19 information hub providing answers  
18 to questions, no doubt with the help of the government,  
19 on public health issues, which was viewed 921 million  
20 times. So that gives you an idea of the scale.  
21 **A.** Yes.  
22 **Q.** Was the work of the Counter Disinformation Unit, quote,  
23 "secret extra judicial censorship with no oversight akin  
24 to how illegal terror content is dealt with by the  
25 government"?

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1 point of getting them to flag trusted health  
2 information, getting them to make sure their terms of  
3 service were clear and transparent about what they were  
4 actually doing in terms of content moderation.  
5 **Q.** And finally, just so we can put the work of the unit  
6 into a wider context it would be very helpful if you  
7 could just describe what you see as the main impacts of  
8 the Online Safety Act in the sphere of public health  
9 disinformation.  
10 The Inquiry is aware that the Act obliges companies  
11 to take action over illegal or harmful content online,  
12 and I think there is in fact, I think, a new offence  
13 created, called a false communications offence, concerns  
14 spreading information that is known to be false, but do  
15 the provisions in the Act cover the same territory as  
16 public health disinformation and misinformation?  
17 **A.** You're asking me to go outside the remit of my current  
18 role but I'm happy to give you a personal view.  
19 So, during the course of the years before and during  
20 the pandemic, we were working on the Online Safety Bill,  
21 which became the Act, and as you rightly point out,  
22 I understand it does contain some measures in relation  
23 to false communication and foreign interference.  
24 As to its effectiveness, I think we need to wait to  
25 see when the Act is fully in force and then see what

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1 happens.

2 **Q.** It wasn't a trick question. It seems to be apparent  
3 from the very features of the Act that you describe,  
4 that it wasn't directed at public health disinformation  
5 and misinformation?

6 **A.** No.

7 **Q.** It deals with illegal and harmful content?

8 **A.** That's right.

9 **Q.** Which may or may not be the same thing.

10 **A.** That's right, it could overlap but that isn't the  
11 primary purpose of it. And it did, in effect, become  
12 the regulatory regime for dis- and misinformation. But  
13 at the time of the pandemic we didn't have such --

14 **Q.** It wasn't in effect.

15 **A.** -- a regulatory regime.

16 **Q.** No. But when was the bill first conceived?

17 **A.** When I came into the job in August 2019, we'd already  
18 had the Internet safety Green Paper and the government  
19 response, and then we were preparing the -- the  
20 White Paper was out and then we were preparing the  
21 response to the White Paper, and then the Bill was  
22 introduced during the pandemic.

23 **Q.** So the Act -- the bill followed the 2017 Green Paper  
24 Internet strategy?

25 **A.** That's right, and then its own White Paper.

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1 identified by those trials, and therefore the signals  
2 for any emerging adverse reactions would need to be  
3 carefully identified and monitored.

4 You've said in your statement that if the CDU came  
5 across a new narrative, and needed to determine the  
6 veracity of the content, it would use third-party  
7 sources to establish whether the content could  
8 constitute mis- or disinformation, and you say that that  
9 involved looking at trusted, publicly available sources,  
10 including the NHS guidance for Covid, credible  
11 journalistic sites, such as the BBC, or using  
12 independent fact-checking sources. I think you gave the  
13 example of Full Fact.

14 **A.** That's right.

15 **Q.** Thank you. So given the context that I've set out of  
16 the stage of the vaccine rollout, would you accept that  
17 given the speed and the novelty of the vaccine rollout,  
18 there could be instances where individuals reported  
19 injuries on social media that they attributed to the  
20 vaccine, but, due to the early stage of the rollout,  
21 third-party sources like the NHS, public health sources,  
22 and the media, might not have yet had sufficient time to  
23 evidence those and verify those claims?

24 **A.** I can agree with the point you're making that it may  
25 well be the public health authorities hadn't had time to

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1 **MR KEITH:** Thank you very much, Ms Storey. Those are all  
2 the questions I have for you. There may be some further  
3 questions.

4 **LADY HALLETT:** There are. Thank you very much, Mr Keith.  
5 Ms Morris, who is sitting at the back there, if you  
6 could make sure your answers get into the microphone,  
7 I'd be very grateful.

#### Questions from MS MORRIS KC

9 **MS MORRIS:** Thank you very much, my Lady.  
10 Ms Storey, I ask questions on behalf of the Covid  
11 Vaccine Adverse Reaction and Bereaved groups, and these  
12 groups represent those who have suffered injury or  
13 bereavement following their voluntary acceptance of the  
14 Covid vaccine, just so you understand where the  
15 questions are coming from.

16 **A.** Thank you.

17 **Q.** I'm going to focus my two questions on the issue of how  
18 the information that members of those groups shared on  
19 social media may have wrongly been labelled by the CDU  
20 as misinformation or disinformation, okay?

21 And by way of context, of course, we're dealing here  
22 with a population-level rollout of a novel set of  
23 vaccines where, even though there'd been clinical  
24 trials, there's an acceptance that there would be  
25 adverse reactions and -- that might not have been

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1 verify what was being said. What I don't know, I'm  
2 afraid, is what then happened to that information,  
3 whether it was picked up by the CDU and/or whether it  
4 was flagged to social media, or whether social media  
5 companies, under their own terms and conditions, might  
6 have taken action in relation to this content.

7 **Q.** Okay. But it may well have been flagged by you if  
8 someone is reporting an injury that you can't find any  
9 third-party verification for?

10 **A.** I think it's conceivably possible, but my understanding  
11 of what the unit was doing was more about really  
12 significant trends and narratives of dis- and  
13 misinformation. So the example I was giving in my  
14 statement was when the 5G masts were being vandalised.  
15 So it's hard for me to give you a definitive answer I'm  
16 afraid.

17 **Q.** Understood. But in the document that Mr Keith showed  
18 you in your evidence earlier on, the list of what you  
19 described as being an anti-vaccination narrative,  
20 vaccinations being harmful to health was part of that  
21 narrative, would you agree?

22 **A.** That was, yes, in the summary document that was giving  
23 ministers illustrations of some of the trends that were  
24 online.

25 **Q.** Yes, okay. So just -- my second question, following on

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1 from that, would you accept that if it did happen, the  
2 labelling of unverified claims as mis- or disinformation  
3 prematurely could discourage a discourse of legitimate  
4 concerns, and thereby potentially delaying the  
5 identification of new signals around safety of the  
6 vaccines?

7 **A.** I mean, I think it was unlikely, given the scale we  
8 discussed, of the amount of information this unit was  
9 flagging, and then what happened to it, that that would  
10 be the case, just because of -- it's much more likely,  
11 I think, that under social media companies' ordinary  
12 terms and conditions, theoretically, they could be  
13 making a decision in a general sense without  
14 understanding the specifics.

15 **LADY HALLETT:** Sorry, could you make sure --

16 **THE WITNESS:** Sorry.

17 **LADY HALLETT:** Don't worry, Ms Morris will understand the  
18 need for --

19 **THE WITNESS:** Sorry if I'm not looking at you.

20 **MS MORRIS:** That's okay.

21 You mentioned scale -- finally, you mentioned scale,  
22 but can you help with whether the social media companies  
23 adopted a similar definition of mis- and disinformation.  
24 Would there have been consistency outside of those  
25 organisations?

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1 think that would be a helpful way to deal with it, not  
2 whether or not you would implement it.

3 **A.** Well, I said in my statement that because it was  
4 a devolved policy area we were primarily not focused on  
5 those areas, but there were *ad hoc* connections between  
6 ministers and their devolved counterparts and also some  
7 of the work of this unit was inputting into wider DHSC  
8 boards which did include the devolved administrations.  
9 So there was some connection in some of these areas,  
10 and obviously if we thought it was helpful, we would  
11 have absolutely done that.

12 **Q.** But do you think it would be helpful?

13 **A.** It's very hard to say, not knowing what the specifics  
14 are of the situation. Potentially. But obviously we'd  
15 have to work out how that would work in a devolved  
16 policy area.

17 **DR MITCHELL:** I'm obliged, my Lady.

18 **PROFESSOR THOMAS:** Thank you very much, Ms Mitchell.

19 I think that completes the questions for you,  
20 Ms Storey. I am extremely grateful to you for your  
21 help. Thank you.

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

23 (The witness withdrew)

24 **MR KEITH:** Would my Lady wish to hear from the next witness,  
25 Charlet Crichton, with or without a break?

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1 **A.** I think you'd have to ask them that. I don't have that  
2 detail of information at the moment.

3 **MS MORRIS:** That's helpful. Thank you.

4 Thank you, my Lady.

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

6 Ms Mitchell, who is opposite you.

#### 7 Questions from DR MITCHELL KC

8 **DR MITCHELL:** I appear as instructed by Aamer Anwar on  
9 behalf of the Scottish Covid Bereaved. It's been said  
10 in this Inquiry many times that Covid does not respect  
11 borders, and the same, I think could be said of social  
12 media. In that regard, do you think that an approach  
13 which was cross-border in relation to how you deal with  
14 misinformation and disinformation, the social media  
15 policy, would be good for all four nations in a future  
16 pandemic?

17 **A.** Mis- and disinformation is a devolved policy area, as  
18 I think you're alluding to, but yes, obviously it is the  
19 case that everything to do with tech policy, in my  
20 experience, goes cross-border and it isn't that a post  
21 can't be read by somebody across the border. So  
22 I appreciate what you're saying but it is really not my  
23 decision as to how that kind of issue would be addressed  
24 in a future pandemic.

25 **Q.** No indeed, but what I'm asking you is whether or not you

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1 **LADY HALLETT:** No, I think just carry straight on. Unless  
2 the witness wanted --

3 **MR KEITH:** No, I think we can do that. Thank you.

4 So the next witness is Charlet Crichton of UK CV  
5 Family.

#### 6 MS CHARLET CRICHTON (affirmed)

#### 7 Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4

8 **LADY HALLETT:** Ms Crichton, I know you were lined up to give  
9 evidence last week but sadly you couldn't because of the  
10 death of your mother. I'm really sorry.

11 **THE WITNESS:** Thank you.

12 **LADY HALLETT:** And it's really kind of you to come and  
13 assist us when you must be still right in the middle of  
14 your grieving process. So thank you very much indeed.

15 **MR KEITH:** Ms Crichton, could you commence, please, your  
16 evidence by giving us your full name.

17 **A.** My name is Charlet Elizabeth Crichton.

18 **Q.** Thank you very much. Thank you for attending today, as  
19 the Chair said, and for providing the Inquiry with the  
20 material you have.

21 You're the founder of a group known as UK CV Family.

22 We'll talk a little bit more in a moment about what they  
23 do. But as the founder, you've produced two statements,  
24 one dated 17 October 2024, and I'm going to mention  
25 this, running to a whopping 344 pages, and a second

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1 supplementary witness statement, a further  
2 176 paragraphs of text with another 117 exhibits to go  
3 with the 500 or so more exhibits -- 500 or more so  
4 exhibits that you produced with your first witness  
5 statement.

6 I want to assure you, the Chair and the Inquiry  
7 legal team, and myself, have read all that material on  
8 a repeated basis so we've gone back through your  
9 statements again and again.

10 UK CV Family is a group which is concerned with  
11 injury and bereavement following vaccination; is that  
12 right?

13 **A.** That's right.

14 **Q.** Now, obviously the phrase "following vaccination" says  
15 nothing other than making a temporal reference that it  
16 followed in time after vaccination, about the cause of  
17 the injury or the bereavement. Presumably in relation  
18 to all your members, they all stepped up and took  
19 a vaccine?

20 **A.** All of us did, yeah, including myself. And I actually  
21 volunteered at a vaccination centre in Kent, which was  
22 the first mass vaccination centre in Kent.

23 **Q.** And sadly, your members suffered injury or bereavement  
24 thereafter, but don't know -- and it's very difficult to  
25 find out of course -- whether that injury or bereavement

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1 a combination of medical conditions.

2 **A.** Yes, it seems to be like a relapsing remitting  
3 phenotype, very similar to Long Covid but slightly  
4 different, and some of the acute conditions, when they  
5 turn chronic, such as neuropathy from Guillain-Barré  
6 syndrome, can affect different systems in different  
7 ways. So many symptoms can be had by one person with  
8 their condition.

9 **Q.** A combination, a combination of conditions?

10 **A.** Yeah.

11 **Q.** And UK CV Family basically operates to provide support  
12 for such people. It signposts how they can get help.  
13 It seeks to raise awareness of their predicament, and  
14 is, I think, the largest online support group for  
15 vaccine injured and bereaved in the United Kingdom?

16 **A.** Yes, and we've just actually received charitable status  
17 as well, so we're now a registered charity in England  
18 and Wales.

19 **Q.** And how many members do you have?

20 **A.** Around 2,500 at the moment with all the three support  
21 forum members combined.

22 **Q.** And is that because there's a -- the group at the heart  
23 of your organisation is the UK CV Family with around  
24 about 2,000 members, but there's a support group for  
25 family members, carers and friends, and there is also

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1 was causatively connected to a vaccine, was the result  
2 of a vaccine, or was coincidental, it just happened; or  
3 was connected to the Covid virus, because of course you  
4 could be infected with the vaccine -- with the virus and  
5 then have vaccination. But in some cases your members  
6 have been able to demonstrate satisfactorily that there  
7 was a link.

8 **A.** Yes, yeah.

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

10 **A.** In around 50% of cases, yes.

11 **Q.** And the remainder, of course, are struggling to try to  
12 demonstrate the link, I presume?

13 **A.** Yes, yeah, for the many reasons that we've outlined in  
14 our witness statement.

15 **Q.** Yes, and we'll come to those in brief in a moment.

16 And do many of your members now suffer from chronic  
17 health conditions?

18 **A.** Yes. Yeah, they do, or they're bereaved, so some of our  
19 members lost loved ones after a Covid vaccination.

20 **Q.** We were particularly struck by the fact in your  
21 statement of which you speak, that some 52% of your  
22 members had between 10 and 25 symptoms. So the  
23 conditions, the chronic conditions which those who  
24 weren't bereaved suffer from, appears to be -- it  
25 appears to be a multiple problem. It's a concatenation,

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1 another group dealing specifically with the bereaved?

2 **A.** Yeah. We realised fairly early on that we needed to  
3 separate the three groups out, because some of the  
4 people in the injured support group would like to talk  
5 about things that they might not want to divulge  
6 elsewhere. 76% of our group members surveyed said that  
7 they'd considered suicide, and it is a topic within the  
8 group. A lot of people are affected, their emotional  
9 health is affected by being vaccine injured.

10 **Q.** And it's -- you say vaccine injured, of course, they may  
11 believe -- they may believe very strongly, but it is yet  
12 to be demonstrated in every individual case that the  
13 condition is vaccine caused?

14 **A.** Yeah, but there is normally a very heavy temporal link  
15 and at least one person has suggested that it's  
16 vaccination, at least one medical professional has  
17 suggested it's vaccination.

18 **Q.** And, of course, you're aware that my Lady, the Chair,  
19 has granted your group Core Participant status and you  
20 have contributed your experiences and your stories  
21 through the ESM process and you are here today because  
22 of the obvious association with the vaccines.

23 Does your group hold a corporate view, if I may put  
24 it that way, on whether vaccines or good or bad, or is  
25 it concerned with the individual predicament of your

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1 members?

2 **A.** We try to remain neutral on the subject of whether  
3 vaccines are good or bad because our members have very  
4 differing views and if we are to support them all, we  
5 have to remain neutral on the wider subject of whether  
6 vaccines are generally a good or bad thing.

7 **Q.** And that's a very fair position to take.

8 So in your voluminous statements, you have raised  
9 a huge number of points, topics and issues of concern,  
10 Ms Crichton, and I simply cannot go through them all.  
11 A lot of them are, I'm afraid, out of scope, that's to  
12 say they're just not within the remit of my Lady's  
13 Inquiry. But we're going to identify those areas that  
14 are within scope and on which you're inviting the  
15 Inquiry to pay particular attention to.

16 And as I read each one out, I'm going to give you an  
17 opportunity of trying to summarise what the main concern  
18 is that's held by your members where a significant body  
19 of them, a significant number of them, appear to you to  
20 be concerned about this issue.

21 **A.** Yeah.

22 **Q.** A very significant thread running through all 600 pages  
23 is the concern of your members about the effectiveness  
24 and safety of the vaccines. Is that general concern  
25 also tied in many places to the nature of the

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1 concerned to know from you, you're concerned with the  
2 clinical trial process. Is it connected to worries  
3 about whether or not it was effective, whether it picked  
4 up side effects?

5 **A.** Yes, I think we'd like to know what is an acceptable  
6 risk/benefit profile.

7 **Q.** All right. Do you have concerns about diversity and  
8 the -- whether or not population groups were  
9 sufficiently represented in the trials?

10 **A.** Yeah, for example pregnant women weren't represented in  
11 the trials.

12 **Q.** Yes.

13 **A.** Yet the vaccines were recommended for pregnant women.  
14 Children, to start with, weren't in the trials. And  
15 obviously ethnic minorities, there wasn't many people in  
16 the trials from that group either.

17 **Q.** Are you aware -- so that you're aware of why we're  
18 focusing on this -- that many of the trials were abroad,  
19 where racial and ethnic make-up proportion ran, in fact,  
20 in the case of Pfizer 80%?

21 **A.** Mm.

22 **Q.** So you're concerned, in fact, with diversity in the UK  
23 trials, I suspect?

24 **A.** Yes.

25 **Q.** All right. Your members express concern about the size

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1 development and authorisation processes that were in  
2 place? So you're concerned about how it worked in  
3 practice and whether or not the system was effective?

4 **A.** I think so, yes. I think the -- obviously the Covid-19  
5 pandemic, there were certain rules that were changed to  
6 accommodate the speed of the rollout of the vaccines and  
7 the manufacturing processes, and in the witness  
8 statement we've gone into quite some detail about those  
9 different processes and how they may have been affected.

10 **Q.** The clinical trial process. Obviously there is a very  
11 significant process by which any medicine has to be  
12 tried, clinically tried, pre-clinically tried, monitored  
13 and authorised. Do your members have concerns about the  
14 integrity and the efficacy of the overarching clinical  
15 trial process?

16 **A.** We do. We know of cases where clinical trial  
17 participants' data has been dropped when they've  
18 suffered an adverse reaction and not been included in  
19 the data.

20 **Q.** All right, I'm going to pause -- stop you there. The  
21 same applies to you as to every other witness, including  
22 state or government witnesses. We can't be looking at  
23 individual cases and it would be wrong to allow anybody  
24 to say, "We know of cases where X and Y has happened",  
25 we don't know whether X and Y has happened, so I'm

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1 and scope of the phase IV trials. Do you mean the  
2 trials that took place by way of the clinical provision  
3 of vaccines after authorisation in the community?  
4 That's what the phase IV trials are.

5 **A.** I would have to refer back to the witness statement to  
6 know exactly what we -- as I said at the start of the  
7 witness statement, we actually had six of us write it,  
8 so that might not be a part that I paid a lot of detail  
9 to myself.

10 **Q.** All right. You've mentioned acceptably safe.

11 **A.** Mm.

12 **Q.** Understandably, your members would like to know more  
13 about how the vaccines were determined to be acceptably  
14 safe, and what the MHRA in particular assessed was the  
15 correct risk/benefit balance.

16 **A.** Yes.

17 **Q.** There are many references to that in your statement.  
18 You're concerned about the batch testing process, the  
19 way in which batches produced by manufacturers were  
20 tested. And you're concerned or many of your members  
21 are concerned about the whole operation of the MHRA  
22 safety surveillance processes?

23 **A.** Yes, in particular the Yellow Card.

24 **Q.** And on the Yellow Card Scheme, Ms Crichton, does your  
25 statement set out actually a lot of areas in which your

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1 members have expressed concerns about the scheme from a  
 2 lack of a mandatory obligation on doctors and public  
 3 health clinicians to report side effects, the lack of  
 4 public awareness of the scheme, how the data is  
 5 accumulated, what the Yellow Card Scheme says about  
 6 causative links, whether the MHRA responded to Yellow  
 7 Card reports by looking for clusters of symptoms --  
 8 that's another big issue -- how difficult it is for the  
 9 scheme to be used, whether or not, after reports are  
 10 made in a Yellow Card and the MHRA has determined that  
 11 they are of significance, the population should be told,  
 12 or at least those persons who have reported side  
 13 effects, of the MHRA's position -- is that a big issue?  
 14 So feedback back to members of the public about side  
 15 effects?  
 16 **A.** Yes. Our members have found that their Yellow Card  
 17 reports were suddenly missing when they tried to follow  
 18 them up. There were no actual follow-ups by the Yellow  
 19 Card system to check on the people that had suffered an  
 20 adverse reaction to see if they were recovering or not.  
 21 Only 6% of people that are -- people in our group that  
 22 actually reported, only 6% of those reports were made by  
 23 medical professionals. So this shows that the public  
 24 are reporting, and not the medical professionals. But  
 25 actually, as you know, the larger studies show that only  
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1 a letter sent by the Public Health England and the Royal  
 2 Society of Haematology to hospitals two weeks prior. So  
 3 the condition was known about but the public weren't  
 4 told.  
 5 **Q.** Do you mean the information that was put into the public  
 6 domain around about the Easter Bank Holiday weekend?  
 7 **A.** So this would be Easter but there was a letter sent to  
 8 hospitals --  
 9 **Q.** Before the weekend.  
 10 **A.** -- from Public Health England on 22 March --  
 11 **Q.** That's right.  
 12 **A.** -- detailing how to manage VITT.  
 13 **Q.** And you're concerned that -- either that the MHRA knew  
 14 about the condition a long time before that letter went  
 15 out or that when the letter went out, it wasn't enough,  
 16 there should have been more data given and more  
 17 information given at that same time?  
 18 **A.** Our concern is that we have members whose loved ones  
 19 died in that period, and they feel that their loved  
 20 one's death may have been prevented if the MHRA had been  
 21 more public sooner.  
 22 **Q.** Right. An important part of your statement deals with  
 23 the Vaccine Damage Payment Scheme, which is the  
 24 non-compensatory flat-rate scheme. Many of your  
 25 members, I expect, have made applications or tried to  
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1 around 10% of people know about the Yellow Card Scheme  
 2 and report. So this is massively underrepresented.  
 3 **Q.** So there is a real issue about public awareness of the  
 4 scheme and the ability to report, but also, the degree  
 5 to which people who report are followed up?  
 6 **A.** Yes.  
 7 **Q.** So the MHRA may well look at NHS data, GP data, health  
 8 data, but that doesn't necessarily mean to say that  
 9 they're picking up the phone and speaking to you or  
 10 getting in touch with the person who made the report?  
 11 **A.** That's correct, yes.  
 12 **Q.** Right. Your members are concerned about the process by  
 13 which vaccines were authorised for younger people.  
 14 You're concerned about the state of public messaging,  
 15 about the risks of adverse reactions, and as with a  
 16 number of other similarly bereaved and injured groups,  
 17 you want to know much more about how the MHRA responded  
 18 to the emerging reports of the most serious conditions,  
 19 like TTS, myocarditis, pericarditis, you've mentioned  
 20 Guillain-Barré syndrome, and ME, myalgic  
 21 encephalomyelitis -- (overspeaking) --  
 22 **A.** Yes, and in particular why the MHRA took such a long  
 23 time in actually announcing the vaccine induced  
 24 thrombocytopenia, thrombosis and thrombocytopenia  
 25 situation to the public, especially as there was  
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1 make applications under the scheme; is that right?  
 2 **A.** That's correct.  
 3 **Q.** And their concerns traverse almost every aspect of the  
 4 scheme, don't they, from what must be established, the  
 5 causative threshold, damage caused by a vaccine,  
 6 prescribed vaccine, as well as the 60% severe  
 7 disablement criteria, the amount of money which may be  
 8 awarded, £120,000, as well as -- well, many other  
 9 aspects, about how the scheme was managed, how long it  
 10 takes, and whether or not, actually, it's fit for  
 11 purpose?  
 12 **A.** That's correct, yes.  
 13 **Q.** All right.  
 14 **A.** Many of our members have tried to claim the vaccine  
 15 damage payment and been rejected. I think you can see  
 16 from the numbers Kate Scott read out last week, but  
 17 there's been 17,500 claims and only 194 claims have been  
 18 processed and awarded, and 416 people were not deemed  
 19 disabled enough to meet the criteria. It isn't  
 20 fulfilling a purpose, and it's very traumatic for  
 21 someone when they're very ill, after they've done  
 22 something that they were told to do, or they've lost  
 23 a loved one, to fill out the form.  
 24 The form asks "Tell us what happened" and when  
 25 I filled mine out, I was still very, very poorly in bed  
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1 and I filled it out laying down in bed on my bedside  
2 cabinet and I literally put three sentences and I just  
3 thought my medical records would speak enough.  
4 I thought I wouldn't have to tell the assessors what had  
5 happened to me because they'd look at my medical records  
6 and go "Yeah, adverse reaction, that's happened, she's  
7 unwell."

8 That didn't happen. I was rejected, along with many  
9 the people. And as you know, you've heard in the impact  
10 film, it has been extremely traumatic for some people,  
11 and in particular one family whose father died and took  
12 his own life, because --

13 **LADY HALLETT:** And I've heard from the brother of the  
14 contributor, who contacted me separately.

15 **THE WITNESS:** Yeah.

16 **LADY HALLETT:** Horrible story.

17 **THE WITNESS:** It's very, very traumatic for us, you know,  
18 and we -- we've had suicides within the group and we've  
19 attended funerals to these people.

20 **MR KEITH:** I think in your statement, Ms Crichton,  
21 appallingly -- well, you referred to a survey that says  
22 that around about 76% of your members had considered  
23 suicide since they began to suffer from their  
24 conditions --

25 **A.** Yes.

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1 **Q.** So we're talking here about your members who weren't, in  
2 fact, carers in a residential care home --

3 **A.** We do have, yeah, that as well.

4 **Q.** You have some of those as well?

5 **A.** Yeah.

6 **Q.** But for those people who weren't in that cohort, because  
7 the English Government, or the UK Government in England,  
8 only introduced VCOD for care home carers --

9 **A.** Nonetheless, there was still pressure on people.

10 **Q.** Right. So they say they felt pressurised through their  
11 occupation --

12 **A.** Huge pressure, yes.

13 **Q.** -- to take a vaccine?

14 **A.** Yes.

15 **Q.** Then they suffered, they say, harm or injury, and then  
16 haven't been able to be awarded payment under the VDPS?

17 **A.** Payment under the VDPS and also no reasonable  
18 adjustments made at work and being medically retired  
19 because of it.

20 So, you know, we think that if you're going to make  
21 vaccines as a condition of deployment, then you need to  
22 make it a workplace injury. And also, there needs to be  
23 better support, emotionally, financially and medically,  
24 for people that are suffering from adverse reactions  
25 before you actually mandate vaccines as a condition of

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1 **Q.** -- (overspeaking) --

2 **A.** It's an extremely stigmatised illness. No one wants to  
3 hear that you've had an adverse reaction to the Covid  
4 vaccine.

5 **Q.** Two final areas, please, on which I'd like your help.

6 There are many references in your statement to the  
7 systems by which members of the public are informed, in  
8 advance of and after taking a vaccine, of  
9 contraindications, side effects, benefits, and risks,  
10 the patient information leaflet, and there's also, as  
11 you know, the summary of product characteristics, and  
12 many of your members are concerned about the  
13 distribution and the use of the PILs, whether they  
14 properly knew the position.

15 And VCOD is in there, the vaccine as a condition of  
16 deployment. What is your members' take on the merits or  
17 otherwise of the vaccine Covid deployment policy?  
18 What's the take on that?

19 **A.** So some of our members were doctors, nurses,  
20 consultants, military personnel, in public service, and  
21 they were -- they felt heavily pressurised to be  
22 vaccinated. When they did, unfortunately, suffer  
23 a vaccine injury, their injury wasn't classed as  
24 workplace injury, and subsequently they had their  
25 employment terminated.

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1 deployment.

2 **Q.** And may we be clear about this. Probably the majority  
3 of your two statements is -- speaks very eloquently  
4 about what you regard and your members regard as the  
5 absence of support, the lack of NHS treatment, the lack  
6 of financial and societal support in the terrible  
7 position in which they find themselves?

8 **A.** Yeah. I mean, the very --

9 **Q.** -- (overspeaking) --

10 **A.** -- fact that UK CV Family exists means that there was  
11 a gap in support.

12 **MR KEITH:** Thank you very much, that's extremely helpful.

13 **LADY HALLETT:** Thank you very much indeed, Ms Crichton.  
14 Again, terribly sorry about your loss, and I do hope you  
15 can now really focus on the grieving process. But thank  
16 you so much for coming along today.

17 **THE WITNESS:** Thank you.

18 (The witness withdrew)

19 **MR KEITH:** My Lady, that concludes the evidence for today.

20 **LADY HALLETT:** Thank you all very much, and I shall sit  
21 again at 10.00 tomorrow.

22 **(3.06 pm)**

23 **(The hearing adjourned until 10.00 am the following day)**

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