**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



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



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



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

that we see in Whitehall, and no focus or even recognition of the need to build up that expertise.

**Q.** And we'll come back in due course to some of the general overarching comments you make in your book about the Civil Service approach.

It's plain from the paperwork that you demanded a number of conditions be met prior to you taking the role as the chair of the VTF. Just to run through them one by one, you demanded a clear mandate with a direct order line to the Prime Minister. Why was that?

**A.** Because I felt that if I did not have the authority of the Prime Minister, there was clearly tensions between the business department and the Department of Health, and that there would be interference at a ministerial level, and from officials if I didn't have a -- very clear reporting to the PM. And that absolutely was the correct decision and was worth its weight in gold.

**Q.** A second condition you demanded was that the VTF be located in BEIS. Why was that?

**A.** Because our job was fundamentally a commercial job, which was to work with manufacturers, industry, to identify the best vaccines, manufacture them and secure contracts. So this is a commercial discussion, not a how do you actually deploy it in the health system.

**Q.** And is governmental supervision of the life sciences



industry insofar as it impacts upon government --

**A.** Yes.

**Q.** -- within BEIS?

**A.** Yes.

**Q.** You demanded the ability to make rapid decisions. You asked for rapid decision making. Again, why was that?

**A.** Because -- I hadn't worked with government before, but the one thing you know about government is it's incredibly slow.

**Q.** You asked for the ability to establish a dedicated budget, with timelines. Why was that?

**A.** Because, again, my understanding was that everything in terms of getting money signed off in government takes a very long time and you've got to go round endless departments and then you go back to Treasury, who say no, and then you go round again and you do it again.

So the idea was not that we had actually -- the VTF Steering Group, we did not have spending authority, we made recommendations, but to the extent we could actually have a dedicated budget from which any contracts could be paid would then again speed up the rate of decision making and execution of what we were trying to do.

**Q.** And was that absolutely vital, in fact, to the proper performance of the VTF's functions?



**A.** Essential.

**Q.** And we'll come to that in due course as well.

Of perhaps lesser importance in the general scheme of things, but nevertheless of considerable interest, you also demanded that you be the chair only for six months, you said, "I want a 6-month term of office", and you also asked that you be given the ability to sign off on all communications in advance. Because --

**A.** I was concerned about leaks --

**Q.** -- this may reflect on your views on the Civil Service and on the way in which government went about things. Why did you ask for those two conditions?

**A.** So, the six months, we'd just raised a new fund, and so -- I'm a key person in the fund and if I wasn't part of the fund, our investors could actually suspend the fund. So that -- it wasn't just for me, I was working *pro bono*, but it's the entire team and the group I work with.

So that -- I wasn't able to do more than that. And the comms was about the worry about leaks coming out of government.

**Q.** It's apparent from your statement and from the paperwork that you were put through quite a robust conflict of interest process. Is this the sum of it: your position was examined in fact by the DHSC and by the Cabinet



Office. You were obliged to declare anything that might conceivably cause a conflict of interest, and in the interests of the government, and of what you were doing, did you in fact step off a number of boards and committees, and in particular, agree that no fund managed by SV, your company, could or would invest in any Covid-19 vaccine company?

**A.** Correct.

**Q.** And to the detriment of one of your funds, did that fund in fact have to pause all investment and divestment for quite a considerable period in relation to the bio sciences industry?

**A.** Yes, correct, it was a public fund, so that it was it's -- its performance was gauged against the index and because the index had spiked so massively with the Covid vaccines, not being able to participate in that was a problem for them, yes.

**Q.** You've referred to the degree of independence that you sought. By and large, were you afforded it?

**A.** Yes.

**Q.** You reported to the Prime Minister ultimately, but VTF remained a formal part of BEIS and presumably the ministerial accountability line was to Parliament through BEIS?

**A.** Correct.

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

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

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

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



private sector, a lawyer.

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

**A.** Programme manager, yeah.

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

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

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

**A.** Phenomenal.

**Q.** And from where?

**A.** Private sector.

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

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

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

**A.** Completely.

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

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



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

**A.** No.

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

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

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

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

**Q.** Quite right.

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

**A.** Yes.

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



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

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

**A.** No.

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

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

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

effective we will be at stemming the impact of the pandemic.

**Q.** And in that regard, the United Kingdom Government had contributed and contributed during your time as chair, a very large sum of money to the international organisation COVAX. Was it your view that more could have been done nevertheless?

**A.** Yes, there was the commitment, but it was very late. So actually, I've got good data to show that we were not even in the top ten of countries donating vaccine, you know, in 2021 when it matters. So yes, maybe by the end of 2022 we had started donating more, but by then it was too late. So it really matters that we play an active role at the time when it matters, rather than afterwards.

**Q.** It is important, though, to note that AstraZeneca, a UK company, of course, made the Oxford adenoviral vaccine available at cost and was, relatively speaking, quite a cheap vaccine, was it not?

**A.** It was cheap and it was the vaccine that will have saved more lives than any other around the world.

**Q.** And to his credit, did the Prime Minister make plain to you that in addition to securing vaccines for the United Kingdom and obviously directing himself to the direct interest of our population, he wanted the



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

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

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

**A.** Did he frequently?

**Q.** Bang that drum?

**A.** Yes.

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

**A.** Yes, he did.

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

**A.** Very modestly.

**Q.** Why?

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



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

**Q.** February 2020?

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

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



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

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

to protect people. And that is what is missing.
**Q.** Remaining for the moment with the issue of the scope of the VTF, there was quite a difficult issue to be circumnavigated concerning whether or not therapeutics, and in particular, as you said, monoclonal antibodies, should be within the remit of the Vaccine Taskforce. We understand in fact that at the first meeting on 11 May, the agenda referred to your body as the Vaccine and Therapeutics Taskforce. How was the issue as to what the remit of the VTF should be resolved?
**A.** Therapeutics is obviously my background, so that is the natural area for me to have included in the remit. What I did is what I would always do, which is to go and talk to the people involved, including in industry, and it was quite clear there was open warfare between BEIS and Department of Health, and the RECOVERY trial at that point had been set up. So this is the big master protocol, phase III three trial that demonstrated dexamethasone. So there was no need for me to have any involvement in that, that was being run beautifully and executed well.

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



ultimately it was quite clear that there was no need to do that, because there are already too many people probably involved. It wasn't functional, and vaccines was ultimately going to be the route out of the pandemic. So the focus for us was to actually focus solely on vaccines, not take on therapeutics.
**Q.** The evidence before the Inquiry appears to be that there were considerable tensions between the funders, the officials, the academics, and the industrialists in the sphere of those phase I and II trials, that there appears to have been a profusion of trials, many of them underpowered, some of them badly recruited, and quite a lot of --
**A.** Just to be clear, you're talking only about therapeutics --
**Q.** I am.
**A.** Yes.
**Q.** I am only talking about therapeutics there.
**A.** Yes, that was the impression I got --
**Q.** You mentioned the RECOVERY trial, which was a therapeutic trial.
**A.** Brilliant.
**Q.** And was this ultimately the position: that if you had brought the whole caboodle of therapeutics within the remit of the VTF, you might have ended up dividing your



attention? You would have been less able to focus ruthlessly on the question of identifying, procuring, and making available vaccines, which of course was your primary goal?
**A.** Correct.
**Q.** We have, in the Inquiry, a number of emails from May in which you debate with Sir Jeremy Farrar, Sir John Bell, Sir Patrick Vallance, as he then was, where this issue about the remit of the VTF would end up, and was it your position that you wanted to keep neutralising antibodies, but you were content to allow the remainder to go off to what became the Therapeutics Taskforce?
**A.** Yes. So I felt strongly that we should have governance over the neutralising antibodies because there are a portion of people in the UK who are immunocompromised. That means they are unable to mount a protective vaccine response if given a vaccine. So people with HIV or people going through bone marrow transplantation or anywhere where you've got basically a dysfunctional immune system, and so I felt, correctly, that that was part of our original mandate, which was to protect the UK -- the relevant UK population against SARS-CoV-2. And that wasn't just to protect those people who could respond to a vaccine, but to protect all those people, including the immunocompromised.



So, yes, that was agreed to be part of our mandate, and as part of that, you've got two different types of antibody: you've got the prophylactic antibody, to treat the people who can't mount a vaccine response, but you've also got treatment antibodies. So they -- they're different only, really, in how long they last.
**Q.** So Evusheld, for example, could be given prophylactically --
**A.** Yes, Evusheld --
**Q.** -- also by way of treatment?
**A.** Yes, so Evusheld was designed to have long-acting half life, so that it would -- could dose every six months or longer. The treatment antibodies would have a normal, short half life of a month or so.
**Q.** All right.
**A.** So that was different. But if we're going to do all the due diligence on it, we should do the diligence together.
**Q.** But those persons who are, sadly, immunosuppressed, nevertheless would also have benefited from other therapeutics made available, not just monoclonal antibodies, they might have benefited from small molecule drugs, from anti-inflammatory drugs. If you had taken on board the other types of therapeutics, in the ultimate -- to the ultimate benefit of those persons

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

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

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

**A.** December.

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

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

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

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



composition of the Therapeutics Taskforce?

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

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

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

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

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

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

**A.** Probably more.

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

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



for the access of those vaccines.

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

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

So it wasn't very complicated.

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

**A.** Sit in the back.

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



pursued and how they'd be negotiated with?

**A.** Correct.

**Q.** All right.

**A.** But just to be clear, that was not a decision for me. That was a political decision. They asked me what was my views and my views was it was worth exploring the E3 until that no longer became an opportunity.

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

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

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

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

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

those formats.

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

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

**Q.** Can I just seek to put some human flesh on the bones. You referred very quickly to mRNA and adenoviral. The mRNA, is that the messenger RNA ribonucleic acid vaccines which in fact turned out to be the Pfizer and the Moderna, the Pfizer BioNTech and Moderna vaccines, and the adenoviral, is that the Oxford vector vaccine --

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

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

**A.** Correct.

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

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



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

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

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

**A.** Yes.

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

**A.** Correct.

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



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

**A.** Yes.

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

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

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

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



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

**A.** Exactly.

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

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

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

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

planning assumption you needed to apply in terms of how many doses we're going to need as a country?

**A.** Yes. And so we went to the JCVI, the Joint Committee on Vaccination and Immunisation, which is a statutory body which advises the Department of Health, and the Secretary of State in England is obliged to take their advice. We first met them on 25 May, and at that point their advice to us was "You have to vaccinate the vulnerable" and their advice to us was the range of vulnerable people were all adults over the age of 50 and all adults under the age of 50 with severe underlying disease and it corresponded to basically an enhanced flu cohort and was about 30 million people -- 30-odd. So that is the --

**Q.** That is the broad range --

**A.** That was the range, because my job was not to decide who should be vaccinated. I need to find out from the experts who they want to vaccinate, and then buy vaccines for those people.

**Q.** With that planning assumption, and bearing in mind the number of people it entailed, you wouldn't have been -- the United Kingdom wasn't the largest country on Earth in terms of numbers with whom the manufacturers might care to negotiate. What did you do to make the United Kingdom as attractive a contractual partner as



possible?

**A.** So we wanted to make ourselves basically the best possible customer, because 30 million people in the UK versus the European Union versus the US, we were tiny. So we took a strategy of basically leveraging the capabilities that we had. So this is a highly collaborative manufacturing scale-up and manufacturing industry, with capabilities, but without a lot of bulk manufacturing capabilities. So that was one task, was how can we turbo-boost what's already there? You can't build stuff *de novo* in a pandemic but you can increase what's already there.

So that was one aspect.

The second aspect was to really leverage the fact that we have a phenomenal national health system that is able to run -- NIHR, to run clinical trials at a population scale with diversity. So that was the second aspect.

And the third aspect was that we would work collaboratively with them and with our regulator, which is the MHRA, so that we could actually get vaccines approved and regulated as soon as possible.

I might just call out June Raine as being a superb vaccine regulator because she, in her own words, moved the MHRA from being a policeman to an air traffic



controller. So instead of waiting until you've got all your data ready and you've got your reports and your submissions, with the Is dotted and Ts crossed, she said, "Bring me the data as soon as you've got it. We will look at it, we will review it. So at the endpoint when you finally give us your last piece of clinical efficacy data or manufacturing quality data, we'll be ready to vaccinate."

And that, again, was a core offer from the UK. So manufacturing, clinical trials, and regulatory, which is what we then presented to the potential vaccine companies and said, "This is the reason you should work with us, because this is what we can offer you."

**Q.** And so we're absolutely clear, this entailed the speeding up of the process by which the paperwork: the data and safety information, was given to the MHRA, but there was no diminution in its safety monitoring?

**A.** No.

**Q.** Or the way in which it looked at the data?

**A.** No. And if I could just give a statistic, the largest ever vaccine trials that had been run anywhere in the world were for the HPV vaccines, and they were 20,000 individuals that were vaccinated. The size of the clinical trials that we're running for Covid vaccines were between 40 and 50,000 people. So it



was -- these vaccine trials were much, much larger than any vaccine trial had ever been done before. And there was additional requirements put in place, and you can talk to June about this afterwards, is -- where 99.9 per cent of any adverse events from a vaccine would happen within the first few days of dosing. And so then the regulators put on an additional 30-day time period to say: we will not receive or consider any vaccine submission until we've actually had that additional 30-day time period, to be doubly sure that there is -- not only have we got the largest trials ever done but we've also got that additional safety monitoring.

So there was no question that safety was taken extremely seriously, and more seriously than any trial has ever been done before.

**Q.** Can we just come back to the general topic of best possible client, and the assistance that was given to the manufacturing process, and to the course of identifying and developing vaccines, by the involvement in the trial process.

Do manufacturers exclusively conduct the trials themselves, or do they extract from trials conducted by the biosciences industry, by government, by the NHS, by a number of these funding bodies, the data that they need for the purposes of verifying their vaccines?

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

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

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

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

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



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

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

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

**A.** No, it --

**Q.** -- or ministers?

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



place statutory protection against liability.

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

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

**A.** Correct.

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

**A.** **(No audible response)**



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

**A.** I'm not in the detail.

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

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

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

up. Was that you endeavouring to try to get advance agreement by way of a spending envelope that you could spend up to a cap on the purchase of vaccines, without having to seek from the Treasury each time particular approval?

**A.** Correct, but I might just comment that --

**Q.** Please.

**A.** -- I wasn't seeking to spend it myself. So the decision on spending came from ministers, but we would recommend it. But you're correct that we didn't want to have to go to the Treasury every time we wanted to make a -- put forward a business case because I think we had 30 business cases.

**Q.** Quite. And each time you'd have had to write it all up, and no doubt at great length, and taking time and energy, and that was obviously not a profitable way of proceeding?

**A.** Well, we did the business cases for all 30 anyway. And I might just, again, so you know, we had a strategic case, an economic case, a commercial case, a financial case, a management case, all of which was repetitive. No science case, which is fundamentally the most important thing. We had to define what a minimum benefit was and in our business case our minimum benefit went between 10 and £200 billion, because it was all so



subjective.

So my problem was the structure was completely rigid and not fit for purpose and didn't actually address the important things that we needed to be discussing when it came to vaccines --

**Q.** But you've referred there to the absence of a science case.

**A.** The business, the Whitehall business case.

**Q.** But in the context of having to get permission to spend vast sums of money, there would have to be of course --

**A.** There has to be something.

**Q.** -- a business case --

**A.** But we submitted a business case to BEIS in June. We did not get an approval from the Treasury until 11 September.

**Q.** And was that the delay to which these emails refer in July, the absence of an answer from HMT?

**A.** There was plenty of -- there was lots of responses but just endless questions.

**Q.** Could we look, please, at INQ000420792, which is the exchange between yourself and Cat Little of the Treasury from whom we heard a couple of days ago.

Can we start on page 3. If we just scroll back out, is that page 3 as opposed to page 4? Yes, it is. Right at the bottom of the page, we can see an email from



Cat Little to you:

"Thanks to you and your colleagues for attending the TAP [that's the Treasury Approval Panel] meeting. It was ... extremely useful ..."

Got a better sense of what you are seeking, will issue formal minutes in due course.

Then she identifies three broad areas: we agree we need to explore further.

Then over the page, they are to do with how the bid breaks down, your resourcing and capability plans and governance and controls.

If we go back to page 3 we can see your response:

"Dear Cat, I am very disappointed in this response. We don't seem to have made any progress ... we requested a meeting with you at the beginning of July ..."

You then refer to the fact you raised with the Prime Minister the fact that the biggest risk facing the taskforce was the government itself and they're very slow, its very slow processes, and how shocked he was.

"We have not received any money even for day-to-day working, nor have we succeeded in speeding up government processes -- with the happy exception of the BioNTech/Pfizer binding term sheet."

Then if we go to page 2, we can see she's disappointed that you're disappointed as to how you



feel. There's no decision that slowed you down. Most of our approvals mentioned have been delivered within 24 to 48 hours, but they too are keen to bust through barriers.

And then page 1. You say at the bottom:

"The issue isn't just Treasury but Cabinet Office and commercial controls ..."

And you agree subsequently to meet.

By and large, strategically, the problem was resolved because a ministerial panel was set up, I think it started on 27 August 2020, and it was empowered to make decisions over any expenditure over £150 million. So the VTF had delegated authority for sums less than that, but the ministerial panel took the decision for sums over that. Did that panel work and did it address the problems which you have so pithily identified?

**A.** Yes, it was fantastic.

**Q.** And who was on the panel?

**A.** We had four ministers. So we had the Secretaries of State for Business, Cabinet, Treasury and then Lord Agnew from the Cabinet Office. So Business, Health, Treasury and then Lord Agnew from the Cabinet Office.

**Q.** So it was a combination of departmental spending ministers as well as the Treasury --

**A.** Oversight.

**Q.** -- brought together by way of an oversight structure. You must have often reflected as to why that couldn't be put into place across the whole of government?

**A.** I think it should be. I mean it is manifestly a better way to make decisions, rather than sequential, and then keep having to go back. What I did find is there are an awful lot of people who want to be engaged, who are unqualified and yet feel qualified to intervene. And the more you enable that to happen, the slower things are going to be, whereas if you basically say, no, it's a single business case, it goes to the ministers, and they have to make a decision, they can't prevaricate, they have to make a decision, yes or no, and that worked.

**Q.** We don't, I think, need to explore the actual negotiations with each of the manufacturers, but it was obviously a protracted and difficult process. But it worked. And of course, a number of contracts were agreed, I think probably by way of binding terms or heads of agreement being agreed and then the minutiae and the detail of it being negotiated and then final contracts being reached for advance purchase.

**A.** Correct. So we -- Clive would basically shape out the scope of what we were seeking to procure from each vaccine company, and we'd draw up a non-binding heads of



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

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

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

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

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



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

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

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

**Q.** And AstraZeneca --

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

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

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



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

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

**A.** Yes.

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

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

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

**A.** There was a threat of that, yes, in July, just before we were about to announce the heads of terms with Pfizer BioNTech, and we were told by the White House that they were going to use the US defence act to requisition that.

We had -- we then agreed with Pfizer and BioNTech that if we agreed to binding language on indemnities, that they would then go back to the White House and say that, no, the UK had already signed up and therefore they weren't willing to comply, which is what we did. And within 24 hours we came back with binding indemnity language. And we then announced the contract and we then secured, as you know, the vaccines, and we were the first to get them approved and we were the first to dose.

**Q.** And I think 40 million doses was the original --

**A.** Yes, which was the -- all we could get.

**Q.** But to make it absolutely plain, notwithstanding the high stakes contractual poker play, the fact is that the indemnities that were agreed in relation to Pfizer BioNTech were not out of kilter with or any different to the approach on indemnities which had been applied to the --

**A.** No, it was -- all -- we had to offer indemnities to all the vaccine companies, as did every other country.



**Q.** Right.

Coming now to the topic of antibody cocktails. Is this the position: that, as you say in your book, Clive Dix, your deputy, led the due diligence relating to the recommendations that were made by the VTF as to what antibody cocktails should be trialled and pursued. And was it the result of the VTF's work on this that the Ronapreve antibody cocktail, which I think is casirivimab and imdevimab, was pursued.

**A.** Correct. That's the Regeneron cocktail.

**Q.** The Regeneron cocktail. And --

**A.** And for therapeutic use. So for people who have been infected by SARS-CoV-2 and then it's used to then treat them, to give them an additional immune response.

**Q.** And what position did the VTF reach in relation to the alternative prophylactic candidate, which was Project Astronaut, Evusheld? When did the VTF first become aware of the potential of that prophylactic candidate?

**A.** In May 2020. We knew about it immediately. Because, again, the BIA, the BioIndustry Association, had been working to basically try and set up standardised assays to assess all potential Covid antibodies, no matter where they came from: academia, industry, small, big companies. So we were aware of that work, of which AZ



was part, right at the beginning. And so we initially signed a heads of terms or a letter of intent, but non-binding, with AZ for a million doses of their long-acting antibody cocktail -- so this was expected to have a six-month therapeutic effect -- right at the beginning.

**Q.** And it needs to be injected?

**A.** No. It's an intra-muscular injection, so it's like all the Covid vaccines, it's like all the trials --

**Q.** It is injected?

**A.** It is injected -- sorry, not intravenous.

**Q.** Right.

**A.** Sorry, that's my fault. Most antibodies would be delivered intravenously, as in through a catheter into the blood. This was unusual because it was both engineered to have a 6-month half life as well as to be delivered through -- intramuscularly.

**Q.** Was the provisional agreement to the effect that 1 million doses would be purchased because that would provide one dose of two antibodies for what was assessed to be the 500,000 or so immunocompromised people?

**A.** Yes. So, again, that -- the numbers of immunocompromised people were data that had come from the Department of Health and that was their estimate. So our thoughts were: you either dose those



immunocompromised people and you cover them for 12 months, so two 6-month doses; or, as we thought at the time, the SARS-CoV-2 might be a winter virus, in which case you would cover them for two winters.

We didn't know at that time, but we thought that two doses was at least enough to secure an order until we knew more about how the virus was going to work.

**Q.** On 26 October your director general, Nick Elliott, wrote to the CMO, Professor Sir Chris Whitty and Clara Swinson of the DHSC and others seeking confirmation on the exact number of immunocompromised patients on whom Evusheld or to whom Evusheld might be deployed?

**A.** Yes. And the reason for that was AZ had come back to us after we had said we wanted a million doses to do our -- to cover our immunocompromised population. They then came back and said the most they could manufacture or have manufactured was 2.5 million doses for the world, and therefore the UK couldn't have a million, and we needed to be scaled back. And so our -- that letter from Nick was to say: well, we can't get a million because that's not reasonable. What is the minimum amount that we would want for the UK which would be consistent with AZ making their antibody available more broadly globally?

**Q.** Now, after this was then debated within the Office of

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

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

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



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

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

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



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

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

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

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



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

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

**A.** JVT's.

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

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

**Q.** Right.

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

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

would have been subject of a recommendation from the VTF. You rightly pointed out earlier that, ultimately, decisions are for ministers.

Before you left in December 2020, were you aware of what the VTF itself would recommend?

**A.** Yes, and of the VTF was strongly supportive.

**Q.** Of purchasing Evusheld in advance?

**A.** As a tool to manage those individuals that otherwise we were not managing.

**Q.** Did you happen to see, or was it brought to your attention, that Professor Sir Chris Whitty had written expressing the views of the Office of the Chief Medical Officer --

**A.** I hadn't seen the letter but I understood -- and I spoke to Chris and I understood the arguments. Well, I heard the arguments. I didn't agree with them.

**Q.** And no doubt, in your inimitable way, you would have pushed back against those arguments?

**A.** So my job was not to tell the Chief Medical Officer how to manage public health in the UK. My job was to make vaccines and prophylactic treatments available for use and for deployment. If they choose not to deploy, that is not for me to influence; I just think it was the wrong decision. And I think it is symptomatic of business as usual in Whitehall, as opposed to what the



Vaccine Taskforce was, which was to deliver some very clear goals.

**MR KEITH:** My Lady, is that a convenient moment? There is only one topic to go.

**LADY HALLETT:** We take regular breaks for everyone's sake but also the stenographer's sake, so I shall return at 11.30. Thank you.

**THE WITNESS:** Thank you.

**(11.44 am)**

**(A short break)**

**(11.30 am)**

**LADY HALLETT:** Mr Keith.

**MR KEITH:** Dame Kate, in part deference to the assistance you've given the tribunal, we're now going to plug your book, The Long Shot, and have a look at it.

It's INQ000474735.

You take the opportunity in your book, this is page 21, to make recommendations for improvements in the future. And this section of your book focuses on the recommendations you make in respect of government, about which you've said a few things already.

And I want to, please, spend a little time, not too much, on these five recommendations, on account of your almost unique position as the chair of the Vaccine Taskforce, and engaging, of course, very, very closely



with the government. And I think it's probably important that I emphasise through you that of course a great deal of what government does is extremely good and very effective. However, the first recommendation that you make is this:

"Reward outcome not process."

And you talk about the need to ensure that Whitehall is refocused on outcomes not procedures, that outperformers need to be promoted and underperformers released, stop rapid rotation of staff, promote specialist science skills, mandate training for ministers, seek robust references on past performance, and recalibrate, in essence, the thinking of government officials.

**A.** Completely agree that those are critical for Whitehall. So I faced working with, not my -- my steering group was excellent and they were hand picked and they did a great job, but I spent so much time basically batting incoming questions, enquiries, having to educate officials. It was obstructive, in many cases. And I might say that the National Audit Office doing a 5-month audit during my 6-month tenure is completely ridiculous, but it is --

**Q.** We can't go there --

**A.** I know, but it's all the mentality --

**Q.** -- for reasons of parliamentary privilege --



**A.** It's going to -- it's in my book and it's in my witness statement, and everybody should read the letter.

But it reinforces this whole box-checking view of the world, which is: we can't be criticised if we follow all these boxes.

So I'll give you an example. Patrick Vallance had to stop Whitehall from investing in a chicken egg manufacturing plant, because that is the way that vaccines always used to be made: with lots and lots of people injecting chicken eggs and that's how you get vaccines. And he had to say: well, have you actually heard about recombinant techniques? Which is the modern day of making vaccines.

And so what happens is you've basically got this groupthink, and we saw it with mRNA, and it's: at last we've got a vaccine, we now can basically ignore everything else we've done! We ignore the fact that we need a breadth of vaccine formats. And in fact even the JCVI now has had to formally put it in their recommendations that they want to have a protein-based vaccine because government, at the moment, is going down a very narrow, "We've got mRNA, and this is all we ever need forever". And that is not true.

And this is the problem: you've just got people that don't understand what it is we're doing, they have

hostile relationships with industry, they distrust them. And again, read my witness statement and the book to see how they behaved with Valneva and Novavax --

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

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

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

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

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

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



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

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

And more importantly, no one has ever done anything, so they're all busy writing policy papers and sending each other, you know, stuff to review and all that. None of that actually gets to the heart of what it is they're trying to do. What are they trying to achieve, and are they measured against the delivery of their goals? And the answer is no. In the private sector, you don't deliver your goals, you're out of a job and you have to move on. And in the private sector you get referenced, and if you don't perform people know about that. That is not the way it works in the Civil



Service --

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

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

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

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

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

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

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



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

**A.** All of them!

**Q.** -- engagement.

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

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

**Q.** And --

**A.** Yes.

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

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

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

**Q.** Please.

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

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

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



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

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

**A.** Correct.

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

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



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

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

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

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

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



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

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

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

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

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

external bells. That was the key.
**A.** I think that is critical. And again, if you continue with the defence analogy, defence isn't being split between different departments with lots of people putting their oars in. They have a very clear goal: protect the UK, support your allies, all of those things. It's very similar. We're much more likely to have another pandemic than we are to be invaded. We've had seven pandemics since 2020. That's a lot.
**Q.** I think you must have read my Lady's forward to the Module 1 report where precisely that point is made in the second paragraph.
**A.** Excellent. I'm delighted. Thank you.
**Q.** So do we take it -- I just want to ask you one or two questions about a second recommendation that you make. You have spoken in the past about the need for a vaccine registry. Without going into the detail of it, the vaccine registry was the process by which I think around about, in total, 500,000 people volunteered by mid-2021 to participate in vaccine trials, and of course the process itself was also used to generate data for other public health policy decisions.
Would you like to see that vaccine registry put on a permanent and perhaps surer footing?
**A.** Thank you for raising this. This is one of the good



news responses. So the registry, you're correct, we have 542,000 people that are signed up on the NHS registry. In middle of 2022 -- I'm obviously one of them -- in the middle of 2022, I received an email saying, "We are shutting down the registry, and if you want to re-register into our new registry, please go ahead." So of course I was not very thrilled with that email, and said so, and shook the trees quite hard. And the outcome was that this registry has not been shut down, and has in fact been enlarged and embedded within NIHR's larger registry. It now has over 42% over the age of 60. So exactly the sorts of people who will need to be tested for every kind of drug. It's not just for vaccines; it's for any therapeutic, and it's been linked with a database where you can search for clinical trials.
So this is starting to deliver the strategy that we set out, which was "We'll do something very specific for vaccines because we need to and we've got to get bodies into the trials quickly but we need to leave something with a legacy so that we are broader, not just for pandemic preparedness but for the UK."
So this is definitely a plus that I am very pleased about.
One of your witness statements suggested that that



was a legacy of something else. That is not the case. This is a completely *de novo* vaccine registry that we stood up in July 2020.
**Q.** And did you and Clive Dix, in particular, also secure approval for another type of capability but broadly on the same lines, namely the Human Challenge Programme, which is a trial in which healthy young adults receive a vaccine before then being given the virus to test the efficacy of the vaccine?
**A.** Yes, we did. And so I asked my friend and colleague, Garth Rapeport, who used to run respiratory medicine -- respiratory at GSK, and I've backed him twice as CEO and I've backed him to do human challenge studies in his respiratory companies successfully and I called him and said, you know, "What do I do?" Because again, I'm not a vaccine expert. I work with lots of brilliant people. I am a mouthpiece compared with all these fantastic people. And Garth then said what you need to do is a human challenge because you will be able to understand how the virus is infecting and therefore you can start thinking about development of vaccines and therapeutics and diagnostics. And, actually, those papers that have been published both in the New England Journal and in The Lancet have shown that exactly. And it did alter the course of government policy. So it showed that



lateral flow tests were able to pick up live virus before PCR and in fact when PCR was still registering positive, a lateral flow showed that you could -- it didn't register dead virus, basically. So it was a more effective test.
So there are some clearly useful things that came out of it. But it's a difficult test, because as viruses mutate, you have to then mutate -- you have to remanufacture. So I think it was a useful experience but it hasn't continued.
**Q.** Drawing some of the threads from what you said earlier about the manufacturing base for vaccines and also therapeutics, together, in very short terms, do you call as loudly as you are capable, for the manufacturing of vaccines and antibodies to be nurtured and secured as far as is possible and for the manufacturing and industrial base, the sites, the factories, to be maintained or reconstructed or certainly grown?
**A.** Yeah, I mean, that's a very large question. We need to have a strategy, and that -- and the plan of how we're going to secure, grow and expand our manufacturing base has to be led by somebody who comes from the manufacturing industry. We were blessed to have Ian McCubbin in our team, and everybody knows Ian and everybody loves him so when Ian would call up and say,

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

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

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

**A.** Completely.

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

**A.** Thank you.

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

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

**THE WITNESS:** Excellent.

**Questions from PROFESSOR THOMAS KC**

**PROFESSOR THOMAS:** Good morning, Dame Kate, can you hear me?



**A.** Yes, just.

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

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

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

You also note at paragraph 41.12 that:

"... the Cabinet Office then [suddenly] blocked expenditure from our budget for advertising the NHS Registry, even though these costs had already been approved."



And you go on to say:

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

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

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

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

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

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



with NIHR to do -- and we worked with the Behavioural Insights unit. We tried lots of different things to try to figure out how to address vaccine hesitancy.

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

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

**Q.** Hence the advertising strategy?

**A.** Everything. So because that was blocked, we ended up having to go -- we went onto local radio. Divya, who was our wonderful person leading clinical trials, went onto Asian radio. We worked with a fantastic physician in Bradford, Dinesh Saralaya, who basically was a sort of community champion who addressed more of the Muslim community. But it wasn't helped -- because trying to do things piecemeal, you know, I'd have interviews with,

you know, breakfast TV doctors to try to say why we should do that. But it was -- it definitely harmed us.

**Q.** Let me move on to my last question. I want to be forward thinking and looking. What recommendations would you make to increase the participation of ethnic minority groups in vaccine clinical trials in the future?

**A.** I mean, we can start now. We have a registry on the NHS website which anybody can sign up to. Once they're signed up, they can go in and search clinical trials that they may be eligible for.

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

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



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

**Q.** Trust is important, isn't it?

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

**Q.** Bureaucratic blockages don't help, do they?

**A.** They certainly don't. You can imagine how thrilled I was when I got that response.

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

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

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

**THE WITNESS:** Excellent.

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

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

**LADY HALLETT:** Thank you.



**(The witness withdrew)**

**MS STEPHENSON:** My Lady, the next witness is Dr Mary Ramsay.

**LADY HALLETT:** Thank you.

**DR MARY RAMSAY (sworn)**

**Questions from COUNSEL TO THE INQUIRY**

**MS STEPHENSON:** Thank you, please sit down.

Please can you say your full name.

**A.** Yeah, Mary Ramsay.

**Q.** Thank you for attending today to assist the Inquiry, Dr Ramsay.

A few preliminary matters. Could I ask you to keep your voice nice and loud, and speak slowly, please.

You have produced a witness statement, that's INQ000496177, dated 26 July 2024. It runs to 70 pages and 102 exhibits. Have you had the opportunity to familiarise yourself with that statement recently?

**A.** I have, thank you.

**Q.** And are you satisfied that its contents are true to the best of your knowledge?

**A.** I am, thank you.

**Q.** Thank you. I'm just going to touch first on your professional background. You're currently Director of Public Health Programmes at UKHSA, and prior to that, you were Head of Immunisation and Deputy Director of the Immunisations and Vaccine Preventable Diseases Division



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

**A.** That's correct.

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

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

**A.** That's correct.

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

**A.** That's right.

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

**A.** That's correct.

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

may be well familiar, the transition of PHE to UKHSA. That was -- UKHSA was established on 1 April 2021 but became operational on 1 October 2021. But of course, when we are referring to matters pre that date, we're talking about PHE?

**A.** That's correct.

**Q.** The role of PHE, its key responsibilities in terms of infectious diseases, was one of a duty to protect the public from infectious diseases, and also, was it not, to evaluate the effectiveness of immunisation programmes and procure and supply of vaccines, and improve population health by supporting health and care services. Is that a fair summary of the duties?

**A.** Some of the duties, I should say.

**Q.** Some of.

It's worth reiterating, however, that Public Health England wasn't mandated or, indeed, funded to be ready to respond to a pandemic of the scale that was encountered with Covid-19; is that right?

**A.** I think that's fair.

**Q.** Moving, then, to touch on the work undertaken by Public Health England, as it was then, on vaccinations when moving towards the rollout of Covid-19 vaccines.

Were there two divisions within PHE: the Immunisation and Vaccine Preventable Diseases Division



(IVPD), which is probably the one you may refer to the most in your evidence today?

**A.** Exactly, yes.

**Q.** And there was another division, the Vaccines and Countermeasures Response Division. Was there also a board, a vaccination -- a Covid-19 vaccination programme board set up in May 2020?

**A.** Yes, so we ran boards at -- the IVPD ran boards with VCR for the introduction of all new vaccines or any changes to the vaccine programme. So in May 2020 we decided to set up one in anticipation that there would be a Covid vaccine at some point to support some of the workstreams that we would need to deliver in preparation for that.

**Q.** And when preparations started for the commencement of the deployment of vaccines, is it right that that board was dissolved in September 2020, but effectively because NHSE were going to take on the vaccine deployment programme through their Vaccine Deployment Delivery Group?

**A.** Yes, I mean, I think they took over a lot of our, sort of, project management stuff, but obviously there was a much greater need to scale up the actual delivery, so it became a -- DHSC decided it made more sense for them to lead that because there was so much additional delivery capacity needed.



**Q.** So, in England, the decision was made that the NHS and NHSE would take the lead on deployment --

**A.** That's right.

**Q.** -- for vaccinations, as opposed to PHE?

In the context of this pandemic, was PHE of the view at the time that that was appropriate, that division of responsibility?

**A.** Yes, I think so. I mean, I think the -- we were a relatively small team within PHE, a much smaller organisation, so it made sense for NHS to take on some of the huge scale. But obviously we wanted to be, and we were, embedded within that work and leading on the areas that we had the expertise on.

**Q.** Perhaps just before we get into the detail of the matters covered in your statement, by way of overview of what the responsibilities were, as opposed to what they were not, PHE took responsibility, importantly, for storage and distribution, taking on the enormous task of building the national infrastructure to enable the storage and distribution of vaccines across the UK, importantly, whilst maintaining the required temperature regimes; is that correct?

**A.** Yes, although because again it was a very different product from previous products, there was an element which, whereas we deliver for normal vaccines, we



deliver to the end user, the doctor and nurse who are giving the vaccines, in this we delivered to, sort of, a series of hubs, and then the NHS commissioned onward delivery at that point. So it was a joint piece of work, but we did substantial amounts of work in getting the infrastructure in terms of freezers, et cetera, set up to receive the vaccines.

**Q.** And the IVPD, the division, mainly dealing with this work, did it, in overview, have the following functions: that it provided scientific advice and secretariat support to the JCVI?

**A.** That's correct.

**Q.** It provided clinical and technical input for NHS England to support the design of that deployment that we have just been discussing?

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

**Q.** Of course the Green Book was also a responsibility that we've mentioned. And then responsibility, too, for the clinical documentation, the supporting guidance, the toolkits, as we've sometimes heard them referred to, training materials, Q&A materials that would be used or would be the basis of NHS health professionals' documentation for the immunisation programme?

**A.** That's correct.

**Q.** So focusing, then, on the first main topic that I'd like

to ask you about, which is vaccine safety, and PHE and the UKHSA's involvement on vaccine safety issues, could you first help us to get an idea of where PHE sat alongside the other bodies involved in safety? So first, MHRA. What work did the relevant division do in assisting MHRA in its safety investigations and surveillance?

**A.** Well, the MHRA has primary responsibility for safety of all therapeutics and vaccines, but we've had a longstanding relationship with them, in particular in relation to -- first of all, we -- because we're the group that monitors how effective the vaccine is, that's part of that risk/benefit, you know, how much benefit you're getting versus any safety concerns. And we've been working with them for many years on developing their methods. We have -- the PHE had privileged access, I guess, to a lot of clinical data systems that allowed us to do some of the investigations of potential safety concerns, and over many years we had done that for MMR and other vaccines in the past, and we worked, as I said, we worked very closely and actually, during the pandemic we embedded people, we had, you know, joint staff embedded within MHRA to try to support them in their role.

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



stronger sort of clinical network, intelligence role with -- so we have -- we tend to get things reported from clinical networks through our clinical colleagues that we work with because we work with frontline health protection, our frontline teams in health protection work with local providers. So we get a lot of soft intelligence that we feed in jointly with the MHRA.

**Q.** And in terms of NHSE, was it the role of the UKHSA when it came to safety, to inform the clinical advice and information about safety that NHSE would be using?

**A.** Well, again, we worked jointly on that but we were the, sort of, work stream lead for surveillance which included safety and so we were the people representing, I guess, some of MHRA interests with the NHS. So we worked very closely with them on the development of those protocols.

**Q.** If we could move on now, then, to that surveillance strategy and the specifics on it. You explain in your statement that there were four main components to the surveillance strategy which PHE, MHRA and NHSE collaborated on, as you describe it, to monitor the implementation of the programme and the safety of it, once vaccines had begun to be deployed. The first of those four elements you describe as enhanced passive surveillance. Could you translate that, please? What



does that mean?

**A.** Well, most people are familiar with the concept of the Yellow Card system which is the reporting system that is basically a passive system which means that people have to report it. There is no active -- we don't go and ask people, it is what comes in through this passive system. So that's the backbone of most safety surveillance. I'm sure the MHRA can explain this better and there are some expert reports explaining it, so that's the, sort of, backbone. But it also includes other sources of intelligence, exactly those things I was talking about earlier. Clinical networks may approach us and say, "We're seeing something unusual", so that sort of passive reporting, which is where people out in the health service report to us without us going out seeking advice.

**Q.** You talk about active surveillance in specific cohorts. What does that --

**A.** That is something that the MHRA established, which is where they set up a system where a group of people are recruited to report any symptoms they got after vaccination, so that's an active reporting system because they are asked, "How are you after your vaccine?" in an active way, so they were recruited to this enhanced surveillance.



**Q.** Also formal epidemiological investigations; really, in summary form, what does that mean?

**A.** Yes, so where you have a potential signal like, say, vaccine X is associated with condition Y, then what we would normally do, and that's where PHE has a really big role, is do a formal investigation where we may collect data especially or we may use an existing dataset and formally look at whether there is an increased risk of that condition in a certain time period following vaccination, for example. So it's an analytical study to test a hypothesis.

**Q.** And the fourth branch, the near realtime monitoring for a set of events of interest. What does that mean?

**A.** So in advance of a vaccine being approved, you may have, from the basis of the trials or from previous experience, a series of conditions that you think may well be potential side effects of the vaccine, and so what you put in place in advance is some process of actively collecting information on those conditions, a list of conditions, in realtime as the vaccine programme is rolled out, and constantly looking at that to see whether you're getting more than you might expect based on the background, background rate.

**Q.** Could we have on screen, please, document INQ000477132.

This is the Covid-19 vaccine surveillance strategy

dated January 2020. If we could go to, please, page 7.
**A.** 2021, I think it probably was, was it?
January 2021, that's all, sorry.
**Q.** Thank you very much, I apologise. Thank you.
If we could go, please, to page 7, at paragraph 4.1 there we see the heading "Signal detection". So this is the policy of the strategy of PHE setting out how signal detection would work:
"A signal of potential adverse events may come from a range of sources such as the pre-licensure clinical trials, MHRA assessments of Yellow Cards reports [and] active follow-up ..."
And also:
"... from other countries or specialist healthcare professionals seeing increases in consultations for specific conditions."
So does this capture what you were referring to earlier about the network of reporting back to PHE being relied upon, not just the Yellow Card system --
**A.** Exactly.
**Q.** -- and waiting for people to report, but this web of routes of feedback?
**A.** Exactly, yes.
**Q.** And then if we just for completeness look at 4.2, please, on the same page.



"Rapid assessment
"To assess any signal coming from these sources, a more detailed investigation is needed before a full epidemiological study is performed."
What does that relate to, please?
**A.** So that relates to these conditions -- so, for example, if the trial had suggested there was a case of condition X and that was in our pre-defined list of conditions, then we would actively look at datasets that collect information on how many cases of disease X are occurring, and comparing that to how many people have been vaccinated to work out whether or not there was any signal of a higher rate in people who are vaccinated.
**Q.** Thank you. We can take that document down now.
Was there also in place a standard operating procedure when it came to surveillance and safety issues that had been agreed with NHS England?
**A.** Yes, it was a surveillance and response, actually. It was in order to manage -- so one of the difficulties with the programme, we were starting to roll it out in old, older people, many of whom were frail and had underlying medical conditions, and so it was not surprising that we would expect to see people being taken ill after vaccination, and we wanted to be sure that that was being captured properly and also assessed



at the time to make sure, one, that they were being managed appropriately and reported to the MHRA, and also that my colleagues who work at local level, as well as ourselves, can provide advice on the implications of that for the programme, particularly where there were potential concerns about, you know, denting confidence in the programme where people hear about a condition that occurs after vaccination.
**Q.** So this was an operating procedure for any clinical incident that arose in the delivery --
**A.** Exactly.
**Q.** -- of vaccines which might include things like storage being an issue --
**A.** Yeah.
**Q.** -- administration errors --
**A.** Yes, exactly.
**Q.** -- (overspeaking) -- incidents that may cause worry and may need further investigation?
**A.** Yeah.
**Q.** Could we have a look, please, at INQ000421370, which we see there is the standard operating procedure, and this particular version is dated 9 December 2020.
Could we go to page 9, please, of that document.
This is something that's described as the Clinical Case Escalation Framework. We -- certainly I do not



intend to ask you questions explaining every element of this diagram but perhaps just to get an overview of those systems of reporting that you described earlier, we see on the left-hand side there that if an incident is identified, that -- on the left-hand side a route is to report to the MHRA by the Yellow Card system, but there is also another route, and just pausing there before we get to it, this document is intended for clinicians delivering vaccines in mass vaccination centres, GPs delivering, the range of routes of delivery, it's intended for them to read if there is a clinical incident at the point of the vaccine being given; is that correct?
**A.** Yes, and also for the wider NHS. At the time the programme in the NHS was being managed as part of the emergency response procedures, because that was what was set up for the whole pandemic, so the NHS, as you realise, was under immense pressure and so was managing things as an emergency, so they had this regional and national escalation system.
**Q.** Just looking at this diagram, is that what we see here?
**A.** In the middle.
**Q.** There are regional points of contact which then feed into the National Incident Co-ordination Centre?
**A.** Exactly.

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



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



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



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

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

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

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

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

If we could have up on screen INQ000528432, please.

This is an email chain between you and others in



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

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

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

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

This is another email in the chain where you say:

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

And you go on to say:

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

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

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



with the parties that you've mentioned there about how to update the information that was going to go out to the public. Can you remember how your concerns on this occasion were responded to, how this was resolved?

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

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

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



want this to be changed.

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

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

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

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

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

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

**A.** Well, I mean, I think a decision was made that the messaging would be managed, sort of, centrally in the Cabinet Office/DHSC. So that was fine, having one message, because it's very important not to have inconsistent messaging because that confuses people more. So I think I have no problem with that, and I think what is good is that there is clinical input into that, and that the clinical expertise is reflected, which it was, even though at the end of the day, subsequently, my opinion was, sort of, overruled in terms of the timing, but certainly when the messaging went out, the tone of the messaging was completely -- you know, I was completely behind making sure that the balance of risks and benefits were going to be reflected hopefully as accurately as possible.

**Q.** What about from a patient or member of the public perspective? We've heard about these different sources of information about the risks and benefit of vaccines, the process of vaccination. Do you think, on reflection, it might have been good to have a central source for the public to access information, so they're



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

**A.** Yeah, I mean, I feel -- I actually personally think a single, sort of, website or a single authoritative source of information on immunisation would be helpful. We did used to have one prior to 2010 but now it's devolved into either the NHS website or the DHSC website. But of course, I do want to remind you it's not just about websites, it's about the whole process where people talk to their health professionals. So having a consistent message is the key thing there, and I do think we managed to achieve that, but I do think it would be easier if people could find everything in one place. So I think it would facilitate that people are accessing information that is aligned and authoritative.

**Q.** I want to move on now to a different topic entirely, that of prioritisation, and PHE and UKHSA's role in that. You've already confirmed that there was the provision of secretariat support for JCVI. Did PHE, in the -- at least in the early stages -- always -- sorry, often attend JCVI committee and subcommittee meetings as observers? Was that a role that --

**A.** Yes. I mean, there was always a number of us. Myself, as the medical adviser, invariably would be there, and



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

**Q.** And an active advisory role, including producing reports, for example citing scientific or surveillance data?

**A.** Exactly, yes.

**Q.** Risk of mortality, for example, PHE produced information about that prior to prioritisation decisions being made in order to inform --

**A.** Absolutely.

**Q.** -- the --

**A.** Yeah, our job would be try to source as much information as possible to support the JCVI decision making.

**Q.** The Inquiry has heard about one particular part of the prioritisation process, and that is the system for deciding who falls into which cohort.

Cohort 6 in particular appears to have been a tricky area in terms of definitions and who was going to be included. I just want to ask you for your perspective on this, particularly as the person responsible for the Green Book.

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



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

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

What was the procedure, please, for changing or deciding on definitions in the Green Book which might directly impact who was going to be included in a particular priority cohort, such as unpaid carers?

**A.** Well, I mean, the Green Book already -- the Green Book really is a sort of clinical document. It's designed for the clinicians. But obviously it reflects policy decisions that have been made on the basis of JCVI

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

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



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

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

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

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

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



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

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

**A.** Yeah.

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

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

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

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



Which sets out the models for reporting.

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

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

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

Thank you, we can take that down.

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

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

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

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

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

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

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



weren't on the system.

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

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

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

**A.** Yes.

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

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



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

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

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

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



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

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

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

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

would require things like taking the vaccine to those individuals.

**Q.** Can I just touch on the issue of local collaboration, by which I mean collaborating from the centre with local authorities, who are best placed, potentially, to identify gaps in coverage locally and to reach those communities.

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

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



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

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

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

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

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



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

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

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

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



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

**Questions from MS NAIK KC**

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

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

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

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

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

And so I just wanted to ask you, what, if any, specific and tailored interventions were made in response to this evidence aimed at migrants?

**A.** So that report, as you've said, it has a lot of information, and that's just one element of it. That was produced by our behavioural surveillance insight unit, I think it's called, and that was really mainly to support local collaborations, so through local directors of public health and our local screening and immunisation teams. So I would have expected that -- I mean, that briefing note went out to those local teams to hopefully support them in understanding what the barriers might be in their area, and how to address that. That is to say however -- that's not a new phenomenon, I think it's something we had found previously looking at Eastern European migrants of, you know, people's perception of what might happen if they came forward for vaccination and whether or not they could register has always been a potential barrier.

So it's something we've been aware of for a while



and been working with migrant groups, I'm not sure if we've worked with the people you're representing yourselves, but I'm sure people within the agency have at some point touched on those areas.

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

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

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

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

**A.** Exactly.

**MS NAIK:** Thank you.

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

Mr Jacobs, I don't know -- can you see Mr Jacobs?



He is at the back there.

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

**Questions from MR JACOBS**

**MR JACOBS:** Hello, Dr Ramsay, good afternoon, I act for the Gypsy and Traveller community and my client is the Traveller Movement which represents the three Roma, Gypsy and Traveller communities in the United Kingdom, and I'll call them the GRT for the sake of convenience.

Did you hear the evidence of Yvonne MacNamara, who is the CEO of the Traveller Movement, on 16 January, that was last Thursday?

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

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

And you also refer to GRT, at paragraph 7.5 of your



statement, as being one of the inclusion health groups which is an umbrella term for people who are socially excluded, tend to have very poor health outcomes and who are considered to be at high risk of missing out on vaccination, and I think Ms Stephenson took you to that around about 12.50.

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

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

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

I wouldn't -- we still don't, as far as I know, have

good data to show how effective that might be and that is something long-term we would very much appreciate. As you say, then, we've been aware that that community in particular, misses out on other vaccines in the past.

**Q.** Really what I wanted to sort of follow up on there, was there was an awareness that the lack of data capture was an issue in relation to vaccine uptake in this group, for example, if a group is statistically invisible, then they can't be looked after and planned for by the medical institutions? Was that something that was at the forefront of your thinking at the time?

**A.** I don't know whether it was at the forefront of everyone's thinking, I think it's very much part of our overall view of the inequalities picture and the inclusion groups picture, that this was one group where we know not only were they less likely to access vaccines, they were also potentially at higher risk because of underlying comorbidities, underlying sociodemographic issues, so I think we were very well aware of that as an organisation, and again, it comes back to how we would try and influence that, it would be mainly at a local level because it's obviously at a local level that people will be aware of where their Traveller sites are, et cetera, and what facilities and services there are for those Traveller sites and how



those have been funded and maintained over a long period of time.

**Q.** That's helpful. I just have two other questions.

We've seen examples, in the evidence, of limited local initiatives to engage the GRT community, for example at Appleby Horse Fair, but we haven't seen in the evidence any concerted effort at a national level to ensure the inclusion of GRT in a systematic manner. And my question for you is, notwithstanding what you've said, but given this lack of data recognition of GRT and the knowledge that GRT faced health inequalities and social exclusion, what specific efforts were made at national level, not locally, but at a national level, to ensure the targeting of GRT communities in the vaccination programmes?

**A.** I'm personally not aware of specific -- but other than holding that national workshop -- which wasn't about data, that was about trying to make sure the guidance was as facilitative as possible -- I'm not aware of anything specifically at a national level. And I'm not entirely sure of the technical issues that stopped that data collection, but I'm very happy to take that forward, and I'm very happy that we would look to a more sustainable solution to ensuring that this community in particular is able to access vaccinations of all types,



not just Covid.

**Q.** Well, that leads me to my final question. In respect of this data desert, if you like, that was raised by Ms MacNamara and others in this Inquiry, what actions to address that will be made that you're aware of in future pandemics?

**A.** Well, I don't -- again, I don't think this is just an issue for the pandemic; I think it's an issue for all time, and I do think we do need sustainable solutions to -- reaching out to that community in order to ensure that they are getting access to vaccination and to other healthcare interventions and other prevention measures, and obviously engagement to improve trust in that community so that they are more able to come forward.

Vaccines are a medical intervention. I think it's very important that people are engaged with the health service in order to receive those, that it isn't just given as a separate thing. So I do think that, as part of the overall reach-out of the whole health service to that community, that would be my kind of advice. I have relatively limited leverage across the whole system, of course.

**MR JACOBS:** Of course.

Just on one --

**LADY HALLETT:** Thank you very much, Mr Jacobs.



I'm sorry, the stenographer has had the toughest of tough mornings, so we'll have to leave it there.

**MR JACOBS:** Of course, I understand. Thank you.

**LADY HALLETT:** Thank you very much indeed for your help, Dr Ramsay, extremely grateful to you.

And we will take a break now and I will come back at 2.05 pm.

(The witness withdrew)

**(1.05 pm)**

**(The Short Adjournment)**

**(2.05 pm)**

**LADY HALLETT:** Mr Keith.

**MR KEITH:** My Lady, the next witness is Susannah Storey, the Permanent Secretary at the Department for Culture, Media and Sport. Could you be --

**LADY HALLETT:** I hope you were warned we wouldn't get to you until this afternoon.

**THE WITNESS:** I was, thank you.

**MR KEITH:** Could you be sworn, please.

**MS SUSANNAH STOREY (affirmed)**

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

**MR KEITH:** Could you please commence your evidence by giving us your full name.

**A.** Susannah Jemima Storey.

**Q.** Thank you very much, Ms Storey. Thank you for attending

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

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

**A.** I was.

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

**A.** Yes.

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

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

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

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

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



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

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

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

**A.** It might do.

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

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

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



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

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

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

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

**A.** I would.

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

**A.** Potentially.

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

**A.** Potentially.



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

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

**Q.** Sure.

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

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

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

**A.** Yes.

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

**A.** Yeah.

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

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

So this team was analysing those narratives and



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

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

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

**A.** Absolutely not.

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

**A.** No.

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

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

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



**A.** Yeah.

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

**A.** Reporting narratives and trends, not always individual instances.

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

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

**Q.** We'll look at that.

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

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

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



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

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

**A.** Yes.

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

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

**Q.** But a piece of data?

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

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

**A.** That's right.

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



It was the substance of the post, it was not the private individual's information. And as I'm sure you're going to say in a minute, there were some specific carve-outs to ensure Parliamentarians and journalists were not captured.
**Q.** Yes. Can we just look at the sorts of disinformation that the CDU had to deal with, and have up INQ000361167.

So this is a note to ministers, dated 22 July 2020. It's a submission, and it comes from the security and online harms directorate. We can see that in the top right-hand corner, can't we?
**A.** Yes.
**Q.** And this isn't actually a -- it's not actually one of the weekly reports, it's a general submission, isn't it, on the work that the unit is doing?
**A.** That's right.
**Q.** If you could turn over, please, to pages 6 to 8.

"Since late April 2020, a range of anti-vaccination narratives have been observed by the ... Counter Disinformation Cell ..."

That's the CDU, isn't it?
**A.** It is.
**Q.** "Vaccines as a form of population control ...

"The UK Government will introduce mandatory vaccines ..."



And:

"The ... vaccine is a means used by governments or the elites to modify/control the population ..."

Microchips will be injected. Vaccines are being deliberately trialled on those from BAME backgrounds or frontline workers.

There's a reference there to the number of deaths, I suppose, of the participants. So one narrative is that there were disproportionate or highly significant levels of death.

Bill Gates gets a note up there.

Vaccines aren't necessary.

Covid is harmless. Vaccines are harming health.

In relation to the harming health element and vaccines, did the unit proceed on the obvious and self-evident basis that all medicines, including vaccines, may have side effects, some of them quite serious or very serious? What was -- the concern, however, held here was that there was a general narrative that the vaccine had had significant side effects on those involved in the trials.
**A.** Yes, so this is just -- this is a summary in the advice to ministers, which was for their information.
**Q.** Right.
**A.** And this was in the summer of 2020 and I think it's



giving an illustration of the sorts of themes and narratives --
**Q.** That were out there?
**A.** -- that were out there.
**Q.** So this wouldn't necessarily trigger any sort of reaction on the part of the CDU; this is just identification of the narratives that are in the public domain?
**A.** That's right, yeah.
**Q.** So if we then look at INQ000361175, we can see an example of a particular report. Was this a weekly report?
**A.** Yes.
**Q.** "Over the past week the Cell has observed 57 pieces of content and made 16 escalations to platforms."

Is that a reference to telling the platforms that these pieces have brought themselves to your attention, and you inviting the platforms to apply their policies as they see fit and do whatever they want to do?
**A.** Yes, so the unit had this status called "trusted flagger status" which the government and some NGOs and academics and other bodies had. And it meant that if, in this instance, the unit was seeing mis- or disinformation that it believed was harmful to public health or public safety and it believed was in breach of that particular

or multiple platforms' terms of service, then it would flag them to them.

So what this is saying is there had been 57 pieces of content that meet those criteria, but only 16 have met the criteria to be escalated to platforms, and then, as we were discussing before, it may well be -- and this document, I think, goes on to show what happened -- not all of the 16 would have had necessarily the same treatment by the platform because it was their prerogative to decide what to do.

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

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

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



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

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

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

**A.** Yes.

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

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

**A.** Yes, there was.

**Q.** How did that work?

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



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

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

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

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

And there's a checklist.

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

**A.** Yeah.

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



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

**A.** That's right.

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

**A.** They did.

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

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

**Q.** Roughly.

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

But, as I say, this was really about an input into a wider process.

But the platforms themselves I think over the course of the pandemic also evolved their own processes, and you would want to talk to them about those specifics.

**Q.** Of course. I think in your statement you say that -- you've obviously done some research on this:

"Meta ... displayed warnings on Facebook on more than 190 million [pages] ... [as being, at least in part] false, partly false, altered or missing context. In September 2021, Meta reported that it had removed more than 20 million pieces of false Covid-19 and vaccine [related] content."

I'm very sorry to observe that, but that rather puts the unit and your department's work in the shade.

**A.** Absolutely. And I think that's important to be clear about, which is the scale of the responsibility of the platforms in these situations and also, as I said there, it wasn't just that they would remove information. You know, a really important thing during Covid was to be the signpost and the flag to trusted health information, and that was something that the team worked closely with them on.

**Q.** Just for a moment on that, so I didn't ask you deliberately at the beginning, but one of the major ways



in which a government may respond to dis- or misinformation is to keep on repeating its own message?

**A.** Yes.

**Q.** And obviously it was important that social media platforms, along with all other organisations which disseminate material into the public domain, they were encouraged to keep on printing, repeating, disseminating --

**A.** Yeah.

**Q.** -- the public health lines?

**A.** Absolutely. Absolutely.

**Q.** All right.

X, you say, had removed over 65,000 pieces of content and suspended over 3,000 accounts for violations of its Covid-19 guidance.

YouTube removed over 130,000 videos, and TikTok introduced a Covid-19 information hub providing answers to questions, no doubt with the help of the government, on public health issues, which was viewed 921 million times. So that gives you an idea of the scale.

**A.** Yes.

**Q.** Was the work of the Counter Disinformation Unit, quote, "secret extra judicial censorship with no oversight akin to how illegal terror content is dealt with by the government"?



**A.** That is not my view.

**Q.** Do you believe that the genuine experiences of the vaccine injured and bereaved were wrongly swept up in this monitoring process and wrongly brought to the attention of social media platforms?

**A.** No, I mean, as I say, the purpose of the unit was very specifically trying to minimise the public health or public safety impact of this mis- or disinformation. Obviously you're doing general searches, so it is possible that some information could be captured and ultimately flagged, if it hit those criteria I said, that might not be mis- or disinformation, and then it's for the platforms to assess whether it meets their terms of service or not and then for them to decide what do.

**Q.** Did the flagging system that you've described, and the trusted status which the CDU have, in any way lead to pressure being applied to social media companies to remove content wrongly?

**A.** No, I don't think so. I mean, I think at the beginning of the pandemic, the Secretary of State and I think the Health Secretary were very keen to work with the platforms, and there was a number of roundtables later in the pandemic, after the vaccine we had this Counter Disinformation Policy Forum, so there was lots of proactive work with them, but that was more about this



point of getting them to flag trusted health information, getting them to make sure their terms of service were clear and transparent about what they were actually doing in terms of content moderation.

**Q.** And finally, just so we can put the work of the unit into a wider context it would be very helpful if you could just describe what you see as the main impacts of the Online Safety Act in the sphere of public health disinformation.

The Inquiry is aware that the Act obliges companies to take action over illegal or harmful content online, and I think there is in fact, I think, a new offence created, called a false communications offence, concerns spreading information that is known to be false, but do the provisions in the Act cover the same territory as public health disinformation and misinformation?

**A.** You're asking me to go outside the remit of my current role but I'm happy to give you a personal view.

So, during the course of the years before and during the pandemic, we were working on the Online Safety Bill, which became the Act, and as you rightly point out, I understand it does contain some measures in relation to false communication and foreign interference.

As to its effectiveness, I think we need to wait to see when the Act is fully in force and then see what

happens.
**Q.** It wasn't a trick question. It seems to be apparent from the very features of the Act that you describe, that it wasn't directed at public health disinformation and misinformation?
**A.** No.
**Q.** It deals with illegal and harmful content?
**A.** That's right.
**Q.** Which may or may not be the same thing.
**A.** That's right, it could overlap but that isn't the primary purpose of it. And it did, in effect, become the regulatory regime for dis- and misinformation. But at the time of the pandemic we didn't have such --
**Q.** It wasn't in effect.
**A.** -- a regulatory regime.
**Q.** No. But when was the bill first conceived?
**A.** When I came into the job in August 2019, we'd already had the Internet safety Green Paper and the government response, and then we were preparing the -- the White Paper was out and then we were preparing the response to the White Paper, and then the Bill was introduced during the pandemic.
**Q.** So the Act -- the bill followed the 2017 Green Paper Internet strategy?
**A.** That's right, and then its own White Paper.



**MR KEITH:** Thank you very much, Ms Storey. Those are all the questions I have for you. There may be some further questions.
**LADY HALLETT:** There are. Thank you very much, Mr Keith.
Ms Morris, who is sitting at the back there, if you could make sure your answers get into the microphone, I'd be very grateful.

**Questions from MS MORRIS KC**

**MS MORRIS:** Thank you very much, my Lady.
Ms Storey, I ask questions on behalf of the Covid Vaccine Adverse Reaction and Bereaved groups, and these groups represent those who have suffered injury or bereavement following their voluntary acceptance of the Covid vaccine, just so you understand where the questions are coming from.
**A.** Thank you.
**Q.** I'm going to focus my two questions on the issue of how the information that members of those groups shared on social media may have wrongly been labelled by the CDU as misinformation or disinformation, okay?
And by way of context, of course, we're dealing here with a population-level rollout of a novel set of vaccines where, even though there'd been clinical trials, there's an acceptance that there would be adverse reactions and -- that might not have been



identified by those trials, and therefore the signals for any emerging adverse reactions would need to be carefully identified and monitored.
You've said in your statement that if the CDU came across a new narrative, and needed to determine the veracity of the content, it would use third-party sources to establish whether the content could constitute mis- or disinformation, and you say that that involved looking at trusted, publicly available sources, including the NHS guidance for Covid, credible journalistic sites, such as the BBC, or using independent fact-checking sources. I think you gave the example of Full Fact.
**A.** That's right.
**Q.** Thank you. So given the context that I've set out of the stage of the vaccine rollout, would you accept that given the speed and the novelty of the vaccine rollout, there could be instances where individuals reported injuries on social media that they attributed to the vaccine, but, due to the early stage of the rollout, third-party sources like the NHS, public health sources, and the media, might not have yet had sufficient time to evidence those and verify those claims?
**A.** I can agree with the point you're making that it may well be the public health authorities hadn't had time to



verify what was being said. What I don't know, I'm afraid, is what then happened to that information, whether it was picked up by the CDU and/or whether it was flagged to social media, or whether social media companies, under their own terms and conditions, might have taken action in relation to this content.
**Q.** Okay. But it may well have been flagged by you if someone is reporting an injury that you can't find any third-party verification for?
**A.** I think it's conceivably possible, but my understanding of what the unit was doing was more about really significant trends and narratives of dis- and misinformation. So the example I was giving in my statement was when the 5G masts were being vandalised. So it's hard for me to give you a definitive answer I'm afraid.
**Q.** Understood. But in the document that Mr Keith showed you in your evidence earlier on, the list of what you described as being an anti-vaccination narrative, vaccinations being harmful to health was part of that narrative, would you agree?
**A.** That was, yes, in the summary document that was giving ministers illustrations of some of the trends that were online.
**Q.** Yes, okay. So just -- my second question, following on

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

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

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

**THE WITNESS:** Sorry.

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

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

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

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



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

**A.** Well, I said in my statement that because it was a devolved policy area we were primarily not focused on those areas, but there were *ad hoc* connections between ministers and their devolved counterparts and also some of the work of this unit was inputting into wider DHSC boards which did include the devolved administrations.

So there was some connection in some of these areas, and obviously if we thought it was helpful, we would have absolutely done that.

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

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

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

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

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

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

(The witness withdrew)

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



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

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

Thank you, my Lady.

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

Ms Mitchell, who is opposite you.

**Questions from DR MITCHELL KC**

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

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

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



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

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

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

**MS CHARLET CRICHTON (affirmed)**

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

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

**THE WITNESS:** Thank you.

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

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

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

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

You're the founder of a group known as UK CV Family. We'll talk a little bit more in a moment about what they do. But as the founder, you've produced two statements, one dated 17 October 2024, and I'm going to mention this, running to a whopping 344 pages, and a second

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

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

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

**A.** That's right.

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

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

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



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

**A.** Yes, yeah.

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

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

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

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

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

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

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

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



a combination of medical conditions.

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

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

**A.** Yeah.

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

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

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

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

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



another group dealing specifically with the bereaved?

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

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

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

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

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

members?
**A.** We try to remain neutral on the subject of whether vaccines are good or bad because our members have very differing views and if we are to support them all, we have to remain neutral on the wider subject of whether vaccines are generally a good or bad thing.
**Q.** And that's a very fair position to take.
So in your voluminous statements, you have raised a huge number of points, topics and issues of concern, Ms Crichton, and I simply cannot go through them all. A lot of them are, I'm afraid, out of scope, that's to say they're just not within the remit of my Lady's Inquiry. But we're going to identify those areas that are within scope and on which you're inviting the Inquiry to pay particular attention to.
And as I read each one out, I'm going to give you an opportunity of trying to summarise what the main concern is that's held by your members where a significant body of them, a significant number of them, appear to you to be concerned about this issue.
**A.** Yeah.
**Q.** A very significant thread running through all 600 pages is the concern of your members about the effectiveness and safety of the vaccines. Is that general concern also tied in many places to the nature of the



development and authorisation processes that were in place? So you're concerned about how it worked in practice and whether or not the system was effective?
**A.** I think so, yes. I think the -- obviously the Covid-19 pandemic, there were certain rules that were changed to accommodate the speed of the rollout of the vaccines and the manufacturing processes, and in the witness statement we've gone into quite some detail about those different processes and how they may have been affected.
**Q.** The clinical trial process. Obviously there is a very significant process by which any medicine has to be tried, clinically tried, pre-clinically tried, monitored and authorised. Do your members have concerns about the integrity and the efficacy of the overarching clinical trial process?
**A.** We do. We know of cases where clinical trial participants' data has been dropped when they've suffered an adverse reaction and not been included in the data.
**Q.** All right, I'm going to pause -- stop you there. The same applies to you as to every other witness, including state or government witnesses. We can't be looking at individual cases and it would be wrong to allow anybody to say, "We know of cases where X and Y has happened", we don't know whether X and Y has happened, so I'm



concerned to know from you, you're concerned with the clinical trial process. Is it connected to worries about whether or not it was effective, whether it picked up side effects?
**A.** Yes, I think we'd like to know what is an acceptable risk/benefit profile.
**Q.** All right. Do you have concerns about diversity and the -- whether or not population groups were sufficiently represented in the trials?
**A.** Yeah, for example pregnant women weren't represented in the trials.
**Q.** Yes.
**A.** Yet the vaccines were recommended for pregnant women. Children, to start with, weren't in the trials. And obviously ethnic minorities, there wasn't many people in the trials from that group either.
**Q.** Are you aware -- so that you're aware of why we're focusing on this -- that many of the trials were abroad, where racial and ethnic make-up proportion ran, in fact, in the case of Pfizer 80%?
**A.** Mm.
**Q.** So you're concerned, in fact, with diversity in the UK trials, I suspect?
**A.** Yes.
**Q.** All right. Your members express concern about the size



and scope of the phase IV trials. Do you mean the trials that took place by way of the clinical provision of vaccines after authorisation in the community? That's what the phase IV trials are.
**A.** I would have to refer back to the witness statement to know exactly what we -- as I said at the start of the witness statement, we actually had six of us write it, so that might not be a part that I paid a lot of detail to myself.
**Q.** All right. You've mentioned acceptably safe.
**A.** Mm.
**Q.** Understandably, your members would like to know more about how the vaccines were determined to be acceptably safe, and what the MHRA in particular assessed was the correct risk/benefit balance.
**A.** Yes.
**Q.** There are many references to that in your statement. You're concerned about the batch testing process, the way in which batches produced by manufacturers were tested. And you're concerned or many of your members are concerned about the whole operation of the MHRA safety surveillance processes?
**A.** Yes, in particular the Yellow Card.
**Q.** And on the Yellow Card Scheme, Ms Crichton, does your statement set out actually a lot of areas in which your

members have expressed concerns about the scheme from a lack of a mandatory obligation on doctors and public health clinicians to report side effects, the lack of public awareness of the scheme, how the data is accumulated, what the Yellow Card Scheme says about causative links, whether the MHRA responded to Yellow Card reports by looking for clusters of symptoms -- that's another big issue -- how difficult it is for the scheme to be used, whether or not, after reports are made in a Yellow Card and the MHRA has determined that they are of significance, the population should be told, or at least those persons who have reported side effects, of the MHRA's position -- is that a big issue? So feedback back to members of the public about side effects?

**A.** Yes. Our members have found that their Yellow Card reports were suddenly missing when they tried to follow them up. There were no actual follow-ups by the Yellow Card system to check on the people that had suffered an adverse reaction to see if they were recovering or not. Only 6% of people that are -- people in our group that actually reported, only 6% of those reports were made by medical professionals. So this shows that the public are reporting, and not the medical professionals. But actually, as you know, the larger studies show that only



around 10% of people know about the Yellow Card Scheme and report. So this is massively underrepresented.

**Q.** So there is a real issue about public awareness of the scheme and the ability to report, but also, the degree to which people who report are followed up?

**A.** Yes.

**Q.** So the MHRA may well look at NHS data, GP data, health data, but that doesn't necessarily mean to say that they're picking up the phone and speaking to you or getting in touch with the person who made the report?

**A.** That's correct, yes.

**Q.** Right. Your members are concerned about the process by which vaccines were authorised for younger people. You're concerned about the state of public messaging, about the risks of adverse reactions, and as with a number of other similarly bereaved and injured groups, you want to know much more about how the MHRA responded to the emerging reports of the most serious conditions, like TTS, myocarditis, pericarditis, you've mentioned Guillain-Barré syndrome, and ME, myalgic encephalomyelitis -- (overspeaking) --

**A.** Yes, and in particular why the MHRA took such a long time in actually announcing the vaccine induced thrombocytopenia, thrombosis and thrombocytopenia situation to the public, especially as there was



a letter sent by the Public Health England and the Royal Society of Haematology to hospitals two weeks prior. So the condition was known about but the public weren't told.

**Q.** Do you mean the information that was put into the public domain around about the Easter Bank Holiday weekend?

**A.** So this would be Easter but there was a letter sent to hospitals --

**Q.** Before the weekend.

**A.** -- from Public Health England on 22 March --

**Q.** That's right.

**A.** -- detailing how to manage VITT.

**Q.** And you're concerned that -- either that the MHRA knew about the condition a long time before that letter went out or that when the letter went out, it wasn't enough, there should have been more data given and more information given at that same time?

**A.** Our concern is that we have members whose loved ones died in that period, and they feel that their loved one's death may have been prevented if the MHRA had been more public sooner.

**Q.** Right. An important part of your statement deals with the Vaccine Damage Payment Scheme, which is the non-compensatory flat-rate scheme. Many of your members, I expect, have made applications or tried to



make applications under the scheme; is that right?

**A.** That's correct.

**Q.** And their concerns traverse almost every aspect of the scheme, don't they, from what must e established, the causative threshold, damage caused by a vaccine, prescribed vaccine, as well as the 60% severe disablement criteria, the amount of money which may be awarded, £120,000, as well as -- well, many other aspects, about how the scheme was managed, how long it takes, and whether or not, actually, it's fit for purpose?

**A.** That's correct, yes.

**Q.** All right.

**A.** Many of our members have tried to claim the vaccine damage payment and been rejected. I think you can see from the numbers Kate Scott read out last week, but there's been 17,500 claims and only 194 claims have been processed and awarded, and 416 people were not deemed disabled enough to meet the criteria. It isn't fulfilling a purpose, and it's very traumatic for someone when they're very ill, after they've done something that they were told to do, or they've lost a loved one, to fill out the form.

The form asks "Tell us what happened" and when I filled mine out, I was still very, very poorly in bed

and I filled it out laying down in bed on my bedside cabinet and I literally put three sentences and I just thought my medical records would speak enough. I thought I wouldn't have to tell the assessors what had happened to me because they'd look at my medical records and go "Yeah, adverse reaction, that's happened, she's unwell."

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

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

**THE WITNESS:** Yeah.

**LADY HALLETT:** Horrible story.

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

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

**A.** Yes.



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

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

**Q.** Two final areas, please, on which I'd like your help. There are many references in your statement to the systems by which members of the public are informed, in advance of and after taking a vaccine, of contraindications, side effects, benefits, and risks, the patient information leaflet, and there's also, as you know, the summary of product characteristics, and many of your members are concerned about the distribution and the use of the PILs, whether they properly knew the position.

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

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



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

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

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

**A.** Yeah.

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

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

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

**A.** Huge pressure, yes.

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

**A.** Yes.

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

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

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



deployment.

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

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

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

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

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

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

**THE WITNESS:** Thank you.

(The witness withdrew)

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

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

**(3.06 pm)**

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

**I N D E X**