I. Welcome and Introduction

1. The Chair welcomed everyone to the meeting and thanked them for attending the extraordinary meeting on vaccines for SARS-CoV-2 (COVID-19). The Chair reminded attendees of the confidential nature of the discussions, presentations and papers for the meeting. None of the information could be shared outside of the meeting. The Chair asked Members to indicate any additional conflicts of interest over and above those declared at the last meeting. None were declared.

II. Vaccination of those aged 12 to 15 years not in a clinical risk group

2. The Chair summarised recent discussions and evidence considered.

3. It was noted that advice had previously been developed for an offer of a first dose for those aged 16 and 17 who were not in a clinical risk group.

4. ONS infection survey data were summarised. It was noted that infections were increasing at a greater rate in younger age groups, including children and young people. It was noted that testing in children and young people would have increased in Scotland with the return of schools.

5. Yellow card reports for vaccine associated myocarditis were noted. Reporting rates for 16 to 17 year olds were low. The latest US data indicated a lower reporting rate in 12 to 15 year olds compared with 16 to 17 year olds.

6. Short term prognosis for vaccine associated myocarditis appeared good, Medium term follow up data were limited, although improvement was seen in a proportion of individuals followed up. Longer term sequelae could not be discounted based on current data.

7. It was noted that in data from Canada, the reporting rate for myocarditis was higher following receipt of the Moderna vaccine compared with the Pfizer-BioNTech vaccine. Limitations of adverse event surveillance were noted, along with the potential for stimulated reporting.

8. Data from Canada and the UK indicated that the second dose reporting rate for myocarditis might be lower with a longer interval between the first and second doses, compared with a shorter interval as used in the US.

9. Information reviewed at the preceding meeting regarding MRI changes in those with vaccine associated myocarditis were considered. The potential for underreporting or asymptomatic myocarditis was noted. Myocarditis following infection was considered different to vaccine associated myocarditis, with a different underlying mechanism being likely. It was considered important not to overinterpret data with new clinical phenomena. It was agreed that longer term follow up data would be important to consider once available.

10. Early PHE data indicated that prior infection was not correlated with post

into account qualitatively.

22. The number of children aged 12 to 15 years was noted, including the proportion in a clinical risk group.

IV. Discussion

23. The Committee further interrogated the risk-benefit analysis and the underlying assumptions. It was noted that it was based on the latest appropriate data.

24. The Chair summarised options for vaccination of those aged 12 to 15 who were not in a clinical risk group.

25. It was agreed that the Committee should consider health inequalities, long COVID, mental health, and ethics. It was recognised that the Committee could not fully take into account the educational benefits of vaccination.

26. The main purpose of the meeting was to consider an offer of a first dose. Later consideration would need to be given to an offer of second doses, including options of offering no second doses, targeted second doses (gender, previous infection), fractional doses and/or the use of heterologous doses.

27. It was noted that paediatric ICUs, which were operating at or near capacity, acted as a buffer for adult ICUs.

28. Indirect benefits of vaccinating those aged 12 to 15 years, in younger children and adults, were noted. The Committee was reminded that indirect benefits were taken into account for advice on childhood influenza vaccination. Members commented that if the direct benefits and disbenefits to children and young people were relatively balanced, then indirect benefits could be considered. Data on the potential impact of vaccination on prevention of infection and onwards transmission were rehearsed.

29. Members commented that if protection from prior infection waned, infections would continue in the longer term in the absence of vaccination.

30. Members commented that the direct benefits to children and young people were marginally in favour of vaccination but were likely to reduce going forward given the current infection rates in this age group and the protection afforded by prior infection (unless vaccination began rapidly). There remained substantial uncertainty regarding the risks from vaccination, particularly of myocarditis following vaccination.

31. Members commented that the key consideration was the marginal benefit in children and young people, compared with uncertainty regarding the long-term effects of COVID-19 vaccine associated myocarditis. Some members agreed with this position, commenting on the potential for an impact of vaccine associated myocarditis events on confidence in the wider COVID-19 vaccination programme and other vaccination programmes. It was noted