

Thursday, 30 January 2025

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2 (10.00 am)  
3 **LADY HALLETT:** Mr Keith.  
4 **MR KEITH:** My Lady, the first witness today is Professor Sir  
5 Nicholas White. Could he be sworn, please.  
6 **PROFESSOR SIR NICHOLAS WHITE (sworn)**  
7 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 4**  
8 **MR KEITH:** Professor, could you commence your evidence,  
9 please, by giving us your full name.  
10 **A.** Nicholas John White.  
11 **Q.** Thank you very much. And thank you for attending today,  
12 of course, and thank you also for your provision of your  
13 expert report, dated 15 December 2024.  
14 Just in terms of the formalities relating to that  
15 report, it is obviously your own work. Were you  
16 provided, for the purposes of writing that report,  
17 a number of documents, quite a lot of material  
18 consisting, in the main, of witness statements submitted  
19 to this Inquiry by witnesses as well as some, but not  
20 I think all, of the expert reports that the Inquiry had  
21 commissioned?  
22 **A.** I was.  
23 **Q.** Commencing, please, with your qualifications. You are  
24 Professor of Tropical Medicine at Oxford University and  
25 at Mahidol University in Bangkok. You have been for

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1 low-resource settings.  
2 **Q.** Thank you.  
3 Happily for you, Professor, much of your report has  
4 been traversed through the evidence that my Lady has  
5 already heard in the course of this module, and  
6 therefore, by the happy coincidence that you're almost  
7 the last witness in this module, much of your report  
8 won't need to be re-examined. But I'd like you, please,  
9 to start by explaining, in the context of trying to  
10 respond to a pathogenic outbreak, a disease, why it's so  
11 important to have drugs or therapeutics available,  
12 whether -- or whether or not there is a vaccine  
13 available?  
14 **A.** So we need -- in the context of an outbreak or  
15 a pandemic, we clearly want to stop people dying and  
16 suffering, and the way we do that in the longer term is  
17 by developing a vaccine, but that takes time. So in --  
18 before a vaccine is generally available, and for the  
19 many people who can't, or some who won't, take that  
20 vaccine, we need to have medicines that will both, if  
21 possible, prevent and also to treat, with the objective,  
22 as I said, of reducing suffering and death.  
23 **Q.** From your report, it's obvious that there are a number  
24 of different types of medicines or therapeutics, from  
25 small molecule drugs to what are known as neutralising

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1 many years a consultant physician at the John Radcliffe  
2 Hospital in Oxford, you've chaired for some time the  
3 Wellcome South East Asian Research Units. They're in  
4 Thailand and Vietnam; is that right?  
5 **A.** Yes.  
6 **Q.** And for many years, your specialty, the area of  
7 research, has been on infectious diseases, and in  
8 particular, the assessment of therapeutic responses?  
9 **A.** Yes, that's correct.  
10 **Q.** In the course of the Covid-19 pandemic, were you in fact  
11 directly concerned in one of the major trials that was  
12 undertaken at that time?  
13 **A.** Yes.  
14 **Q.** Was that the COPCOV trial?  
15 **A.** Yes.  
16 **Q.** We'll come to that later. And therefore, you were  
17 directly concerned with an important piece of  
18 pharmacometric assessment?  
19 **A.** Yes.  
20 **Q.** You also chair, is this right, the Scientific Advisory  
21 Committee of the Drugs for Neglected Diseases  
22 Initiative. What is that?  
23 **A.** It's a non-governmental group based in Geneva, founded  
24 with the money from the MSF Nobel Prize, which develops  
25 drugs for diseases that predominantly affect

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1 monoclonal antibodies.  
2 Is it of benefit, in very general terms, to have as  
3 wide a variety of types of drug or medicine as possible?  
4 **A.** Initially, yes, because we don't know what we are  
5 facing. Ultimately, you would like to be able to  
6 develop a highly potent, highly cost-effective, safe,  
7 well tolerated medicine. But at the beginning you  
8 don't, so yes, you need to have a large armamentarium  
9 from which to choose your best weapons.  
10 **Q.** Does the time that is required to identify, develop and  
11 make available a drug vary between different types of  
12 drug?  
13 **A.** Yes. It does. It depends on many factors, but yes, it  
14 varies.  
15 **Q.** In the course of responding to the Covid-19 pandemic,  
16 it's self-evident that some drugs which were already in  
17 production and available, and for which authorisation  
18 had been given, were repurposed to face the exigencies  
19 of the Covid-19 pandemic. Other drugs had to be made  
20 from scratch. Presumably, those repurposed drugs are  
21 able to be brought to the marketplace and to be made  
22 available much more speedily than new drugs; that's  
23 self-evident, isn't it?  
24 **A.** Yes, that's correct.  
25 **Q.** And therefore, for the purposes of that latter category,

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1 new drugs, you've got to have up and running, have you  
2 not, an efficient, rapid and well-managed process by  
3 which those drugs can be identified, trialled, and  
4 ultimately authorised?

5 **A.** Yes, because the repurposed drugs, in general, will not  
6 be as good as the bespoke drugs that you develop  
7 specifically for the infection.

8 **Q.** Why is that? Is that because if they had been suitable  
9 for the particular pathogenic outbreak, they would have  
10 been already authorised for that particular purpose?

11 **A.** Yes.

12 **Q.** And in the course of this pandemic, of course, one of  
13 the greater successes was dexamethasone. Was that  
14 a repurposed drug?

15 **A.** Yes, dexamethasone is a drug -- it's a corticosteroid,  
16 a drug that's widely used in medicine, and it was not  
17 really expected to be very effective in Covid.

18 **Q.** Given that one of the most successful therapeutics was,  
19 in fact, a repurposed drug, why is it necessary to still  
20 keep on pushing for the identification and production  
21 and manufacture of new therapeutics?

22 **A.** So the -- so dexamethasone was an anti-inflammatory  
23 drug. It's not a drug specifically for infections; it's  
24 a drug to stop the harsh effects of infection on the  
25 body. But you need specific drugs to treat infections.

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1 we could use to prevent the infection, and we could save  
2 lives in hospital.

3 **Q.** And was dexamethasone in fact a corticosteroid?

4 **A.** Dexamethasone is a potent corticosteroid.

5 **Q.** So just on this issue of, in very broad terms, of the  
6 benefit of therapeutics, it's important to make sure  
7 that you can identify, develop and make available drugs  
8 that reduce not just hospitalisation and death at the  
9 top end of the terrible consequences of a pathogenic  
10 outbreak, but that you can also develop drugs, and make  
11 them available, that reduce the symptoms of the disease  
12 and the general levels of illness that they bring about?

13 **A.** Yes, in general, yes. So if I may amplify that  
14 a little?

15 **Q.** Please.

16 **A.** We try to develop vaccines to stop people getting ill at  
17 all and we try to persuade people -- we provide the  
18 evidence that these work. If people do get ill for  
19 whatever reason, either they didn't get the vaccine or  
20 it didn't work, we still need to treat those people.  
21 Ideally, from a public health perspective, we want  
22 people to not go to hospital and die. So if we can  
23 treat people early in the community, that's better than  
24 later on in the hospital, when they may become sick and  
25 die. But, of course, you have a trade-off there,

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1 We call them antibiotics, antibacterials, antivirals,  
2 anti whatever the nasty pathogen is. And those ones you  
3 need to develop. If you haven't got one already, we  
4 need to develop it specifically. And we did not have  
5 any drugs available specifically for coronaviruses.

6 **Q.** You say, I won't take you to it, but you say at page 84  
7 of your report:

8 "The more severe the illness is, the broader the  
9 potential use of antiviral medicines."

10 What did you mean by that?

11 **A.** In a potentially lethal pandemic, your objective,  
12 primary objective, initially, is to save lives. So  
13 anything that works is to be welcomed, but if it doesn't  
14 work very well, clearly you're going to have to try to  
15 develop something which is more effective. So,  
16 initially, we had no idea what would work or what didn't  
17 work. The first studies showed that a lot of the things  
18 we thought might work, the repurposed drugs, didn't, and  
19 then we were very gratified, in fact the most important  
20 outcome, I think, of all clinical research in Covid, was  
21 the discovery that steroids worked. That was  
22 a surprise, but it saved lots and lots of lives.

23 But then we still had to address the problem of the  
24 infection itself. So we had to get drugs that worked to  
25 stop that infection that we could use in the community,

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1 because the -- so that's why we have to identify who  
2 needs it most, can we afford to give it to those people?  
3 Is it safe and well tolerated, and so on.

4 So in the end you have to make some choices.

5 For drugs that are very safe and very well tolerated  
6 and very inexpensive and affordable, we deploy them more  
7 widely and for drugs which are not so available, more  
8 toxic and so on, we are more restricted in who we advise  
9 should get them. And we have this debate commonly about  
10 antibiotics.

11 **Q.** Still on the subject of the potential benefit of  
12 therapeutics, the great benefit and the great purpose of  
13 the use of dexamethasone was recognised I think in the  
14 summer of 2020. Vaccines were not, of course, made  
15 available until the winter, until December of 2020, and  
16 then January 2021.

17 But had new therapeutics been identified, trialled  
18 and made available, in the summer of 2020, particularly  
19 antivirals, would that have had a dramatic impact upon  
20 the course of the pandemic and the response, in terms of  
21 societal illness and the consequences?

22 **A.** I think so.

23 **Q.** And is that what the aim has to be in any future --

24 **A.** Yes.

25 **Q.** -- pandemic: is to make sure that you've got that option

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1 of therapeutics being available, pending the development  
2 or, perhaps, in the complete absence of a vaccine?

3 **A.** Yes, Covid killed seven million people around the world.  
4 That's far too many. We don't want that to happen  
5 again.

6 **Q.** Turning to the issue of the trial process, we've heard  
7 a great deal of evidence about the way in which in  
8 particular the phase II clinical trial process operated  
9 in the United Kingdom. It is clear from your report  
10 that there was a great deal of funding available for  
11 clinical trials. We've seen some evidence to suggest  
12 that the Clinical Research Network of the National  
13 Institute of Health, now the Health and Care Research,  
14 NIHR, received, I think, over 1600 applications for  
15 trials. 101 of them were badged with urgent public  
16 health approval, and there were, I think, over a million  
17 participants, is that right, some 1.3 million  
18 participants?

19 So it's obvious that a great deal of attention was  
20 paid to the trial process and it was a massive  
21 undertaking.

22 At the same time, Professor, the Inquiry has  
23 received some evidence that's quite critical of, in  
24 particular, the phase II therapeutic process, from  
25 Sir Jeremy Farrar, from Eddie Gray, and

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1 studied to show that very large benefit. But when you  
2 have a relatively small benefit, for example a reduction  
3 in the death by 20%, you need very many people to show  
4 that with confidence. So yes, large trials. In  
5 general, trials are too small. Very seldom are they  
6 too big.

7 **Q.** We'll come back to the question of why and what can be  
8 done about ensuring there aren't so many underpowered,  
9 that is to say small, trials next time, in a moment.

10 I enter into the next topic with some degree of  
11 trepidation, Professor, but in the course of phase II  
12 trials, there are two particular assessments which are  
13 required to be carried out, are there not? One is that  
14 of pharmacokinetics, that is to say assessing the  
15 concentration in the body over time, of the amount of  
16 drug which is left in it, in the body; and secondly, the  
17 issue of pharmacometrics, which is trying to assess how  
18 quickly the infection in the body resolved by the  
19 receipt of the drugs; is that broadly right?

20 **A.** Yes, very briefly, pharmacokinetics is what your body  
21 does to the drugs, how -- the levels that you get in  
22 different parts in the body. Pharmacodynamics is what  
23 happens to the infection, in this case, how quickly it  
24 goes away, how quickly it is killed, and melding those  
25 together is called pharmacometrics. It's rather

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1 Professor Sir John Bell in particular.

2 At the heart of any clinical trial process at the  
3 phase II stage, are there quite considerable  
4 difficulties associated with identifying the standard  
5 that must be reached, what that phase II trial is trying  
6 to achieve?

7 **A.** Yes. So let me say that in the -- overall, if we look  
8 at medical research in Covid, the UK was very strong in  
9 clinical research. And perhaps the weakest part of that  
10 impressive portfolio was phase II. So phase II is that  
11 transition, when you've got a drug, a new drug or even  
12 an old drug at a different dose, your first attempt to  
13 try to see does it work in people or not? And for that,  
14 you need a way of measuring that. And unfortunately, we  
15 didn't have a good way of measuring it and what people  
16 did was a large number of small, and unfortunately  
17 inconsequential trials, which could never have answered:  
18 did the drug work or not? We needed a better method and  
19 that was not developed.

20 **Q.** And just pausing there, it's self-evident that the more  
21 people you have in a trial, the wider the range of  
22 results, of course, and the firmer the conclusions are  
23 that can be drawn from it?

24 **A.** Yes, this is a very important point. When you have  
25 a very large benefit, you do not need many people to be

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1 complicated terminology but it's the science of trying  
2 to understand how much drug do I need to give -- first  
3 of all, does it work, how much do I need to give?

4 **Q.** And a phase II trial in general terms will only be  
5 effective or useful if it can answer those questions?

6 **A.** Yes.

7 **Q.** Are there standards, technical standards in place, as  
8 far as you understand, to ease the path of the  
9 scientists and the clinicians and the researchers, in  
10 answering those questions?

11 **A.** I think this is one of the weakest parts of the drug  
12 development. It requires innovation, and, in general,  
13 the regulatory authorities who ultimately make the  
14 decision whether a drug should be registered or not, are  
15 fairly conservative. Both on this side of the Atlantic  
16 and on the other side.

17 **Q.** So is one of the recommendations that you invite the --  
18 invite my Lady to consider the production or the call  
19 for clearer, technical standards, in order that  
20 everybody may better assess the worth or the efficacy,  
21 the effectiveness, of phase II trials?

22 **A.** Yes, standards and methodologies.

23 **Q.** That's on the technical side. Then, in terms of the  
24 administration of this process, there are obviously,  
25 we've heard from the evidence, a number of moving parts,

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1 from the setting up of the trials, the funding of the  
 2 trials, the regulation and the administration  
 3 surrounding the trials, and of course recruitment.  
 4 Is it your assessment that there needs to be  
 5 a higher degree of co-ordination on the administrative  
 6 side? That is to say, a better management of the  
 7 funding, the setting up, and the oversight of the  
 8 phase II trial process?  
 9 **A.** In simple terms, yes. We have to have some sympathy at  
 10 the beginning of this dreadful pandemic for the  
 11 organisation -- or disorganisation that -- but  
 12 ultimately, I think, it should have coalesced into  
 13 something simpler. We had probably too many committees.  
 14 But yes, overall my short answer is yes.  
 15 **Q.** You're aware that in her July 9 witness statement  
 16 Professor Charlotte Deane, of UKRI, UK Research and --  
 17 innovate, is it?  
 18 **A.** Probably.  
 19 **Q.** The acronyms have finally, on the last day, defeated me.  
 20 Anyway, UKRI, the very significant funding body.  
 21 **LADY HALLETT:** Research and Innovation?  
 22 **MR KEITH:** Research and Innovation. There we are. Thank  
 23 you very much.  
 24 She has suggested in her witness statement that  
 25 there should be a UK-wide structure to select potential

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1 that appear to have been in place during the course of  
 2 the pandemic, such as the UK Covid-19 Therapeutics  
 3 Advisory Panel, the therapeutic subcommittee of NERVTAG,  
 4 RAPID-C19, the Neutralising Monoclonal Antibodies  
 5 Independent Advisory Group and the prophylactic  
 6 oversight group?  
 7 **A.** Well, the short answer is I think that could have been  
 8 rationalised, but I understand how it evolved.  
 9 **Q.** Turning to the important issue of diversity, diversity  
 10 may be measured, of course, in a number of different  
 11 ways, but perhaps two of the most important ways are  
 12 ethnicity and age.  
 13 How important is it that all clinical trials have  
 14 a sufficient depth and breadth of diversity?  
 15 **A.** This is a very important point. I think it depends at  
 16 which stage of the development we are. So it's not  
 17 necessary at the beginning, in, for example, the  
 18 pharmacometric studies we've just discussed, to have  
 19 a range of diversity, because these are small trials.  
 20 Then, based on prior knowledge and understanding of the  
 21 drugs, when you go to the larger, the definitive,  
 22 phase III trials, which are the ones which precede the  
 23 regulatory approval, at that stage you do need to  
 24 proactively try to engineer diversity.  
 25 But I think there is an important point, if I may

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1 interventions to direct resources, and to coordinate  
 2 with regulators the rapid setting up of trials. Would  
 3 you agree?  
 4 **A.** In general, yes.  
 5 **Q.** As it happened, there were, though, nevertheless, some  
 6 extremely impressive and effective phase II trials; is  
 7 that right?  
 8 **A.** There were some.  
 9 **Q.** There were some?  
 10 **A.** There were some, and there were a lot of ones which were  
 11 not. And I'm afraid the ones which were not were -- the  
 12 majority wasted resources and effort.  
 13 **Q.** And so that we can be clear not to damn the very  
 14 effective phase II trials with that observation,  
 15 Professor, AGILE is a trial of which we've heard much,  
 16 at the University of Liverpool --  
 17 **A.** Yes.  
 18 **Q.** -- which is one of the very effective phase II trials?  
 19 **A.** Yes.  
 20 **Q.** ACCORD is another trial which produced very useful and  
 21 effective results.  
 22 If there were a better UK-wide structure for the  
 23 administration, funding and oversight of, particularly,  
 24 phase II trials, do you think there would be a need for  
 25 the amazing proliferation of panels and review groups

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1 add, and that is that in the context of a rapidly  
 2 evolving pandemic which is killing lots of people, speed  
 3 is paramount, and that speed benefits the diverse  
 4 population. So getting to an answer more quickly is  
 5 more important than having an engineered diversity which  
 6 might slow down the recruitment to the trials.  
 7 **Q.** That's very clear. In general terms, but particularly  
 8 by comparison to vaccines, do therapeutics have the same  
 9 effect on all aspects or all parts of the population?  
 10 So are there sectoral or subpopulation groups who may be  
 11 more adversely affected by the receipt of a therapeutic,  
 12 or who may not benefit to such a degree as other --  
 13 **A.** Yes.  
 14 **Q.** -- other parts of the population?  
 15 **A.** Yes, there are well described genetic and, therefore,  
 16 ethnic differences in the way our bodies process drugs.  
 17 And that we know a fair amount about, but we need to be  
 18 aware of that with new drugs, and to proactively try to  
 19 investigate whether there are issues that might result,  
 20 ultimately, in a different way of dosing, or some people  
 21 not getting the drug, or not being -- not you  
 22 recommending against giving the drug to a particular  
 23 population. So yes. Short answer: yes.  
 24 **Q.** So diversity is vital not just for the purposes of  
 25 promoting public confidence and reducing hesitancy in

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1 the receipt of therapeutics, but it's directly relevant  
 2 to both safety and effectiveness?  
 3 **A.** Yes, in general, most -- it's in general not a problem  
 4 but it can be an important problem and therefore in  
 5 developing new treatments one has to be aware of it.  
 6 **Q.** I apologise, I forgot to ask you one final question in  
 7 relation to phase II trials that I want to go back to.  
 8 You had mentioned the -- you'd observed that there  
 9 was, in your opinion, a large number of small or  
 10 underpowered trials. Do you think that if there is  
 11 a clearer technical standard, a better understanding of  
 12 what threshold, in terms of effectiveness and outcome,  
 13 phase II trials should be required to meet, and better  
 14 administration of the overarching process, that there  
 15 would be a reduction in the number of, ultimately, not  
 16 very helpful underpowered trials?  
 17 **A.** Short answer, yes. But I would like to emphasise that  
 18 the method of doing the trial is critical. You can be  
 19 very efficient in figuring out whether something works  
 20 or doesn't, using a relative -- in a relatively small  
 21 trial. But that was not the design that was employed in  
 22 most trials. So it's the way you do the studies as well  
 23 as the size of the studies.  
 24 **Q.** And if the health authority, the DHSC, or the regulator,  
 25 the MHRA or its advisers, the CHM, set out more clearly

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1 actually prove to be less effective?  
 2 **A.** Yes. So as we all know, the pandemic changed  
 3 dramatically over a few years. So, at the beginning,  
 4 there were no drugs, nothing worked, and we had no  
 5 vaccine, and there were a lot of deaths. But very  
 6 quickly the vaccine substantially exceeded our  
 7 expectations. I mean, WHO would have taken a 30%  
 8 protective vaccine. We got much better vaccines than  
 9 that. And that took the pressure off developing the  
 10 drugs.  
 11 **Q.** It's well established that there are two particular  
 12 cohorts, children and pregnant women, who are, by and  
 13 large -- well, they're often excluded from clinical  
 14 trials because investigators assess that it's simply not  
 15 worth the risk, you don't know what the consequences  
 16 might be of trialling unknown therapeutics on children  
 17 and pregnant women. There is always the possibility,  
 18 perhaps the probability, that the next pandemic,  
 19 particularly if it's a flu pandemic, may hit children  
 20 more, or worse. How do we resolve that conundrum, which  
 21 is that children, having been by and large excluded from  
 22 trials may nevertheless be the people to whom those  
 23 trials will most benefit? Or are required to benefit,  
 24 I should say.  
 25 **A.** Yes, this is a very, very important point and it is

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1 how the trial should work and what is the ultimate  
 2 outcome, do you think that problem would dissipate to  
 3 some extent?  
 4 **A.** I think so. If I may give one specific example.  
 5 **Q.** Please.  
 6 **A.** So with the monoclonal antibodies, there was, as I think  
 7 you've all heard, some concerns about whether some  
 8 should have been approved, some shouldn't have been  
 9 approved and so on. The overall problem was that the  
 10 decisions on whether to deploy the monoclonal antibodies  
 11 were based on tests in the lab. Those tests were never  
 12 calibrated. So a particular value in the lab, it wasn't  
 13 known what that meant. If the monoclonal was completely  
 14 useless in the lab, it probably was completely useless  
 15 in a person. But let's say the measure of how good it  
 16 was had gone down tenfold, we had no idea what that  
 17 meant in a person. You need to calibrate these things.  
 18 **Q.** Was there another, additional difficulty, which was that  
 19 for many of the trials, the in vitro work was going on  
 20 at a time, well, further towards the beginning of the  
 21 pandemic, but by the time that certain drugs were  
 22 authorised and then being utilised in the community, the  
 23 context had changed violently, both by way of the  
 24 success of the vaccine programme, but also because there  
 25 were variants circulating against which the drug might

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1 a dilemma. But in general, and I'll be very general,  
 2 I think everyone, including the regulatory authorities,  
 3 now accepts that we should much earlier, in the course  
 4 of developing new therapies, evaluate them in children  
 5 and have a plan for evaluating them in pregnant women,  
 6 if that is the appropriate thing to do.  
 7 So whilst I can't resolve the dilemma, I can just  
 8 say that everyone accepts that it is a dilemma and we  
 9 need to move more quickly into these two very large and  
 10 very critical subgroups of people who may  
 11 disproportionately benefit.  
 12 **Q.** Standing back, as you were asked to do in your report,  
 13 and looking in an overall sense at the regulatory  
 14 process that applied to the development and  
 15 authorisation of therapeutics in the United Kingdom, is  
 16 it your view that in terms of output, and you refer  
 17 particularly to the PRINCIPLE, RECOVERY, and PANORAMIC  
 18 trials, the regulatory system worked well? It  
 19 produced -- it allowed the production of properly  
 20 regulated and safe therapeutics?  
 21 **A.** Yes.  
 22 **Q.** Do you have a view as to whether or not in that  
 23 difficult balance between imposing regulatory  
 24 requirements, perhaps a certain degree of administrative  
 25 bureaucracy, and speed of output, that the system worked

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1 well enough?

2 **A.** Reasonably well.

3 **Q.** Professor, I detect a certain reticence on your part in  
4 answering that question. Do you -- and the solution has  
5 presented itself, it may be thought, but do you say in  
6 your report, that there was at least the impression that  
7 there was quite a significant degree of bureaucracy in  
8 the process, and the process was generally becoming  
9 quite a burdensome one in terms of the regulation of  
10 trials, but that, as it happened, since the pandemic,  
11 the legislative process for regulating clinical trials  
12 has been significantly amended by the introduction of  
13 new legislation, in fact in December of last year?

14 **A.** Yes, and I hope that that does facilitate the  
15 development of new medicines and vaccines.

16 **Q.** Can we now turn, please, to the issue of Evusheld, which  
17 was, as we all now know, a monoclonal antibody, which  
18 was authorised but which was never bought by way of  
19 advance purchase and ultimately was not made generally  
20 available for use, it simply wasn't -- a decision was  
21 taken that it wouldn't be made available.

22 I'm not going to ask you any questions about the  
23 first stage of the process, that's to say the decision  
24 making around the lack of an advanced purchase in 2020,  
25 but I wanted to ask you, please, about the process that

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1 two monoclonal antibodies, and it was clear that as the  
2 virus was evolving, the lab tests were showing that the  
3 monoclonal antibodies were not as good as they had been  
4 before. But what did that mean in people? Nobody knew.  
5 And that uncertainty pervaded the decision-making  
6 process.

7 **Q.** So, coming back to the point you made earlier, was there  
8 a heightened requirement, something that wasn't in fact  
9 done, for there to be greater pharmacometric testing on  
10 the effectiveness of that combined monoclonal antibody?

11 **A.** Yes, and that was recognised by the panel. But none was  
12 commissioned or recommended.

13 **Q.** Why do you think a decision was taken not to make it  
14 available --

15 **A.** I think --

16 **Q.** -- without those clinical tests, the pharmacometric  
17 tests, having been done?

18 **A.** I assume that the panel or panels made a decision that  
19 these laboratory tests created sufficient uncertainty as  
20 to the value of the monoclonal antibodies that it wasn't  
21 worth deploying it, I guess.

22 **Q.** Might an alternative or perhaps better outcome, have  
23 been to say: well, we won't make a decision about  
24 whether it should be made available until those  
25 pharmacometric tests have been done, so that we can have

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1 was applied towards the end of 2021, and into 2022, when  
2 there was a reassessment of whether or not it should be  
3 made available.

4 In very general terms, a recommendation was made by,  
5 in particular, the Office of the Chief Medical Officer  
6 in the form of the Deputy Chief Medical Officer,  
7 Professor Jonathan Van-Tam, that the Evusheld  
8 therapeutic was required to be put through its paces in  
9 terms of an assessment by what was called the RAPID-C19  
10 Committee. There was a debate as to whether or not it  
11 should be assessed by another process called the  
12 PROTECT-V process, and ultimately, it was assessed by  
13 a body -- a process operated by NICE, the National  
14 Institute for Clinical Excellence.

15 It appears that all that took quite a long time, and  
16 by comparison to the assessment of the effectiveness of  
17 vaccines and other therapeutic drugs, it appears to have  
18 become somewhat bogged down.

19 Why do you think that was?

20 **A.** I agree, it was rather slow in comparison to other  
21 decision-making processes. I think the problem was, and  
22 I think some of the -- this has been highlighted in some  
23 of the reports -- was that there wasn't a way of  
24 extrapolating from the lab tests to the clinical use, as  
25 I just described. So it's a monoclonal -- so, actually,

22

1 a better understanding of the effectiveness of Evusheld?

2 **A.** Yes.

3 **Q.** All right. And are you, insofar as one is ever critical  
4 in this scientific field, are you critical of that  
5 process in your report?

6 **A.** Yes.

7 **Q.** By the time that decisions had to be taken as to whether  
8 or not Evusheld should be put through the RAPID-C19  
9 process and ultimately the NICE process and a decision  
10 taken on benefit, had, as you were saying earlier, the  
11 context changed radically? So we're talking now about  
12 the beginning of 2022. What had changed in terms of the  
13 use of a moderately effective therapeutic?

14 **A.** Well, everything was getting better. The vaccines were  
15 much better than we thought, people were acquiring  
16 natural immunity, and we saw the arrival, now, of  
17 bespoke, specific small molecule drugs, notably  
18 molnupiravir and then Paxlovid, so the need for other  
19 interventions was diminishing.

20 However, had they been very, very good, I think --  
21 as always, it's a balance between costs and risks and  
22 benefits and deployability.

23 **Q.** Do we take it that if there had been those technical  
24 standards in play, of which you spoke earlier, if there  
25 had been a greater focus on pharmacometric testing, and

24

1 if, as you say, speed and rapidity of outcome has to  
 2 sometimes outweigh competing considerations, do you  
 3 think, if all that had been done, as you suggested  
 4 should generally be done, Evusheld -- the outcome of  
 5 Evusheld might have been different?  
 6 **A.** It might have been different.  
 7 **Q.** And, of course, Evusheld is a therapeutic which could  
 8 have been of great assistance to, in particular, the  
 9 immunosuppressed?  
 10 **A.** Yes, but we also have to acknowledge that that  
 11 information, that calibration, still hasn't been done,  
 12 but it is beginning diminished -- well, pretty confident  
 13 it wouldn't work now. But was there a window of  
 14 opportunity for Evusheld? Possibly.  
 15 **LADY HALLETT:** Mr Keith phrased his question in a particular  
 16 way. Isn't it speculation to say it might -- I mean,  
 17 I appreciate it's conditional, "might have", but because  
 18 it's not been done it's speculation, isn't it?  
 19 **A.** Yes.  
 20 **MR KEITH:** I think, to be fair, I've put it on the basis  
 21 that we're concerned here with the processes and the  
 22 systems. It's important to recognise that you've got to  
 23 have a better system in place and -- regardless of what  
 24 the outcome might have been in an individual case.  
 25 That, then, brings us on to the last specific

25

1 **Q.** The study, which raised the issue of whether or not  
 2 hydroxychloroquine in fact would harm recipients or  
 3 patients, was published in an article. Was that article  
 4 subsequently retracted when concerns came to light  
 5 concerning the accuracy of the study?  
 6 **A.** Yes. If I may, just a little bit -- so these drugs are  
 7 very safe if you use them at the right doses, but they  
 8 are dangerous if you use them at the wrong doses. So --  
 9 and we knew that because this extensive experience both  
 10 in malaria and in rheumatological conditions.  
 11 But then suddenly, in May of 2020, this report  
 12 appearing in The Lancet claiming that, actually,  
 13 hydroxychloroquine killed people, and made the heart go  
 14 too fast, and that people died. But it very -- well,  
 15 over 48 hours we investigated this and realised that  
 16 this study could not have taken place as it had been  
 17 described, and ultimately it turns out that the data  
 18 have never been provided. They couldn't have been  
 19 provided. And the editor of the Lancet himself declared  
 20 that they'd been fabricated. But the damage was  
 21 substantial.  
 22 **Q.** As a result of the publication, the MHRA, the  
 23 UK regulator, got in touch with the investigators of  
 24 I think the eight trials that were then going on  
 25 concerning hydroxychloroquine, and posed questions of

27

1 discrete issue, which is hydroxychloroquine.  
 2 Hydroxychloroquine was, I believe, a therapeutic  
 3 which was licensed, already licensed, for some  
 4 conditions; is that right?  
 5 **A.** Yes, its older brother, chloroquine, was developed  
 6 in 1945 and actually became the drug to which human  
 7 beings have most been exposed, 300 metric tonnes were  
 8 used every year to treat malaria, and then in the 1950s,  
 9 but more in the 1960s, it became clear that chloroquine  
 10 or hydroxychloroquine could be used in rheumatological  
 11 conditions like rheumatoid arthritis.  
 12 **Q.** The issue of whether hydroxychloroquine should be  
 13 authorised by way of repurposed use for Covid and  
 14 whether it was beneficial at all, became highly  
 15 polarised, did not --  
 16 **A.** Yes.  
 17 **Q.** -- in the public domain? Why did that particular  
 18 therapeutic, Professor, become so viciously polarised?  
 19 **A.** There was a subsequently retracted claim from a very  
 20 prominent French, previously very eminent researcher  
 21 claiming that it works in a very small trial. This was  
 22 endorsed by heads of state on both sides of the  
 23 Atlantic. This then made it politically polarised, and  
 24 the scientific community became, I think, affected by  
 25 this.

26

1 them as to what the meaning of the study was, of course,  
 2 and no doubt asked for data. Did there come a time  
 3 when, as a result of the article, recruitment in the  
 4 majority, the vast majority, of those trials was  
 5 suspended and of course the process came to a juddering  
 6 halt?  
 7 **A.** Yes. So regulatory authorities across the world acted  
 8 in a similar way. In the UK, the RECOVERY trial was  
 9 nearing the end of its enrollment with  
 10 hydroxychloroquine and got a special dispensation from  
 11 the MHRA. All other trials were stopped immediately.  
 12 And then it took some time for them to restart and by  
 13 that time the wave of cases had declined so recruitment  
 14 became difficult, and also the adverse publicity  
 15 lingered. So many of the trials never restarted.  
 16 **Q.** One of the trials, and you referred to it earlier, did  
 17 restart, the COPCOV trial. That was the trial with  
 18 which you were directly associated, were you not?  
 19 **A.** Yes.  
 20 **Q.** But ultimately, on 5 June, the Commission on Human  
 21 Medicines was in fact in session. It was informed  
 22 through a press release from the RECOVERY trial that the  
 23 RECOVERY trial itself had been stopped by its own  
 24 investigators. Was that because -- it had nothing to do  
 25 with any suggestion of harm, it just appeared that the

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1 data was beginning to indicate that the clinical benefit  
2 was less than perhaps had been hoped, and therefore was  
3 insufficient to justify the continuation of the trials?

4 **A.** Yes, it's an important point that RECOVERY was a trial  
5 in severe disease, COPCOV was a prevention trial. So  
6 you have prevention, you have treatment of mild disease,  
7 and treatment of severe disease, and it's not -- you  
8 shouldn't extrapolate necessarily from one to the other.  
9 But the reason the RECOVERY trial stopped was it was  
10 quite clear that hydroxychloroquine was not beneficial  
11 in the treatment of hospitalised patients.

12 **Q.** But it might have been or could have been beneficial in  
13 the context of addressing symptoms and allowing people,  
14 perhaps, to return home or to recover more quickly in  
15 the community.

16 **A.** That would be speculation.

17 **Q.** But we'll never know?

18 **A.** We'll never know. But just to say that it's much easier  
19 to prevent a disease than it is to treat it. So drugs  
20 which are quite weak in treatment can still be useful in  
21 prevention.

22 **Q.** And is it for all those reasons, the story of the  
23 suspension of the trials in hydroxychloroquine and the  
24 retraction of, or at least the difficulty in pursuing  
25 the trials at the time that the article was published,

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1 moment.

2 So I think that's the protection: the protection to  
3 maintain honesty and to try to facilitate the  
4 understanding of the science by the public.

5 And then the other thing which -- the other  
6 organisations which bent under political pressure were  
7 the regulatory authorities themselves. And that  
8 shouldn't happen. I mean, the regulatory authorities  
9 should be absolutely independent, and they should not be  
10 pressurised, as they were, for example, across the  
11 Atlantic. The US FDA was definitely pressurised by  
12 government and that should not be allowed to happen.  
13 I think that is something you can enforce.

14 But I agree with you, you know, people -- you can't  
15 protect people from -- well, in a free society, you  
16 can't protect people from access to information. But  
17 what you can try to do is ensure that lies are not told.

18 **MR KEITH:** That brings us quite neatly back to the phase II  
19 trial process to which you were speaking earlier, and  
20 the final remaining problem that arose in the course of  
21 the pandemic, which was, in a general sense,  
22 recruitment. And you've referred to the problems of  
23 recruitment.

24 Although, overall, there were a very large number of  
25 people who were recruited, and you've told us there were

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1 lead you to one of your recommendations, which is that  
2 in quite a general sense, it's vital, in the context of  
3 therapeutic clinical trials, to protect the system, to  
4 protect that process from political or press  
5 speculation, and to allow the professionals, the  
6 scientists, the clinicians, the investigators, to go  
7 about their work uninterrupted or un -- (inaudible).

8 **A.** Yes.

9 **LADY HALLETT:** I'm not quite clear how one could do that  
10 without impinging on the freedom of expression. How  
11 could one protect the system from media believing it's  
12 a legitimate interest upon which, a public interest upon  
13 which they want to comment? And politicians the same.  
14 How would one protect the system?

15 **A.** I think the -- with a clinical trial, it's -- there are  
16 various ways in which a clinical trial can be obstructed  
17 or facilitated. So clearly a clinical trial involves  
18 recruitment of people, and it's really important that  
19 people have a fair chance to understand why -- to give  
20 fully informed consent, as we say. So of course we  
21 can't protect people from learning all sorts of things,  
22 but what we should do is try to discourage politicians,  
23 journalists, from making claims which are not true, and  
24 which might influence people adversely. I mean, it's of  
25 great contemporary interest across society at the

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1 over a million people, a problem arose particularly  
2 towards the end of 2020 with reaching the right levels  
3 of recruitment for particular trials. There were trials  
4 going on and they were coming to a halt because they  
5 just couldn't recruit enough people.

6 In the context of vaccines, there was a vaccine  
7 registration system which allowed members of the public  
8 to sign up to trials for vaccines. Do you think more  
9 needs to be done in terms of encouraging recruitment in  
10 the context of clinical therapeutic trials and/or for  
11 setting up of a more formal system for recruitment  
12 through registration?

13 **A.** Yes, I think that can be done. It was done, to a  
14 certain extent. The particularly favoured trials,  
15 particularly, for example, PANORAMIC and PRINCIPLE  
16 trials, had extensive support via the National Health  
17 Service to encourage recruitment, and I think that could  
18 be -- that process can certainly be strengthened.

19 **Q.** And so turning, then, to your conclusions and your  
20 recommendations, we've covered many of them in the  
21 course of your evidence, but, to summarise, you would  
22 endorse the strong rationale for having a -- as  
23 effective and as rapid a process of development for  
24 non-vaccines prophylactics and therapeutics, you would  
25 endorse the need for a better co-ordination, both by way

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1 of technical standards and administratively, of, in  
2 particular, phase II clinical trials?  
3 Thirdly, you make a broad appeal for better  
4 pharmacometric analysis to be carried out in the course  
5 of, particularly, phase II trials, so as to avoid the  
6 sorts of problems that arose in relation to Evusheld?

7 **A.** If I may interrupt?

8 **Q.** Yes, please.

9 **A.** Specifically to calibrate laboratory tests which are  
10 used to inform decision making.

11 **Q.** Thank you.

12 And finally this: the Inquiry is well aware that  
13 under the 2011 government pandemic strategy, we  
14 stockpiled large numbers of therapeutics -- a large  
15 number of a therapeutic, I think Tamiflu, to cater for  
16 the possibility that the next pandemic would be a flu  
17 one. Of course it was a gamble that failed to come off.

18 There is obviously a very high level of risk in  
19 terms of stockpiling for Disease X or the pandemic. You  
20 just don't know which one it's going to be. But is  
21 there nevertheless a huge importance in stockpiling  
22 something to cover a range of pathogenic outbreaks, just  
23 to be able to try to reduce, at the outer edges, the  
24 worst impacts of it?

25 **A.** Yes, and I think we are reasonably confident what the

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1 Mr Wagner. Mr Wagner is over there.

2 **Questions from MR WAGNER**

3 **MR WAGNER:** Good morning, Professor White. My name is  
4 Adam Wagner and I act on behalf of Clinically Vulnerable  
5 Families, who represent the clinically vulnerable, the  
6 clinically extremely vulnerable, and the  
7 immunosuppressed.

8 I've just got one area to ask you about, and it  
9 relates to the different kind of drugs that were  
10 trialled during the pandemic and the resources that were  
11 allocated respectively to the different trials.

12 So, at paragraphs 5.26 to 5.29 in your reports, you  
13 discuss the large-scale trials, for example, PRINCIPLE,  
14 that were established to evaluate the efficacy of  
15 repurposed drugs in the treatment of Covid-19, and you  
16 say that PRINCIPLE eventually published results for six  
17 candidate drugs but five of these showed no benefits in  
18 terms of reducing the risk of hospitalisation and death.

19 Then you say, at 5.39 -- you refer to the efficacy  
20 of specific antivirals, so specifically designed  
21 antivirals, molnupiravir and Paxlovid, that were  
22 ultimately procured for the treatment of early Covid-19  
23 disease.

24 So my two questions are these: first of all, in  
25 light of those results, do you think that an appropriate

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1 next pandemic will be. It will be influenza. It was  
2 for every decade except the last one. And I think we're  
3 all rightly concerned today about the potential for  
4 a devastating or at least a bad flu pandemic, and were  
5 avian influenza to become readily transmissible we'd be  
6 in very, very serious trouble. So whereas I don't think  
7 we need to stockpile drugs for Ebola or Marburg or Lassa  
8 fever or exotic viruses, the one that is most likely to  
9 come is influenza, and we do know that coronaviruses  
10 may come as well, so those are two virus groups where  
11 I think it would be wise, I think, to have a stockpile.  
12 Indeed, the country does have a stockpile, I understand,  
13 for influenza. And that's a wise decision.

14 What we don't have is information about what to  
15 stockpile, for the reasons we've just discussed at  
16 length.

17 **Q.** But some therapeutics will have some effect or likely to  
18 have some effect, by way of a repurposed use, and  
19 therefore it's essential to have something there to at  
20 least help ease the passage of the response to the next  
21 pathogenic outbreak?

22 **A.** Yes, for those two specific viruses, influenza viruses  
23 and coronavirus, yes, we have drugs which should work.

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

25 **LADY HALLETT:** Thank you very much, Mr Keith.

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1 balance was struck in terms of resources and time that  
2 were being allocated to the evaluation of repurposed  
3 drugs in comparison to the resources and time allocated  
4 to the development of direct acting antivirals for the  
5 treatment of Covid-19?

6 **A.** In brief, overall, yes. Because we -- you have to think  
7 at the beginning we had nothing, and then we had  
8 something. So initially, when we have nothing, we look  
9 for the most promising of potential repurposed drugs  
10 with a low expectation that they will be successful.  
11 But then, as the specific, if you like, bespoke  
12 antivirals develop, these have a high prospect of being  
13 successful. And so resources then shift towards the  
14 evaluation of those.

15 But overall my answer to your question is yes,  
16 I think the balance was approximately -- was, in my  
17 opinion, reasonable.

18 **Q.** And having had that experience of the Covid-19 pandemic  
19 and the success and failure of various developed drugs,  
20 do you think there are any lessons to be learned for the  
21 future in terms of that respective attention and  
22 resources? In other words, do you think that is  
23 precisely the model that will always be seen, at the  
24 beginning you forecast on one thing and then you move on  
25 to another, or are there other lessons we can learn

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1 about different models of resource allocation to try to  
 2 get better, more, and faster drugs available?  
 3 **A.** Well, I think we've already discussed that to some  
 4 extent. The idea that you have a reasonable  
 5 predictive -- a reasonable prediction about what's  
 6 coming, what might come, and therefore the probabilities  
 7 of these things happening, and then you have things  
 8 in-house that you think should work against those  
 9 particular organisms.

10 Now, you might need to modify those. So, initially,  
 11 you would repurpose or use the things that you already  
 12 have, but then you would try to improve them. This  
 13 is what the pharmaceutical industry does all the time.  
 14 It takes a drug that works reasonably well and tries to  
 15 make it better. So that process, I think, does work  
 16 reasonably well.

17 **MR WAGNER:** Thank you.

18 **LADY HALLETT:** Thank you, Mr Wagner.

19 And Mr Thomas who is just there, you'll see him when  
 20 he stands up.

21 **Questions from PROFESSOR THOMAS KC**

22 **PROFESSOR THOMAS:** Good morning, Professor White, my name is  
 23 Leslie Thomas and I'm representing FEMHO, the Federation  
 24 of Ethnic Minority Healthcare Organisations.

25 Professor White, in your report at paragraph 8.3,  
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1 Specifically, you, say:

2 "With regard to the UK's Covid-19 therapeutics  
 3 trials, although not perfectly matched to the  
 4 population, the representation was generally better than  
 5 many other trials. Whilst the RECOVERY trial did not  
 6 report a detailed breakdown of ethnicities,  
 7 the proportion of its participants who were non-white  
 8 was similar to the UK population in the 2021 census,  
 9 reflecting broad recruitment across many different  
 10 hospitals."

11 My question is this, how might lessons from the  
 12 RECOVERY trial be applied globally to standardise  
 13 proportional representation in rapid clinical trials?

14 **A.** It's a very good question, and I think the UK is better  
 15 placed, perhaps, than most to respond to that  
 16 appropriately. So by simply spreading the net very  
 17 wide, one got the -- or the RECOVERY trial got  
 18 a reasonable representation of the community at large.  
 19 I think in other countries it is more difficult.

20 It is an important point, but I'd just like to  
 21 reiterate a point I made earlier: what really matters is  
 22 speed, because everyone will benefit if we get an answer  
 23 more quickly. And if there are underrepresented groups  
 24 in the trial, then after getting the result, then you  
 25 can then address that, whereas slowing a trial down in  
 39

1 you state that as part of your recommendations:

2 "An open forum for exchange of information in the  
 3 relevant scientific community should be created with  
 4 clear and capable leadership."

5 Question. From the perspective of securing  
 6 proportional representation, would you see benefit in  
 7 this sort of open forum, including medical experts or  
 8 healthcare leads from ethnic minority communities who  
 9 can speak directly to ethnic minority interests?

10 **A.** Yes and no. So it depends entirely on the experience,  
 11 capability, qualifications of those individuals. I  
 12 really think it's important to have ethnic minority  
 13 representation in some form, but it might be better to  
 14 have that in terms of community representation. For  
 15 example, often the problem isn't so much of biology but  
 16 it's of access or behaviour, and these people understand  
 17 that better. So whether it's critical to have medical  
 18 experts represented, I'm not so sure, but I do think  
 19 representation is important in the way that is most  
 20 effective, which perhaps you would guide.

21 **Q.** Thank you. Can I move on to my second question. You  
 22 talk positively in your report about the success of the  
 23 RECOVERY trial. For example, at paragraph 5.69 of your  
 24 report you talk about the proportional representation by  
 25 ethnicity that that trial was able to recruit.  
 38

1 order to engineer representativeness may be to  
 2 everyone's disadvantage.

3 So I think it's a very important point, and I think  
 4 the NHS was particularly well suited to engineering  
 5 this, and -- but I do think that speed is of paramount  
 6 importance in an epidemic or a pandemic.

7 **PROFESSOR THOMAS:** Thank you, Professor White.

8 Thank you, my Lady.

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

10 That completes the questions we have for you,  
 11 Professor, thank you so much.

12 Have you flown in from Thailand especially for us?

13 **THE WITNESS:** Yes.

14 **LADY HALLETT:** Thank you very much for going to that amount  
 15 of effort. As you appreciate, there's an awful lot in  
 16 your report that we haven't been through today but  
 17 I will make sure that I am completely on top, with the  
 18 assistance of my team, of all the matters there, and  
 19 your report has helped inform our investigation and our  
 20 questioning of others witnesses.

21 So thank you very much indeed for your help.

22 **THE WITNESS:** Thank you, my Lady.

23 **MR KEITH:** My Lady, may I just make plain, before I get  
 24 a phone call from His Majesty's Treasury, that  
 25 Professor White flew into Europe in part to attend this  
 40

1 Inquiry, but also for other professional purposes.  
 2 (The witness withdrew)  
 3 **LADY HALLETT:** Thank you very much. I shall return at  
 4 11.20.  
 5 **(11.01 am)**  
 6 **(A short break)**  
 7 **(11.20 am)**  
 8 **LADY HALLETT:** Ms Williams.  
 9 **MS WILLIAMS:** My Lady, the next witness is Helen Knight.  
 10 Please could she be sworn.  
 11 **MS HELEN KNIGHT (sworn)**  
 12 **Questions from COUNSEL TO THE INQUIRY**  
 13 **MS WILLIAMS:** Thank you for coming today and assisting the  
 14 Inquiry. You have provided a witness statement dated  
 15 18 November 2024 on behalf of the National Institute for  
 16 Health and Care Excellence, also known as NICE. And the  
 17 INQ for that is 000474611. Are the contents of that  
 18 statement true to the best of your knowledge and belief?  
 19 **A.** Yes, they are.  
 20 **Q.** Thank you. Just, first, touching briefly on your  
 21 professional background, you are currently the Director  
 22 of Medicines Evaluation at the Centre for Health  
 23 Technology Evaluation at NICE?  
 24 **A.** Yes, correct.  
 25 **Q.** And during the pandemic you were also -- you were

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1 **Q.** So, early on in the pandemic, was it recognised that  
 2 there was a need to adapt NICE's usual ways of working  
 3 to provide access to treatments for Covid patients as  
 4 quickly as possible?  
 5 **A.** Yes, that's right. Yeah.  
 6 **Q.** And ultimately that's what led to the establishment of  
 7 RAPID-C19?  
 8 **A.** Yes.  
 9 **Q.** I should say that stands for research to access pathway  
 10 for investigational drugs for COVID-19.  
 11 Ms Knight, the focus of your evidence today is going  
 12 to be on RAPID-C19's consideration of the prophylactic  
 13 drug Evusheld, but before that, I'd like to ask you just  
 14 a few questions about the work of RAPID-C19 more  
 15 broadly.  
 16 So RAPID-C19 was established in April 2020.  
 17 **A.** Yes.  
 18 **Q.** And was it stood down at the end of March 2023?  
 19 **A.** Yes, that's right.  
 20 **Q.** It was a multi-agency initiative involving, in  
 21 particular, NHSE, MHRA, NIHR and NICE. And is it right  
 22 to say its focus was on access to therapeutics within  
 23 England because it's a devolved activity?  
 24 **A.** Yes, that's right.  
 25 **Q.** But representatives from the devolved nations

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1 Programme Director for Health Technologies at the start?  
 2 **A.** Yes.  
 3 **Q.** And then Deputy Director, and then Acting Director?  
 4 **A.** Correct.  
 5 **Q.** In terms of the centre, is it its role to undertake  
 6 health technology evaluations?  
 7 **A.** It is, yes.  
 8 **Q.** Could you please explain, just in brief terms, what  
 9 a health technology evaluation or appraisal actually is.  
 10 **A.** So at NICE we conduct independent and evidence-based  
 11 guidance to the NHS on treatment of new medicines and  
 12 health technologies, and we make that assessment on  
 13 a review of the clinical effectiveness and the cost  
 14 effectiveness to provide guidance to the NHS.  
 15 **Q.** Thank you. I think it's right to say there are  
 16 different forms of these evaluations, but during the  
 17 relevant period for this module, the majority of the  
 18 evaluations for non-Covid treatments followed the single  
 19 technology appraisal process; is that right?  
 20 **A.** Yes, that's right. So for medicines, yes, the majority  
 21 of the work was single technology appraisals.  
 22 **Q.** Does a standard one of these appraisals usually take  
 23 about 44 weeks?  
 24 **A.** So that's an average. It varies, sometimes between  
 25 39 and 60 weeks, but yeah, on average, 45-50 weeks.

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1 participated in the initiative and attended meetings?  
 2 **A.** Yeah.  
 3 **Q.** RAPID-C19's role was to identify and monitor the  
 4 development of potential therapeutics, and then assess  
 5 their clinical effectiveness in order to facilitate  
 6 rapid access; is that correct?  
 7 **A.** That's correct, yeah.  
 8 **Q.** Was this primarily through clinical trial evidence?  
 9 **A.** Yes, that's right.  
 10 **Q.** And did RAPID-C19 initiate, approve, conduct any trials  
 11 itself?  
 12 **A.** No, we weren't responsible for, kind of, research  
 13 initiatives or commissioning any research studies.  
 14 **Q.** And is it right to say that unlike the usual technology  
 15 appraisal process, the RAPID-C19 process didn't consider  
 16 cost effectiveness?  
 17 **A.** Correct. No consideration of cost effectiveness.  
 18 **Q.** Could you just explain why that approach was taken?  
 19 **A.** Yeah, I mean, the initiative was set up as part of the  
 20 temporary emergency circumstances of the time, and the  
 21 focus was very much around identifying medicines for  
 22 Covid that had, you know, a signal that they would be  
 23 clinically effective and therefore important to roll out  
 24 rapidly in the NHS once we were confident that they  
 25 would work.

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1 **Q.** Thank you. You've set out in your statement how  
 2 RAPID-C19 went about its work. I'm not going to go  
 3 through this in detail but if I could just summarise in  
 4 very broad terms. First, potential therapeutics were  
 5 identified through horizon scanning of clinical trials,  
 6 and then ranked against various criteria to, kind of,  
 7 prioritise them for consideration?  
 8 **A.** Yeah, that's right.  
 9 **Q.** And then topic briefings were produced and kept up to  
 10 date with emerging evidence?  
 11 **A.** Yes.  
 12 **Q.** And was there an oversight group that then met to review  
 13 these topic briefings and consider the therapeutics?  
 14 **A.** Yes, we did, yeah.  
 15 **Q.** Were the senior members of that group the same --  
 16 representatives from the same organisations we've  
 17 touched upon, so NHSE, NICE, MHRA, NIHR?  
 18 **A.** Yes, that's correct.  
 19 **Q.** A long list. And were you one of the representatives  
 20 for NICE?  
 21 **A.** I was, yeah.  
 22 **Q.** So is it right to say that the Oversight Group would  
 23 meet and then decide (a) whether to recommend access,  
 24 (b) whether to continue monitoring the drug, or (c)  
 25 whether to deprioritise?

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1 **A.** Yes.  
 2 **Q.** And in your statement you helpfully set out some tables  
 3 which show the timescales for access to these drugs. We  
 4 don't need to bring them up now, but is it right to say  
 5 for repurposed drugs the majority of them were made  
 6 available within a few days of the trial results --  
 7 RAPID-C19 becoming aware of the trial results?  
 8 **A.** Yeah, that's right.  
 9 **Q.** And, in fact, for dexamethasone it was on the same day  
 10 as the trial results?  
 11 **A.** It was on the day that the trial results were published  
 12 so we were able to -- patients in the NHS were able to  
 13 access it on the same day.  
 14 **Q.** And in terms of new drugs which, of course, need a  
 15 marketing authorisation, is it right to say that  
 16 generally access was made to those within two to six  
 17 weeks from authorisation?  
 18 **A.** Yes, that's right.  
 19 **Q.** So I think it's fair to say that both repurposed and new  
 20 drugs were made available through the initiative much  
 21 quicker than would have been the case through NICE's  
 22 usual processes?  
 23 **A.** Yes.  
 24 **Q.** Ms Knight, in your view, what were the principal factors  
 25 that contributed to RAPID-C19 being able to achieve

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1 **A.** Yeah, so in particular on the recommendation, it was  
 2 where we felt that we had seen or we could be confident  
 3 that the medicine looked to work, and therefore, we  
 4 would provide that signal to the Chief Medical Officer  
 5 for England, and the Department of Health, to be  
 6 considered for rollout into the NHS.  
 7 **Q.** And you'd do that by producing a report, a written  
 8 report with an opinion for the Chief Medical Officer,  
 9 and DHSC.  
 10 **A.** That's right.  
 11 **Q.** But ultimately, it was for DHSC to decide whether to  
 12 actually go ahead and provide access to the drug?  
 13 **A.** Correct.  
 14 **Q.** Just turning now to the therapeutics that were  
 15 recommended for rapid access, I think -- is it right to  
 16 say that at the end of October 2022, the initiative had  
 17 resulted in over 200,000 patients receiving treatments?  
 18 **A.** Yes.  
 19 **Q.** Did RAPID-C19 contribute to access to both repurposed  
 20 and also new drugs?  
 21 **A.** Yes, it did.  
 22 **Q.** I think there are ten set out in your statement. I'm  
 23 not going to list them all but did they include  
 24 remdesivir, dexamethasone, sotrovimab, molnupiravir, and  
 25 Paxlovid?

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1 this?  
 2 **A.** I think it was key to have the right representation  
 3 within the groups. There is, as you identified, four  
 4 key organisations that all are experienced in reviewing  
 5 clinical effectiveness data, clinical trial data, but  
 6 brought slightly different perspectives from the  
 7 organisation. We were, when we met regularly, every  
 8 week, we were able to have an open discussion,  
 9 transparent discussions, to make sure that we could  
 10 make, you know, the best quality review of the data and  
 11 support rapid access where it was, you know, where  
 12 a medicine was shown to be effective.  
 13 **Q.** And I think one of the other things you say in your  
 14 statement is that the horizon scanning of the trials  
 15 worked particularly well; is that right?  
 16 **A.** Yeah, so it was a comprehensive undertaking from the  
 17 team to actually monitor all of the ongoing trials for  
 18 Covid medicines. And that wasn't just UK trials; it was  
 19 worldwide. So that was a significant level of activity  
 20 that was done on a daily basis.  
 21 **Q.** Thank you.  
 22 I'd like to turn now to Evusheld, because that was  
 23 one of the drugs that was not made available through the  
 24 initiative.  
 25 **A.** Yeah.

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1 Q. So the Inquiry has heard a considerable amount of  
 2 evidence about this prophylactic drug, and in particular  
 3 the Vaccine Taskforce's early work and the ministerial  
 4 decision not to proceed with it at that stage. Was  
 5 RAPID-C19 involved at that moment?  
 6 A. We weren't involved in those early stage discussions, so  
 7 we first became aware of Evusheld from February 2021.  
 8 Q. And that's when you first started to consider it?  
 9 A. Yeah, that's right.  
 10 Q. And how did that come about, in February 2021?  
 11 A. So my recollection was that this came via the ATTF at  
 12 the Department of Health, so we were -- it was signalled  
 13 that there was a conversation with the company  
 14 AstraZeneca, and that's when -- we had already  
 15 identified it, but we brought that discussion -- within  
 16 RAPID-C19 we brought that forward and had the first  
 17 discussion in February.  
 18 Q. And its focus on Evusheld was as a pre-exposure  
 19 prophylactic?  
 20 A. So it was being trialled for several different uses, but  
 21 the key focus at RAPID-C19 or the majority of the  
 22 discussion was around the pre-exposure prophylaxis.  
 23 Q. And of course, as the Inquiry has heard, the  
 24 significance of this is that that could benefit those  
 25 who might not be protected by a vaccine?

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1 benefit in pre-exposure prophylaxis."  
 2 And then moving down, please, there's "some  
 3 unanswered questions" about the results, and we can see,  
 4 in the middle of that, it says:  
 5 "The ... Prophylaxis Oversight Group noted that  
 6 there is a risk associated with introducing a partially  
 7 or minimally effective therapy and do not currently  
 8 recommend routine use of this treatment until more data  
 9 on efficacy against Omicron are available."  
 10 And then at the bottom:  
 11 "Overall ..."  
 12 There's a reference there to:  
 13 "... strong signal of efficacy that warrants action  
 14 to prepare for ... access subject to:  
 15 "[First] marketing authorisation being granted, and  
 16 "[Second] confirmation of continued activity against  
 17 Omicron ..."  
 18 A. Mm.  
 19 Q. That can come down for now, thank you.  
 20 So, at this stage, the main concern was whether  
 21 Evusheld was effective against the Omicron variant?  
 22 A. Yes, that's right.  
 23 Q. And was this is an issue that not only affected Evusheld  
 24 but actually other types of neutralising antibodies?  
 25 A. Yeah, that's right.

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1 A. Yeah.  
 2 Q. So just looking at the period between February 2021 and  
 3 November 2021, RAPID-C19 essentially at this stage were  
 4 just noting the ongoing trials and monitoring them for  
 5 any key results?  
 6 A. Yeah, that's right.  
 7 Q. And then it was in December 2021 that there was trial  
 8 evidence which first suggested it might be effective?  
 9 A. Yeah.  
 10 Q. So if we could just turn to the report in December 2021,  
 11 then.  
 12 And that's INQ000479901. Thank you. We're on the  
 13 right page already, page 12.  
 14 We can see there that's the report to the CMO dated  
 15 23 December 2021. We've got the various names for  
 16 Evusheld. We can see the senior RAPID-C19 members, and  
 17 it includes -- there's expert advice from the  
 18 Prophylaxis Oversight Group. We'll come back to that  
 19 group in a moment. We can see then it's -- RAPID-C19 is  
 20 reviewing the trial results from PROVENT.  
 21 And if we could go straight to the recommendation at  
 22 page 16, please.  
 23 So we can see there on the second bullet point it  
 24 says:  
 25 "[Evusheld] is the first medicine to show robust

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1 Q. I think in fact you say in your statement that changes  
 2 in effectiveness due to the variants was one of the key  
 3 challenges for your work?  
 4 A. Yeah, it was.  
 5 Q. Could you just explain what the implication was for this  
 6 in respect of clinical trial evidence?  
 7 A. Yes, so the key challenge really was, although the trial  
 8 data would show there are clinical -- there's clinical  
 9 effectiveness in terms of protection, what we couldn't  
 10 be sure of is if that same level of protection would be  
 11 seen in clinical practice when different variants were  
 12 circulating, in clinical practice, versus the variants  
 13 that were circulating during the trial period.  
 14 Q. So essentially you couldn't be sure it was effective at  
 15 the time you were actually looking at considering access  
 16 based on what might have been outdated trial results?  
 17 A. Yes, that's right.  
 18 Q. Was there a difficulty with getting update clinical  
 19 trial evidence?  
 20 A. Yeah, I think we recognised that, kind of, repeating  
 21 those clinical trials would be a challenge, particularly  
 22 with the way that the virus was changing, that we would  
 23 be presented with that problem moving forward.  
 24 Q. I think one of the other things you say is that there  
 25 was little appetite from commercial sponsors to

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1 undertake further trials?

2 **A.** Yes, that's right.

3 **Q.** So then were in vitro -- and when I say in vitro, I mean

4 lab-based studies -- were they the quickest way of

5 trying to assess any ongoing activity against the

6 variants?

7 **A.** Yes, so obviously -- and you've referred to it -- we

8 invite the Prophylaxis Oversight Group experts to come

9 because we recognised within RAPID-C19, which was set up

10 to assess clinical effectiveness data, we didn't have

11 the necessary expertise, and with the neutralising

12 monoclonal antibodies it became clear that, actually,

13 in vitro data was going to be an important consideration

14 for these products.

15 **Q.** Just in relation to the lab-based studies, you obviously

16 said that RAPID-C19 didn't have the necessary expertise.

17 Is it right that another issue with these studies is

18 that they were quite difficult to interpret and to

19 extrapolate from the lab tests to clinical

20 effectiveness?

21 **A.** Yeah, what we heard at the time is that there were no

22 real standard methods for assessing the quality of the

23 in vitro studies and the results of those in vitro

24 studies, and we didn't have any scientific consensus on

25 how in vitro results could actually be interpreted into

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1 certainty that Evusheld would work, and there was

2 a particular concern about the population that might get

3 Evusheld in terms of their vulnerabilities?

4 **A.** Yeah, that's --

5 **Q.** You can just see at the bottom it says:

6 "... the risks of proceeding to ... access are

7 considered to outweigh the risks of not providing the

8 treatment ..."

9 **A.** Yeah.

10 **Q.** Could you just explain that a little more?

11 **A.** Yeah, of course. I mean, we were very aware that we

12 were discussing a prophylactic medicine for patients who

13 had a high unmet need, but were also very clinically

14 vulnerable and shielding at the time. And so we felt,

15 you know, these were people that weren't infected with

16 the virus and therefore, you know, we wanted to make

17 sure that we had a high confidence that the treatment

18 would protect this clinically vulnerable group because,

19 you know, we wanted to be confident that that protection

20 would continue and we didn't see the evidence to say

21 that it would.

22 **Q.** Thank you. And just staying on this page, moving up

23 slightly, it's recognised it is:

24 "Not feasible to obtain clinical effectiveness data

25 ... There is a need to understand how non-clinical trial

55

1 clinical effectiveness outcomes.

2 **Q.** Thank you. Just moving on, then, to May 2022. I think

3 there was an Oversight Group meeting on 18 May, and that

4 resulted in another report to the CMO --

5 **A.** Yes.

6 **Q.** -- on 30 May 2022.

7 Could we have back up that same document, please,

8 and this time turning to page 8. Thank you.

9 So is it right to say that at this point Conditional

10 Marketing Authorisation has been granted, and you now

11 have the in vitro data from UKHSA, and also from Oxford

12 University, but I think the focus was on the UKHSA data.

13 **A.** Yeah, that's right.

14 **Q.** Turning then to page 10, which is where the

15 recommendation is set out. Thank you.

16 At the second bullet point, it says:

17 "RAPID-C19 does not consider that the available

18 non-clinical data supports ... clinical

19 effectiveness ..."

20 It refers to difficulties interpreting the data, and

21 I think that's the point we were just discussing.

22 **A.** Yeah.

23 **Q.** And then if we go down to the last bullet point, for

24 now, on this page, essentially because of the

25 difficulties, is it right to say that there was no

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1 data [so that's the lab tests] could be used to support

2 decision making on clinical effectiveness," in the face

3 of the variants essentially.

4 And then it also says it's going to be an ongoing

5 issue for these types of drugs.

6 Then if we could turn over to the next page, at the

7 top we've got the ultimate recommendation which is not

8 to proceed. But under the "proposed actions" in the

9 final bullet point:

10 "RAPID-C19 will contribute as needed to system-wide

11 work to consider what evidence is required to be

12 confident ... The Antivirals and Therapeutics Taskforce

13 will be taking this work forward."

14 Thank you. That can come down now, thank you.

15 What type of work is being referred to there?

16 **A.** So what we were trying to understand was, you know,

17 exactly we what we'd said about creating, you know,

18 standardised methods for actually understanding the

19 quality of in vitro studies and therefore the results

20 that you can take from them, and more importantly, how

21 can you then translate in vitro results to the clinical

22 effectiveness of a medicine? So they were the

23 particular areas that we were wanting to be explored.

24 **Q.** I think you will have seen in his report, and probably

25 heard this morning, as well, Professor White raises the

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1 issue of pharmacometrics, and I think he explained this  
2 morning, that's the combination -- forgive the technical  
3 detail -- of both pharmacokinetics and pharmacodynamics.  
4 His view is that this type of data may have answered any  
5 unresolved questions about Evusheld's efficacy.

6 Did RAPID-C19 consider getting this type of data?

7 **A.** So during the discussions at RAPID-C19, and again, you  
8 know, acknowledging we, around the table, weren't  
9 experts in that field, we had the Prophylaxis Oversight  
10 Group come to help us, the term "pharmacometrics" was  
11 never raised or discussed. We talked about the  
12 neutralising effect that you can get from in vitro  
13 studies, and we referenced more PK/PD analysis but  
14 pharmacometrics studies was not something that was ever  
15 raised or discussed.

16 I don't know that that would actually answer the key  
17 question that we were looking at, which was how can you  
18 translate in vitro data into clinical outcomes? I'm not  
19 sure that pharmacometrics studies would actually answer  
20 that question.

21 **Q.** Thank you. In terms of the work that was discussed, are  
22 you aware whether the Antivirals and Therapeutics  
23 Taskforce took this forward?

24 **A.** So NICE was invite to a roundtable in September of 2022  
25 to start some discussions. There was a brief follow-up

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1 clinical effectiveness evidence to roll a medicine out.  
2 And where there were gaps in the evidence, we certainly  
3 signalled that for consideration within the -- and  
4 I think you can see that in the CMO reports.

5 **Q.** Well, on the CMO reports, we're going to come to the  
6 last one now, in August 2022, and at this point is it  
7 right that the ATTF had asked you to look at real-world  
8 evidence from countries which had deployed Evusheld?

9 **A.** Yes.

10 **Q.** The same document again, please. Page 1, thank you.

11 At this point, we can see the Prophylaxis Oversight  
12 Group is still providing experts' advice.

13 Again, just turning to page 6, please, for the  
14 recommendation.

15 At the bottom there -- thank you -- essentially the  
16 evidence is still insufficient at this stage to  
17 progress.

18 **A.** Yes.

19 **Q.** Then, looking at the proposed actions, please, on the  
20 next page. So here RAPID-C19 is recommending further  
21 research, and is recommending pharmacokinetic analysis.

22 Do you know whether this work at this point was taken  
23 forward?

24 **A.** So this -- because this report was in the August,

25 I think that was what led to the roundtable that was

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1 meeting but I'm not aware of anything further that  
2 happened.

3 **Q.** Just pausing there for a moment because I think we're  
4 going to come on to the final report in the chapter,  
5 which is in August 2022, but between May and August,  
6 were you asked to contribute to any further work on  
7 this?

8 **A.** So we were aware of the potential considerations of the,  
9 kind of, real world evidence studies that were being  
10 conducted in other countries, and we were also  
11 considering and having, you know, discussions about  
12 whether or not there may be a potential for Evusheld to  
13 be enrolled in one of the platform studies, in  
14 particular PROTECT-V, but other than that, I'm not aware  
15 of anything else that happened.

16 **Q.** Just in terms of RAPID-C19's role, I think one of the  
17 other things that Professor White says in his report is  
18 that the various committees were generally passive in  
19 that they did not direct or initiate research. Insofar  
20 as that might relate to RAPID-C19, do you think that's  
21 a fair assessment?

22 **A.** I mean, I wouldn't necessarily say RAPID-C19 was  
23 passive. I mean, it was a significant undertaking  
24 working proactively to identify medicines for Covid-19.  
25 I think what we tried to do was signal when there was

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1 taken forward in the September by the ATTF.

2 **Q.** Could you just help the Inquiry -- obviously, we can see  
3 here that you are recommending further research and  
4 also, specifically, pharmacokinetic analysis, but didn't  
5 recommend that back in May. Can you explain why.

6 **A.** I think -- you know, from the notes, I wasn't actually  
7 at that May meeting myself but, you know, I think -- you  
8 know, had it been a key area for consideration, we would  
9 have flagged that for the ATTF to consider.

10 I mean, I think with pharmacokinetic and  
11 pharmacodynamic data, it requires, you know, the drug to  
12 be able to understand that, and of course the RAPID-C19  
13 members were not in control of accessing the treatment,  
14 nor were the other research organisations.

15 **Q.** Is it right by this point that NICE then received  
16 a referral from DHSC to conduct a full technology  
17 appraisal of Evusheld, and ultimately it is not  
18 recommended through that process either?

19 **A.** Yes, that's right. In -- but if I can just also add,  
20 during that kind of summer period, you know, I mentioned  
21 that we were potentially exploring whether Evusheld  
22 could be used within the platform study PROTECT-V, and  
23 really, that -- you know, we felt that would have  
24 provided an opportunity to somehow link in vitro data to  
25 actual clinical outcomes. But as I said, unfortunately

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1 that was never taken forward.

2 **Q.** Are you aware why it wasn't taken forward?

3 **A.** No. I mean, again, it would require the company making  
4 the treatment available for us to roll out that in  
5 a clinical trial.

6 **Q.** Just looking overall at the picture between  
7 February 2021 and August 2022, to the extent you've not  
8 already answered this, do you think RAPID-C19 could have  
9 done more to consider the effectiveness of Evusheld?

10 **A.** I think we responded as quickly as possible to all the  
11 new available data. We -- you know, you can see from  
12 all of the reports, you know, we considered it  
13 extensively. And as I said, because of the particular  
14 patient population whom we were talking to, you know, we  
15 detailed that we required a high level of confidence to  
16 be able to signal that, you know, this would be  
17 considered for use in the NHS, and ultimately we didn't  
18 have that confidence from the data.

19 **Q.** I think this is probably self-evident from your last  
20 answer, but did you have in mind, when making these  
21 decisions, just how important a possible prophylactic  
22 treatment for these types of groups might be?

23 **A.** Absolutely.

24 **Q.** Just in terms of the overall system more broadly, not  
25 just RAPID-C19, if we could just get up paragraph 136.

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1 difficult to keep up with that, and I also don't know  
2 what resources the UKHSA and the MHRA would have to be  
3 able to track and monitor that.

4 **Q.** But, for the future, do you think that's something that  
5 those organisations should be looking at?

6 **A.** Yeah, I think it should be explored.

7 **Q.** Thank you. And just on lessons for next time, I think  
8 one of the things you refer to in your statement is an  
9 in vitro expert advisory group that's been commissioned  
10 by NICE. Could you tell the Inquiry a little bit more  
11 about that, please.

12 **A.** So at NICE, we stood up an in vitro advisory group to  
13 help inform the technology appraisals that we were to  
14 conduct as part of the routine consideration of these  
15 Covid treatments. And, in the absence of data, we  
16 pulled together a representative group of experts, and  
17 that discussion and framework helped us understand the  
18 neutralising effect of the monoclonal antibodies and how  
19 that could be considered within the appraisal and  
20 translated into clinical effectiveness.

21 **Q.** So has it actually made a practical difference to NICE's  
22 work since the pandemic?

23 **A.** Yeah, I mean, like I said, in the absence of anything,  
24 because we knew we were going to have to undertake the  
25 appraisals, we felt we needed to, you know, to provide

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1 I think it's at page 55 of your statement. Thank you.

2 We can see there that you discussed the European  
3 Medicines Agency's Emergency Task Force statements on  
4 antibodies and Evusheld, and the FDA's suspension of  
5 Evusheld in the US. You then go on to say:

6 "NICE considers that, with the benefit of hindsight,  
7 the UK public health and regulatory system could have  
8 looked more intensively at whether or not Evusheld was  
9 effective against SARS-CoV-2 variants."

10 Could you just help us understand which parts of the  
11 system you're talking about, and how you think they  
12 could have looked at this issue more intensively?

13 **A.** Yeah, I think here this is -- you know, it became clear  
14 that these neutralising monoclonal antibodies were very  
15 much impacted by the changing virus, and, you know,  
16 I wonder whether more could have been done to help try  
17 to create that link between in vitro data and clinical  
18 outcomes.

19 You know, as I said previously, when RAPID-C19 were  
20 considering this information, there were no standardised  
21 methods to assess the quality of that -- you know, those  
22 in vitro studies. So, you know, potentially that was  
23 something that, you know, would have helped us  
24 understand the confidence of that data. But equally,  
25 the virus was changing so quickly, you know, it would be

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1 that information to our independent committees. Was it  
2 perfect? I don't know. Is there more that could be  
3 done? Potentially. But, you know, it was very clear  
4 when we looked at the medicines at that time that the  
5 neutralising effects in some was either reduced or  
6 absent, and that really help to guide the committee's  
7 decision making.

8 **Q.** So do you think that could be helpful in the face of  
9 a future pandemic?

10 **A.** Yes.

11 **Q.** Are there any other improvements that you think could be  
12 made around research on this issue?

13 **A.** I think -- we've obviously touched on the key aspects  
14 already. I think it would be helpful to consider how we  
15 might be able to have more diverse people included in  
16 clinical trials. You know, we didn't really see very  
17 much data particularly on those clinically vulnerable  
18 groups. There may be a challenge, there may be ethical  
19 issues with that, but, you know, more understanding on  
20 how differently or not a medicine might work in those  
21 groups would be helpful. And in particular, exploring  
22 medicines in groups of people who we think won't respond  
23 to the vaccine or can't have a vaccine.

24 **Q.** In your statement -- we don't need to get it up -- but  
25 you say, just in terms of development of therapeutics,

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1 that the system could do more. Is that essentially what  
2 you've just touched upon in terms of the types of trials  
3 and the types of participants in those trials?

4 **A.** Yeah, and also -- I mean, we obviously, you know,  
5 particularly for the monoclonal antibodies, we know that  
6 the effectiveness can be impacted with different  
7 variants. So maybe in the research and development  
8 actually trying to identify, you know, the particular  
9 spike proteins that they will work on to try and get  
10 a broader -- you know, to maintain a broader  
11 effectiveness even when the virus changes. It's not my  
12 area of expertise, but I wonder whether it is something  
13 that could be taken forward.

14 **MS WILLIAMS:** Thank you.

15 My Lady, those are my questions.

16 **LADY HALLETT:** Thank you very much.

17 Ms Douglas has some questions for you. She's over  
18 there.

19 **Questions from MS DOUGLAS**

20 **MS DOUGLAS:** Thank you, my Lady.

21 Could morning. I act on behalf of Clinically  
22 Vulnerable Families who represent the clinically  
23 vulnerable, the clinically extremely vulnerable, and the  
24 immunosuppressed. You have explained in your statement,  
25 and also touched upon earlier this morning, that the

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1 clinical trial data, which obviously was positive, but  
2 how that would translate into clinical effectiveness in  
3 the NHS. We didn't consider cost for Evusheld in the  
4 same way that we didn't for all of the other medicines  
5 that we were considering, some obviously which did show  
6 effectiveness and then were rolled out in the NHS, and  
7 others that didn't show effectiveness and therefore  
8 weren't.

9 So at no point were we thinking about cost or cost  
10 effectiveness in our discussion on the evidence and our  
11 advice up to the CMO.

12 **Q.** Thank you. And so you would have no concerns that those  
13 types of considerations influenced any of the ultimate  
14 advice?

15 **A.** I mean, in RAPID-C19 there was no consideration at all.  
16 I can't, obviously, comment on conversations that may  
17 have happened elsewhere but I can confidently say that  
18 it was not a discussion point within the RAPID-C19.

19 **MS DOUGLAS:** Thank you.

20 Thank you, my Lady.

21 **LADY HALLETT:** Thank you, Ms Douglas.

22 That concludes the questions we have for you,  
23 Ms Knight. Thank you very much indeed for your help to  
24 the Inquiry and for coming along today and thank you  
25 also for the work you and your team did -- I think the

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1 RAPID-C19 process did not include consideration of cost  
2 effectiveness, and that that was appropriate in  
3 responding to an unprecedented public health emergency,  
4 for the focus to be on the clinical effectiveness and  
5 not the cost effectiveness.

6 You've also explained that that approach was  
7 a deviation from the standard routes of access to  
8 therapeutics available on the NHS.

9 But we've seen it, of course, that the ultimate  
10 decisions in government regarding Evusheld did cite cost  
11 effectiveness. As an example, Sir Sajid Javid has said  
12 that the advice he was given in June 2022 was that  
13 Evusheld was too expensive for the advantages that it  
14 would give.

15 So my question is this: if NICE's primary purpose  
16 ordinarily in routine times is to conduct a cost  
17 effectiveness analysis to ensure value for the taxpayer  
18 and the financial sustainability of the NHS, how did you  
19 ensure that those cost considerations did not end up  
20 influencing your discussions, advice, and  
21 recommendations about Covid-19 therapeutics, and  
22 particularly Evusheld?

23 **A.** Yeah, I mean, obviously I attended those meetings, and  
24 we never considered the cost, particularly with  
25 Evusheld, we were very much focused on understanding the

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1 horrid modern word is pivot, isn't it? -- but for  
2 getting the process done more smoothly and more  
3 efficiently because we were in a national emergency. So  
4 thank you very much indeed.

5 **THE WITNESS:** Thank you.

6 **(The witness withdrew)**

7 **LADY HALLETT:** Mr Mansell?

8 **MR MANSELL:** My Lady the next witness is Dr Clive Dix. If  
9 he could be sworn, please.

10 **DR CLIVE DIX (affirmed)**

11 **Questions from COUNSEL TO THE INQUIRY**

12 **LADY HALLETT:** Sorry if we kept you waiting, Dr Dix, but you  
13 are, I think, our last witness.

14 **MR MANSELL:** That's right, my Lady, the last witness of this  
15 module.

16 Dr Dix, could you give it your full name to the  
17 Inquiry, please?

18 **A.** Clive Dix.

19 **Q.** Thank you very much for coming today to assist the  
20 Inquiry. You have provided a witness statement for  
21 Module 4, that's INQ000474423. It's signed by you, and  
22 is it true?

23 **A.** Yes.

24 **Q.** Thank you.

25 You served as deputy chair of the Vaccine Taskforce,

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1 or VTF, under Dame Kate Bingham, from June to  
 2 December 2020?  
 3 **A.** Yes.  
 4 **Q.** We've heard from Dame Kate -- I don't wish to embarrass  
 5 you, Dr Dix, but she described you in one word:  
 6 phenomenal. There we go. Perhaps I have embarrassed  
 7 you.  
 8 **A.** Yes, you have.  
 9 **Q.** Then you served as chair of the VTF from December 2020  
 10 to April 2021?  
 11 **A.** That's correct.  
 12 **Q.** Briefly just going back through your education and  
 13 career, you graduated from Leeds with a first class  
 14 degree in pharmacology?  
 15 **A.** That's right.  
 16 **Q.** Following which you obtained a doctorate?  
 17 **A.** True.  
 18 **Q.** And after several post-doctoral fellowships at the Royal  
 19 Free Hospital in London, you moved into the  
 20 pharmaceutical industry?  
 21 **A.** That's correct.  
 22 **Q.** Since 2001, you have held several chief executive  
 23 officer, chairman and non-executive director posts, at  
 24 a range of pharmaceutical companies, specialising in  
 25 vaccine research and development, some of which you

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1 drug pricing, which tended to be adversarial events  
 2 anyway.  
 3 **Q.** The aim was to have a diverse portfolio of vaccines,  
 4 including vaccines based on different technologies?  
 5 **A.** Yeah.  
 6 **Q.** You were working on a list of around 200 vaccine  
 7 candidates initially?  
 8 **A.** That's right.  
 9 **Q.** How did you go about the task of narrowing down that  
 10 list?  
 11 **A.** It was a very rigorous process that -- the sort of  
 12 process you use when you're looking at science generally  
 13 in pharmaceutical companies deciding what to do. So we  
 14 had access to a thing called Airfinity, which was  
 15 a database, it was a brilliant database that was  
 16 continually being updated with what was going on in the  
 17 world of vaccines. And then we set a set of criteria of  
 18 which we tested each, looked at each of the vaccines in  
 19 turn and decided whether they met those criteria and  
 20 then moved on. So it was a set of filters, if you like.  
 21 And that honed it down quite quickly.  
 22 One of the key filters was could this vaccine ever  
 23 be in a human being, to be tested within that year, so  
 24 by the end of December 2020? And that took a lot of  
 25 them out, basically. So it wasn't a difficult process

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1 co-founded?  
 2 **A.** Yes, that's correct.  
 3 **Q.** And you explain in your statement that you have  
 4 significant experience and knowledge of the  
 5 pharmaceutical industry and the finance community  
 6 supporting the sector?  
 7 **A.** That's right.  
 8 **Q.** And it was no doubt that experience that you drew on in  
 9 your work with the VTF. And the first topic I'd like to  
 10 ask you about, please, is your role as Deputy Chair of  
 11 the VTF, particularly in building the UK's vaccine  
 12 portfolio. Is this right: that on joining the VTF your  
 13 role was to build and head a team which would identify  
 14 the most promising vaccines currently in development?  
 15 **A.** That's right.  
 16 **Q.** How prepared, in your assessment, was the UK to  
 17 undertake such a task?  
 18 **A.** It didn't have any infrastructure or thinking at the  
 19 time, at all.  
 20 **Q.** What about the links between the government and  
 21 industry? What state were they in when you took that  
 22 role on?  
 23 **A.** They were sort of transactional, to do with buying  
 24 things and very, I would say, adversarial. They weren't  
 25 fabulous relationships. Partly because of things like

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1 to get to a smaller number, but then what we had to do  
 2 was meet with the businesses, the companies that were  
 3 making these vaccines. So we set up NDAs with all of  
 4 them and we contacted them, built relationships with  
 5 them, and asked them to show us all of their data so we  
 6 could analyse it together as a team and look at it from  
 7 all the different aspects and decide whether it was  
 8 a going concern, really.  
 9 **Q.** You explain that the list of 200 was reduced through  
 10 applying this criterion to around 15, before you  
 11 approached the various companies.  
 12 **A.** Yes.  
 13 **Q.** And at that stage you were carrying out what you  
 14 described as deep due diligence. So what did that  
 15 involve?  
 16 **A.** Well, that involved asking the company to let us into  
 17 all of their documents, and see every piece of  
 18 information that they'd already gained on these  
 19 molecules, and also what their plans were. So we judged  
 20 whether their plan was going to work and whether they --  
 21 also we did a lot of detailed analysis of their  
 22 manufacturing capabilities, and we saw where the  
 23 weaknesses were and the strengths. And, in fact, in all  
 24 of them, there was a chance, then, to say, "Well, we can  
 25 help you with some of this because you haven't quite got

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1 it right", and then, you know, we brought in experts  
2 that would help with the clinical trials sometimes,  
3 sometimes help with manufacturing, and linking them to  
4 the MHRA so they could get advice on what was required  
5 for the full clinical studies.

6 So it was just detailed analysis of the science  
7 behind these vaccines.

8 **Q.** Would that result in a report that your team put  
9 together on whether a particular company or vaccine  
10 candidate was a promising one, which you would then  
11 present to the Vaccine Taskforce steering group for  
12 a decision ultimately --

13 **A.** Yeah.

14 **Q.** -- to be made on whether it would be backed?

15 **A.** Yeah, every single vaccine had a diligence report with  
16 a recommendation in it that went into the steering  
17 committee and eventually, if it became the one we took  
18 forward, it went as far as the ministerial panel.

19 **Q.** You would then look at what could be done to incentivise  
20 development of a particular vaccine, you've touched upon  
21 this, but clinical trial support, providing and  
22 investing in manufacturing facilities and fill and  
23 finish capabilities for that particular candidate?

24 **A.** Absolutely. Right from the outset, Kate and I sat down  
25 and talked about how can we be the first? What's it

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1 So it became very difficult, because we knew that  
2 the success of the VTF at that point was basically down  
3 to that single point of accountability, and the ability  
4 to ensure that the steering group really did scrutinise  
5 all the recommendations and have all the right expert  
6 input before it went to ministers.

7 **Q.** Why was that so important, that single point of  
8 accountability to a minister?

9 **A.** Because you wanted to ensure that all of the input that  
10 came from the Vaccine Taskforce from all the experts, as  
11 well as the government officials, was sound, and it was  
12 brought together as one, and that there wasn't any room  
13 for, you know, manoeuvre into the wrong areas. So it  
14 was important to ensure it was crisp and clean and moved  
15 fast.

16 **Q.** You stepped down in April 2021 as chair and soon after  
17 that Sir Richard Sykes became the chair of the VTF.

18 **A.** That's correct.

19 **Q.** The Inquiry has heard a great deal of very positive  
20 evidence about the work of the VTF and what it achieved.

21 I'd be interested in your views, please, in whether  
22 the key features are captured in a document authored by  
23 Lord Vallance.

24 Can we have on screen, please, INQ000101626.

25 This is a document which was authored by

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1 going to take to make the vaccine industry come here  
2 rather than go to America, for instance? And so we  
3 basically were salesmen on "This is the best place to do  
4 it, so we can show you what we can help you with", and  
5 we did, and we put things in place, and clearly that  
6 worked.

7 **Q.** Being the best client?

8 **A.** Yeah.

9 **Q.** And that 200 list of promising -- or vaccine candidates,  
10 initially, went down to 15, and then the 7 in the  
11 Vaccine -- the VTF's portfolio.

12 There came a point in December 2020 when you took  
13 over as chair of the VTF?

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

15 **Q.** And I don't want to go into the details, but suffice it  
16 to say you were not happy with how the role of chair was  
17 framed post Dame Kate's position. And in particular,  
18 you were concerned about the lack of having a single  
19 point of accountability to a minister, which Dame Kate  
20 had had and wasn't going to be the case for you?

21 **A.** Absolutely. I got a letter of appointment which didn't  
22 have that, and I then rewrote my letter of  
23 appointment -- with a bit of help from Kate, as it  
24 happened -- and asked for this to be considered. And it  
25 was considered and rejected.

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1 Lord Vallance, titled "Key features of the  
2 Vaccine Task Force", dated 10 February 2021. And we can  
3 see here that he has set out the seven factors which he  
4 has highlighted as being the key features which led to  
5 the success of the VTF:

6 "Content experts were brought in rapidly ..."

7 Number 2:

8 "An at-risk investment mindset was taken ..."

9 Number 3:

10 "Procurement was part of the process ..."

11 **A.** Yeah.

12 **Q.** Number 4:

13 "There was a very clear and measurable outcome  
14 objective."

15 Number 5:

16 "... a single point of accountability for the whole  
17 activity and that person was empowered and answerable to  
18 the PM."

19 So the point, perhaps, you were making a moment ago.

20 **A.** Yes.

21 **Q.** Number 6:

22 "Private sector engagement was key ..."

23 Number 7:

24 "Long term legacy was built into the thinking from  
25 the beginning."

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1 Do you agree with the analysis set out in this  
2 document? Does this capture what made the VTF so  
3 successful?

4 **A.** Absolutely, and the long-term legacy was at the  
5 forefront of the minds of everybody as we were doing the  
6 deals with the companies, so that -- can we attract them  
7 to be here as part of the future, and therefore part of  
8 preparedness for the future?

9 **Q.** Thank you. That document can come down.

10 And it really is that long-term legacy that I'd like  
11 to turn to now, Dr Dix, because in your statement you  
12 are highly critical of the UK's current preparedness for  
13 the next pandemic. You say the UK is in a weaker  
14 position now than it was prior to the Covid-19 pandemic,  
15 you say we have less resilience now, and have failed to  
16 learn the lessons from the pandemic.

17 And I just want to focus on some of the specific  
18 criticisms you make, with a focus on the lessons that  
19 can be learned, please.

20 **A.** Okay.

21 **Q.** The first topic is Valneva. And the Inquiry has heard  
22 that the contract with Valneva was terminated in  
23 September 2021. And this matter has been raised with  
24 a number of the Module 4 witnesses, including  
25 Professor Dame Jenny Harries, Sir Sajid Javid, and

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1 **A.** COM-COV boost study. And they only left two months, two  
2 and a half months between primary vaccination and boost.  
3 And anybody that knows about vaccines and vaccine  
4 development would know you would not see significant  
5 boosting at that time. So it was putting a vaccine  
6 through a test that was going to be negative. And given  
7 that the government had funded the study, the phase III  
8 study, which was about to report out 6,000 people, that  
9 the MHRA had put together the criteria that needed to be  
10 passed for it to be approved, and that study was going  
11 to read out one month after that decision was made.

12 That study showed the vaccine was better than the AZ  
13 vaccine.

14 **Q.** So the final, the final --

15 **A.** -- (overspeaking) --

16 **Q.** -- data from the study, did it contradict the COM-COV  
17 booster?

18 **A.** Well, doesn't contradict, it was just a very poor study.  
19 So you know when you do vaccine development that you do  
20 some small studies and sometimes there's a bit of a red  
21 flag or sometimes they look really good. But you don't  
22 suddenly stop because of that, you wait and see the  
23 real, proper, well-controlled, large studies, and get  
24 the full readout. And when that readout came, it showed  
25 that the vaccine was as good as and probably was going

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1 Nadhim Zahawi, and I'm just going to briefly encapsulate  
2 what's said about that, and then we'll get your view,  
3 please.

4 But in essence it's said that the advice, which was  
5 from the VTF -- although given after you had left -- was  
6 that the contract should be cancelled because trial data  
7 suggested the Valneva vaccine would be ineffective as  
8 a booster dose. It was appropriate for the  
9 UK Government to try to achieve value for money for the  
10 taxpayer by cancelling the contract in light of that  
11 trial data. And that the relationship with the company  
12 was considered as part of the decision and the  
13 cancellation has not damaged relations with industry.  
14 What do you say?

15 **A.** Not that. In terms of relationships with industry, it  
16 was devastating, I would say. Devastating for the  
17 company but also the ripple effect from that to other  
18 companies, that this was the way they were treated.  
19 That was the first thing.

20 The second thing was that the data they used to make  
21 that decision was poor. It actually wasn't a full  
22 study. It was a study that was done in a rush to see if  
23 we could get booster data because we wanted to boost by  
24 the end of the year.

25 **Q.** Just pausing there, this was the COM-COV boost study?

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1 to be one of the better vaccines, if it was still  
2 around, even today.

3 And what still perplexes me is the phase I and  
4 phase II studies, which had been done and were  
5 available, were not looked at for that decision. The  
6 small, what I would say was a flawed booster study, was  
7 the only study that was used to make that decision and  
8 that was -- I don't believe any experts were part of  
9 that analysis. I just can't believe there's an expert  
10 that would ever make a decision based on that data.

11 **LADY HALLETT:** So who conducted the flawed analysis?

12 **A.** It wasn't the company. It was a Professor Saul Faust in  
13 Southampton, and it was done under a UK research group's  
14 funding. They did it across all the vaccines, because  
15 they were looking for ones that would definitely be best  
16 for boosting. And unfortunately, some of the science  
17 says that once you've vaccinated people with an mRNA  
18 vaccine, the level of antibodies are so high, until  
19 they've fallen down, you shouldn't even try boosting  
20 because it's probably going to be very difficult to  
21 boost.

22 So it was just a flawed study.

23 **MR MANSELL:** This advice had come from the VTF, you weren't  
24 the chair at the time, but it --

25 **A.** But I don't think --

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1 **Q.** It had come from the VTF, so in terms of who was looking  
 2 at it, the VTF had looked at it --  
 3 **A.** Clearly.  
 4 **Q.** -- and had something changed in the approach the VTF was  
 5 taking? Or --  
 6 **A.** Well, I heard some of the evidence that the experts  
 7 round the table agreed. Well, unfortunately, I know all  
 8 the experts, because I worked with them. None of them  
 9 were consulted.  
 10 **Q.** These are members of the VTF --  
 11 **A.** Well, they were the diligence team, basically, the  
 12 people that knew the vaccines inside out and were part  
 13 of the people that you would consult when you made big  
 14 decisions, and none of them were ever consulted on this  
 15 decision. So I actually don't know who the experts were  
 16 and I didn't see any experts in the VTF once, once  
 17 I left.  
 18 **Q.** Moving on. Next topic, another issue about which you  
 19 were critical is the Vaccines Manufacturing and  
 20 Innovation Centre, or VMIC, and the Inquiry has heard  
 21 that VMIC was sold in April 2022, and that's  
 22 subsequently been mothballed.  
 23 You characterise that as having a serious negative  
 24 impact on the UK's ability to develop and manufacture  
 25 vaccines at speed in the face of a future pandemic.

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1 those vaccines properly and the Vaccines Manufacturing  
 2 and Innovation Centre was there to encourage that to  
 3 happen and therefore bring people to the UK because it  
 4 was going to be a centre of excellence.

5 There was a decision which I didn't particularly  
 6 agree with, I wasn't part of, but to actually turn it  
 7 into a manufacturing centre, which is a very --  
 8 manufacturing is very cut and dry. It's -- you know,  
 9 it's hard, grungy work, it's not innovative, and they  
 10 tried to mould the two into one in that centre and it  
 11 sort of went astray, and then the whole thing got sold,  
 12 the innovation piece got lost, and that's the piece that  
 13 the country should still have. That innovation centre  
 14 was a fantastic idea, it came out of the Office for Life  
 15 Sciences' strategic reviews, and we've lost it.

16 But coming back to manufacturing, what we need is  
 17 the ability to have really good relationships with the  
 18 pharmaceutical industry, show them -- like we did at the  
 19 beginning of the VTF, show them what the UK can offer,  
 20 and encourage them to come here and do their research,  
 21 development, clinical trials, and then manufacturing,  
 22 and have manufacturing as part of their remit in the UK,  
 23 and then you've got manufacturing, and it's run by them,  
 24 it's paid for by them, and the government can just be  
 25 there incentivising and understanding it, not trying to

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1 The Inquiry has heard evidence about the new  
 2 strategic partnership with Moderna, Moderna's Innovation  
 3 and Technology Centre, and the AstraZeneca investment in  
 4 Speke, Liverpool. Do those projects allay your  
 5 concerns.

6 **A.** No. It is very good that we have got the manufacturer  
 7 of an mRNA vaccine, because they will be part of the  
 8 future, without a doubt. On their own, they are not the  
 9 answer, though.

10 The AstraZeneca investment actually hasn't happened  
 11 and it seems to be faltering.

12 But what needs to be made clear -- I heard a lot of  
 13 evidence about manufacturing, and I think some people  
 14 talked about having "sovereign" manufacturing. The  
 15 UK Government does not have to invest in manufacturing,  
 16 and shouldn't invest in manufacturing, particularly for  
 17 a pandemic. It's impossible for the government to be  
 18 running state-owned or even state-invested  
 19 manufacturing. It's not the future.

20 VMIC was an example of something that went wrong.  
 21 VMIC was a vaccine innovation centre. The idea was that  
 22 when small companies that make vaccines or are  
 23 developing vaccines want to move through to clinical  
 24 trials and then move on to manufacturing, they don't  
 25 normally have the wherewithal to know how to formulate

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1 run it. And I think that's really important.

2 It's a bit different to saying we need to invest in  
 3 manufacturing. I don't think we do.

4 **Q.** So the state doesn't --

5 **A.** No.

6 **Q.** -- invest in manufacturing --

7 **A.** No.

8 **Q.** -- instead, you make the UK an attractive place for  
 9 companies --

10 **A.** Absolutely.

11 **Q.** -- to invest in and build manufacturing facilities  
 12 here --

13 **A.** Yeah.

14 **Q.** -- that they run, and presumably you'd then have step-in  
 15 rights in the event that --

16 **A.** Well, step-in, probably not necessary, because if you've  
 17 got good relationships, you can say that -- you know,  
 18 make sure you've got a line that's available. And you  
 19 can go all the way to step-in rights if you want, but  
 20 I don't think that's necessary.

21 **Q.** So how do we do it? How do we make the UK attractive  
 22 for that type of investment?

23 **A.** Well, we do the sort of things that we did with Valneva  
 24 to start with: we helped them with clinical trials, we  
 25 helped extend their factory, because they hadn't got

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1 enough cash at the time. And if that was still in place  
2 now, we would be selling vaccine to the rest of the  
3 world, which would have fitted our second objective, and  
4 we'd have had something as part of a legacy for the  
5 third objective.

6 So it's having the vision and understanding of how  
7 you can do that and do it over and over again. And we  
8 have all the right elements. The vaccine registry needs  
9 extending, the MHRA probably need to think about having  
10 a more dedicated vaccine unit within there that  
11 understands regulation and knows how to deal with the  
12 vaccines all the time. And I think we need this vaccine  
13 agency.

14 **Q.** And we will come to it, Dr Dix, I promise, the  
15 recommendation you made in December 2020 for a national  
16 vaccines agency.

17 Just before we move away from this issue of VMIC and  
18 investment in manufacturing, I've made reference to the  
19 Moderna Innovation and Technology Centre. Do you share  
20 a concern that others have about an overreliance on mRNA  
21 technology when it comes to vaccines?

22 **A.** Absolutely.

23 So there's rose-tinted glasses for mRNA because it  
24 was so good in the pandemic. It was a brilliant vaccine  
25 for an emergency. It's far from a perfect vaccine. At

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1 still put that one there behind and you may still win.  
2 Valneva was that. If a virus comes along that we don't  
3 know a lot about, all we've got to do is condition it to  
4 grow in cells, and we can start manufacturing it as  
5 a whole virus and then just inactivate it.

6 It may not be a future-sexy technology, but it  
7 works. And we've eradicated polio, we use a very  
8 similar technology for flu at the moment. It works and  
9 it's trusted and it's safe and it's less reactogenic  
10 than all the other vaccines.

11 So there's nothing wrong with it, it's just  
12 old-fashioned and people don't like old-fashioned, but  
13 it works.

14 **Q.** Next topic, please, is the monoclonal antibody cocktail  
15 Evusheld. We've heard a lot of evidence about Evusheld.  
16 We've heard some of it today from Helen Knight. The  
17 story is really in two chapters, the first is about the  
18 VTF's position and the OCMO advice, the CMO, DCMO advice  
19 in late 2020, early 2021, and the second chapter is on  
20 RAPID-C19, that's what Helen Knight was giving evidence  
21 about.

22 But focusing on the first chapter, the Inquiry has  
23 heard from Professor Sir Chris Whitty and Professor Sir  
24 Jonathan Van-Tam about Evusheld, and I just want to  
25 sketch out their rationale for the decision making that

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1 the moment, the cold chain is terrible and storage is  
2 difficult. The duration of action of these vaccines  
3 isn't great, six months it seems to wane.

4 The cellular immunity, which is a classic important  
5 part of an immune response for vaccines to give you  
6 long-term immunity, is weak.

7 So they will get there but they still need  
8 developing to become the perfect vaccine but they're not  
9 there yet.

10 And then when it comes to pandemic, resilience for  
11 pandemic will not come from just having RNA. I can  
12 paint a picture of a virus coming our way that mRNA will  
13 not work for, and that's not what we want. We don't  
14 know what virus is coming but if it's a virus that we  
15 haven't done a lot of background research on, like we  
16 had with SARS and MERS -- and we knew the best protein,  
17 the spike protein, was the antigenic protein; if we  
18 don't know that, an mRNA vaccine won't work. What  
19 you've got to do is take every single protein on that  
20 virus and develop every one to see which one works.  
21 That's a huge amount of work, and it takes a long time.

22 I have always said that the reason we had Valneva,  
23 it's a live, attenuated -- a live, inactivated virus.

24 For me, it was like crown green bowls, you always have  
25 your back stop, so if everything goes wrong, you've

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1 they made, that they fed into the advice they gave, so  
2 you can give your response.

3 They say in essence this: that the clinical picture  
4 on Evusheld was unclear, there was no clinical trial  
5 data, no information on side effects. Indeed, it was  
6 not authorised by the MHRA until 17 March 2022.

7 It was not clear to whom it would be given, because  
8 even those with a degree of a compromised immune system  
9 can benefit from a vaccine.

10 It would be wrong to compare it to purchasing  
11 vaccines at risk, because they're very different  
12 products. Unlike vaccines, you have to keep giving  
13 Evusheld over and over again and it's less likely to be  
14 effective as the virus mutates.

15 And finally, it was a lot more expensive on  
16 a per-dose basis than a vaccine, and had a short shelf  
17 life, which could lead to wastage. That is the  
18 rationale underpinning the advice that was given. What  
19 is your view?

20 **A.** I actually feel most of those are excuses, and the  
21 actual reason that it wasn't purchased was cost.

22 I'll take you through the thinking. So, shelf life  
23 is -- it's an error. The shelf life of the -- we did  
24 all the diligence on these vaccines, by the way, on  
25 these antibodies. The shelf life was, at the time when

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1 we put the recommendation in, already six months, but  
2 with a statement that all of the antibodies in this  
3 category in the past had had shelf lives of over  
4 18 months to 2 years and that they were likely to have  
5 the same.

6 Shelf life isn't even an issue, because you don't  
7 get a medicine of any type into your hands until it's  
8 approved. And once it's approved, you agree a delivery  
9 schedule to have it at the rate that you can use it. So  
10 that just isn't an argument, it's fatuous.

11 In terms of giving it over and over again, this  
12 antibody protected people for six months, and we were  
13 talking about buying enough to give people two doses, to  
14 get them through this early stage of the pandemic and  
15 free them from a lockdown. So I don't understand, over  
16 and over again. Two doses, six months.

17 And then there were some discussions about it being  
18 difficult to deliver to the patient and they needed  
19 specialist clinics. It was intramuscular. It was an  
20 injection in the bum. There was -- so these arguments  
21 sound great but I honestly don't believe they're valid  
22 at all.

23 **Q.** You were in post when this advice was being received --

24 **A.** I think I was leaving at the time, so it was right  
25 towards the end, yeah.

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1 a very different way. And so yes, there was less  
2 enthusiasm.

3 Interestingly though, Professor Jonathan Van-Tam was  
4 part of the VTF and was very enthusiastic about us  
5 getting the antibodies to start with, and was a sponsor,  
6 if you like. So I don't know what changed, but in the  
7 end, the only thing I can see that's consistent is cost.

8 **Q.** Antivirals. The VTF looked at whether to include  
9 antivirals within its remit. You had experience of  
10 antiviral drug discovery and development, but it's your  
11 view that including antivirals in the remit of the VTF  
12 would distract from the task in hand, and you note that  
13 antivirals need a very long development time and  
14 extensive long-term safety data to be approved.

15 Now, in a context where everything is being thrown  
16 at vaccines, in order to expedite normally long  
17 development timelines, why couldn't the same approach  
18 have been taken to antivirals?

19 **A.** I think it could, but it would have overwhelmed the VTF  
20 and I don't think we'd have been successful. One of the  
21 things you learn when you run particularly small  
22 businesses, unless you focus, you die. You've got to  
23 focus and you've got to keep that focus really honest,  
24 and antivirals is a completely different set of skills,  
25 we'd have to have had a completely different set of

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1 **Q.** Do we have a sense of a wider view, in terms of  
2 prophylactics, from this document, please, INQ000066712.  
3 This is an email from Charlotte Taylor regarding  
4 Astronaut data on prophylaxis. Charlotte Taylor, of  
5 course, was the acting director of the Antivirals  
6 Taskforce and Therapeutics Taskforce, and she is  
7 relaying here a conversation she's had with  
8 Lord Vallance about trial data on Evusheld as  
9 a prophylactic. And she says this:

10 "I've had a brief conversation with GCSA, including  
11 the Astronaut data on prophylaxis. I said that there is  
12 limited enthusiasm for prophylactic use across the  
13 system. His reply:

14 "I think that is misguided. There is a clear place  
15 for them and it just needs to be defined."

16 That can come down, please.

17 **A.** Yeah, I agree.

18 **Q.** Does that accord with your experience?

19 **A.** Yes, absolutely.

20 **Q.** A lack of enthusiasm for prophylaxis?

21 **A.** The Vaccine Taskforce had a very entrepreneurial way  
22 about going about things, and very much getting things  
23 done, and the prophylactic antibodies moved into the  
24 therapeutics space rather than stay within the Vaccine  
25 Taskforce, and therefore it started to be looked at in

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1 people looking at them and it would have made the VTF's  
2 role rather complex, I would say.

3 **Q.** That's a case for not including them within the remit of  
4 the VTF?

5 **A.** Yes, yes.

6 **Q.** Should antivirals have been looked at in a more  
7 intensive way by a VTF-like body tasked with that, or  
8 were they?

9 **A.** I think so. I think it could have been -- they are  
10 still very difficult things to find, and it does take  
11 a long time to develop them -- so unless there's  
12 something in development already that happens to flip  
13 over into Covid use, then it would take a long time. So  
14 it didn't look like it was in the same timeframe as the  
15 vaccines.

16 **Q.** Final topic, Dr Dix, is recommendations. And we are  
17 there, we are at the National Vaccines Agency, which  
18 I know you're keen to talk about.

19 Can we have on screen, please, INQ000330659.

20 This is a recommendations document from  
21 December 2020 that was co-authored by you and Dame Kate  
22 Bingham. Is that right?

23 **A.** Yes, and a lot of input from the Vaccine Taskforce.

24 **Q.** We can see at the bottom of that page, that you  
25 recommend the creation of a National Vaccines Agency,

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1 and it states that it's clear that having the ability to  
2 draw together networks is crucial to pandemic  
3 preparedness.

4 Just pausing there, that is perhaps a key lesson, is  
5 it, of the VTF?

6 **A.** Absolutely.

7 **Q.** Bringing together industry, academia and government;  
8 yes?

9 **A.** Yes, absolutely.

10 **Q.** You state:

11 "The VTF recommends the creation of a new executive  
12 agency within BEIS [it's no longer BEIS] as its  
13 successor as the central body responsible for  
14 co-ordination of industrial and public sector  
15 assets ..."

16 And then you talk there about maintaining the  
17 relationship with the UK vaccines industrial base and  
18 HMG.

19 Over the page, page 2, please. Just a couple more  
20 aspects of this, we can see it says:

21 "It would also monitor and relay current threat  
22 assessment of novel diseases to industrial partners,  
23 working in partnership with cross-government functions  
24 on horizon-scanning and intelligence."

25 And "Governance", please, a bit further down. You  
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1 the diseases that are there already, and maybe ones that  
2 are coming down the line that aren't going to be  
3 pandemic or endemic. So there is a proper long-term  
4 role for a group that really understand this, and at the  
5 same time, become world renowned for being able to do it  
6 and understand it.

7 And then linked to all these bodies like the WHO,  
8 like CEPI, and be a world leader on the world's -- name  
9 the person in the government that's a world leader in  
10 vaccines? You need it. And I think an agency might be  
11 the wrong word. I mean, I think it comes up with all  
12 sorts of connotations. It just needs that -- the UK  
13 needs a central body that understand vaccines, and  
14 actually understand new vaccine developments that are  
15 happening and whether they're the right things to do,  
16 and encourage them to be done in the UK, and so we're  
17 really on top of it, and we are the world leader in the  
18 whole area of vaccines. Then you're, sort of, safe for  
19 the pandemic. Because you've got so much access to  
20 everything, and the knowledge.

21 **Q.** If Matt Hancock was here now, he may say that such an  
22 agency as you've sketched out was unnecessary because  
23 that is what UKHSA are doing. That's essentially what  
24 he said when he was giving evidence to the Inquiry  
25 a little earlier in this process. And we heard from  
95

1 say:

2 "An independent, industrially experienced chairman  
3 and board should be established to bring together the  
4 work of the various strands ..."

5 So that is what you're setting out in that  
6 recommendation document.

7 Thank you, that can come down.

8 Before you expand on some of these points, perhaps,  
9 Dr Dix, can I just put the counterargument to you: is it  
10 really necessary to add another permanent level of  
11 bureaucracy to the vaccine development landscape?

12 Why can't we rely on existing systems that are in  
13 place now and then, if necessary, just set up a VTF-like  
14 body when the next pandemic hits?

15 **A.** You can, and then you're relying on what the UK has at  
16 the time, which wasn't very much when we started the  
17 VTF, and probably wouldn't be -- it might be even less  
18 next time. But I think the real point here is this is  
19 part of peacetime now. The -- if you think about  
20 vaccines, vaccines are the best preventative medicine.  
21 We're talking about health prevention rather than  
22 waiting to deal with health problems. So there's a need  
23 to understand vaccines in a much broader context all the  
24 time, and to be sure that we, as a country, are  
25 vaccinating our population with the best vaccines, for  
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1 Professor Dame Jenny Harries about the Vaccine  
2 Development and Evaluation Centre, or VDEC. Why aren't  
3 the systems that are in place now, put in place by the  
4 UKHSA, why aren't they sufficient, in your view?

5 **A.** First, I'd like to say that the UKHSA has a much broader  
6 remit and has to do an awful lot of things and it does  
7 an awful lot of things very well for the country.  
8 That's important. But it hasn't got any leadership in  
9 vaccines.

10 And the Vaccine Development Evaluation Centre, as  
11 it's called, was a small little lab when we started the  
12 VTF with some very good people that could test vaccines  
13 if they were brought to them in live assays, and some  
14 very specialist stuff. That's what it is. It's  
15 a testing centre. It has no vision, it has no  
16 leadership, and no understanding of how you develop  
17 vaccines. So the name is false, it's actually just  
18 a laboratory testing centre, but a very specialised one.

19 And I think that's misguided or it misinforms,  
20 I would say.

21 **Q.** The final thing I want to ask you about is this: that  
22 the Inquiry has heard a suggestion from Lord Sharma that  
23 short of creating a National Vaccines Agency, what  
24 should be established is a vaccine expert advisory  
25 panel, a body which comprises industry experts,  
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1 ministers, civil servants, perhaps people from academia  
 2 drawing together those strands, which is something  
 3 you've stressed. They would meet regularly, horizon  
 4 scan, audit the UK's capabilities, and make  
 5 recommendations for investment. Rather than an agency,  
 6 an expert panel, and then use that as the platform for  
 7 establishing the VTF if and when a next pandemic hits.

8 What are your thoughts on that?

9 **A.** I just don't think it'll work. I think the agency has  
 10 to be a place that -- or the activity has to be a place  
 11 that fosters the relationships with industry, and an  
 12 advisory panel getting together every so often is no way  
 13 of doing that. And it has no power, so it's not going  
 14 to make things happen. And we know what happens to  
 15 advice. It gets put on the shelf. It doesn't get --  
 16 it's got to be part of the business. It's got to be  
 17 part of running the country. And so I just don't agree  
 18 with advisory panels.

19 **MR MANSELL:** My Lady, those are all my questions.

20 **LADY HALLETT:** Can I just pursue that point about an agency.  
 21 As you'll probably know, it's not that easy to persuade  
 22 any government, whatever political hue, to create a new  
 23 body that will cost money. How would you, if I were to  
 24 be persuaded to make the recommendation, how would you  
 25 frame it to persuade government that it was worth the

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1 **LADY HALLETT:** Because that's the kind of argument that  
 2 might appeal to government.

3 **A.** Well, I think that's what I was saying earlier, about  
 4 the VTF actually leveraged the activities in the UK to  
 5 attract investment. So we were very close with two  
 6 other companies of having them come to the UK and set up  
 7 their manufacturing there as I left, and I understand  
 8 that those discussions just became so entrenched in  
 9 government thinking that they just walked away in the  
 10 end, because they weren't being given the vision of why  
 11 it would be great to be here. And there is plenty of  
 12 very good things the UK has that you can actually  
 13 attract companies to come to the UK.

14 **LADY HALLETT:** Thank you.

15 Just a couple more questions from Mr Thomas, who is  
 16 over there.

17 **Questions from PROFESSOR THOMAS KC**

18 **PROFESSOR THOMAS:** Good afternoon, Dr Dix. I've just got  
 19 a couple of questions for you. My name is  
 20 Leslie Thomas, I'm representing FEMHO, the Federation of  
 21 Ethnic Minority Healthcare Organisations.

22 At paragraph 7.4 of your statement, you make mention  
 23 of the communication plan that was fronted by Dame Kate  
 24 Bingham. You state that:

25 "[Our] members of the [Vaccine Taskforce] were asked

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1 amount of money it would cost to set up the agency in  
 2 the long term?

3 **A.** I think I would use the analogy of the MoD. And we  
 4 spend a lot of money there, and we have real expert  
 5 people. We have military soldiers that know what  
 6 they're doing, running it, and being part of it. And  
 7 unless we have that in the UK for vaccines, then when  
 8 the next pandemic comes, we'll be back where we started.  
 9 We really need to invest in -- and I think investing in  
 10 vaccines for health is the way to think about it, not  
 11 for a long-term future thing. That's very hard to  
 12 justify, but knowing that having it for health and being  
 13 the best place in the world for vaccines, means that you  
 14 are covered. And I don't think it needs to be hugely  
 15 expensive, either. It's not a -- they won't be doing,  
 16 they will actually be corraling and bringing on board  
 17 the industry and making it all work and helping putting  
 18 it together. So I don't think it needs to be this huge  
 19 cost centre.

20 **LADY HALLETT:** Is there any argument that if such an agency  
 21 was set up and the expertise were gathered together and  
 22 they corralled and developed the relationships you're  
 23 talking about, that that might attract investment into  
 24 the UK?

25 **A.** Absolutely, absolutely.

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1 to participate in podcasts and zoom meetings with  
 2 various ethnic groups to help disseminate understanding  
 3 of vaccines. As I recall, this was frowned upon by HMG  
 4 comms [that's the government communication centre] and  
 5 eventually stopped. In particular, the [Vaccine  
 6 Taskforce] podcast had been paused indefinitely by  
 7 17 November 2020, with one episode remaining  
 8 unpublished. In my opinion this was wholly  
 9 short sighted."

10 Dr Dix, could you elaborate on the reasons why the  
 11 Vaccine Taskforce sought to participate in the podcast  
 12 and Zoom meetings with ethnic groups? Why was that  
 13 important?

14 **A.** We felt that, as a group, we had a level of credibility  
 15 and trust, and that these groups desperately needed  
 16 information and they needed to be given solid  
 17 information that was well thought through and presented  
 18 in a way that was digestible by different groups.

19 **Q.** Just on that, what sort of reach were you expecting to  
 20 have?

21 **A.** Well, you never know with podcasts, sometimes they go  
 22 nowhere and sometimes they become the podcast of the  
 23 year. So, you know, we were working with communicators  
 24 to actually make those podcasts, you know, live and  
 25 real. So we didn't really know what was the reach; we

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1 just thought it was an important thing to do.

2 **Q.** And further, at paragraph 7.5 of your statement, you say  
3 this, you say:

4 "HMG comms did not want the [Vaccine Taskforce] to  
5 participate in comms. In fact they were paranoid about  
6 the Vaccine Taskforce saying anything publicly."

7 Question: why did you think this type of  
8 communication was frowned upon by HMG comms?

9 **A.** I don't really know, apart from that the government was  
10 fixated in controlling all information. And there was  
11 probably a lack of trust, I think. But we were just  
12 told to stop doing it and -- or Kate was told to stop  
13 doing it. And she had a proper programme of  
14 communication and was told that it was the government's  
15 job to do that and not the taskforce.

16 **Q.** In any event, no rational explanation provided?

17 **A.** No, no, there wasn't a rational reason. It was  
18 paranoia, I think.

19 **PROFESSOR THOMAS:** Thank you, my Lady.

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

21 Dr Dix, I'm going to embarrass you again: to be  
22 described as "phenomenal" by someone like Kate Bingham  
23 is praise indeed.

24 **A.** I had to pay her a lot of money.

25 **LADY HALLETT:** I'm sure you did, but we are very fortunate  
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1 I'll refer to in the course of my submissions as "the  
2 Department", and by this closing statement the  
3 Department wishes to confirm that it has carefully  
4 listened to and reflected on all of the evidence adduced  
5 and the issues that have emerged in the course of these  
6 hearing sessions.

7 By these submissions, the Department would also like  
8 to address some issues that pertain to its role in the  
9 implementation of the vaccine rollout programme in  
10 Northern Ireland.

11 We would also like to make some points about the  
12 lessons that the Department has learned and its  
13 preparedness for the next pandemic.

14 My Lady, it is considered on a fair analysis that  
15 the vaccination programme in Northern Ireland was  
16 a success. Some successful factors included the level  
17 and extent of preparedness which was in place at the  
18 time when the vaccines began to become available, the  
19 manner in which the Department was able to overcome  
20 logistical and technical problems in order to develop  
21 and administer a programme which resulted in the vaccine  
22 being made available to everyone who was eligible, in  
23 line with JCVI advice, the development of the Vaccine  
24 Management System, which has been referred to as the  
25 VMS, that accurately recorded all Covid-19 vaccinations  
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1 that people of your skills and ability and experience  
2 were prepared to step up in a national emergency, so, on  
3 behalf of us all, I express my gratitude for what you  
4 did during the pandemic and for your help to the  
5 Inquiry.

6 **THE WITNESS:** Thank you, and I'd do it again.

7 **LADY HALLETT:** Good.

8 **THE WITNESS:** Thank you.  
9 (The witness withdrew)

10 **LADY HALLETT:** Right, I think that completes the evidence,  
11 Mr Keith.

12 **MR KEITH:** It does, my Lady.

13 **LADY HALLETT:** Very well. I shall return at 1.45 to begin  
14 the closing submissions.

15 **(12.43 pm)**  
16 **(The Short Adjournment)**  
17 **(1.45 pm)**

18 **LADY HALLETT:** Ms Murnaghan. There you are. You were over  
19 there earlier, weren't you?

20 **MS MURNAGHAN:** No.

21 **Closing statement on behalf of the Department of Health  
22 (Northern Ireland) by MS MURNAGHAN KC**

23 **MS MURNAGHAN:** Good afternoon, my Lady.  
24 My Lady, I make this closing statement on behalf of  
25 the Department of Health for Northern Ireland, which  
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1 which were administered; the fact that the Department  
2 ensured that the Northern Ireland programme closely  
3 coordinated with the other UK vaccination programmes  
4 which were considered to be important, both in terms of  
5 vaccine equity, and also in terms of public confidence.

6 Finally, my Lady, we considered that the  
7 maximisation of access to the vaccination programme  
8 which was delivered from GPs through HSE trusts and  
9 through over 400 community pharmacies throughout  
10 Northern Ireland resulted in a high percentage of the  
11 population being vaccinated in an orderly and an  
12 efficient manner.

13 Another key aspect of the programme and one which  
14 the Department believed represented a strong outcome was  
15 the fact that the Department ensured that residents in  
16 care homes were prioritised and vaccinated in the first  
17 tranche of vaccinations, thereby providing protection to  
18 some of the most vulnerable in our society.

19 This success, of course, must be viewed in the  
20 context wherein the Covid-19 vaccination programme was  
21 the largest and most challenging in the history of the  
22 Northern Ireland self-service.

23 Another important aspect, my Lady, of the successful  
24 rollout of the vaccination programme was the close  
25 co-ordination across the four nations. As my Lady no  
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1 doubt remarked was clear from the evidence that was  
2 given by all four of the Senior Responsible Officers,  
3 that close co-ordination between the SROs meant that  
4 Northern Ireland was able to benefit from the experience  
5 of others when issues were encountered and, in turn,  
6 provide insight into how it resolved issues when they  
7 arose in Northern Ireland.

8 Of course, my Lady, there were naturally challenges  
9 in the implementation of such a significant vaccination  
10 programme, both in terms of the unprecedented scale, and  
11 the speed within which it had to be established.

12 The Inquiry has heard evidence about the challenges  
13 faced throughout the UK, and there were challenges in  
14 the vaccination programme that were particular to  
15 Northern Ireland. For example, the Department had to  
16 consider and address issues arising from the additional  
17 regulatory requirements that were imposed by dint of the  
18 Northern Ireland Protocol. These additional  
19 requirements were relevant both to the authorisation and  
20 the access to the vaccines.

21 The Department worked closely with the MHRA to  
22 ensure that appropriate measures such as the use of the  
23 temporary authorisations under Regulation 174 of the  
24 Human Medicines Regulations 2012 were progressed in  
25 order to ensure that Northern Ireland could access the

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1 the appropriate grassroots level was as a result of the  
2 PHA having a longstanding and trusted relationship with  
3 many of those groups.

4 In terms, of course, then, my Lady, of  
5 misinformation and its impact on vaccine hesitancy, we  
6 would say that the Department confronted the challenges  
7 of misinformation and vaccine hesitancy largely by  
8 seeking to understand the challenges of the anti-vax  
9 messages and the specific concerns that were particular  
10 to Northern Ireland. In addition to engagement with the  
11 low uptake groups, we were conscious of the importance  
12 of public messaging and the Department accordingly  
13 published myth buster or fact file information that was  
14 delivered through public health campaigns, through its  
15 community pharmacies in its Living Well service.

16 My Lady, it should also be noted that Northern  
17 Ireland residents were able to and in fact did  
18 participate in a large number of the Covid trials, some  
19 of which included RECOVERY, REMAP-CAP, PANORAMIC and  
20 others. Additionally, Northern Ireland recruited well  
21 for the Novavax vaccine study.

22 I'd like to say something more about the Vaccine  
23 Management System which was a considerable undertaking.  
24 The Department had realised from the spring of 2020 that  
25 if there was going to be a mass vaccination programme,

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1 vaccines at the same time as others in the UK.

2 The Department was also obliged to work closely with  
3 the Vaccine Management Taskforce to ensure that the  
4 vaccines that were supplied to Northern Ireland met all  
5 regulatory requirements, again, arising from the  
6 Northern Ireland Protocol.

7 I'd like to say something now, my Lady, about the  
8 hard-to-reach groups. The Department confirms that it  
9 took specific action to address those difficult-to-reach  
10 groups in order to promote vaccine equity. These  
11 actions included proactive outreach to ethnic minority  
12 groups, to socially deprived areas, to isolated  
13 occupational groups, to migrant workers, to the  
14 disabled, the housebound and those living in our rural  
15 communities.

16 In order to improve vaccine uptake the Department  
17 deployed a range of award-winning communications which  
18 included the use of specifically-targeted social  
19 influencers and trusted voices in its engagement with  
20 community groups.

21 My Lady, these actions were driven by data that was  
22 gleaned from the Vaccine Management System, and also  
23 from local intelligence that came through our Public  
24 Health Agency's links with community groups. The  
25 ability to communicate and connect with those groups at

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1 it would need a sophisticated system in order to be able  
2 to record accurately all of the vaccinations.

3 Accordingly, from that early stage, steps were taken  
4 to investigate how such a system could be developed. As  
5 more information regarding the vaccines became  
6 available, those steps were put in train.

7 Although the capability of the Vaccine Management  
8 System developed over time it should be noted that it  
9 was operational from the first day of the vaccine  
10 programme on 8 December 2020.

11 There was clearly a challenge to make sure that the  
12 operators were able to confidently use the system, and  
13 that it effectively interacted with our GPs' IT systems,  
14 but all of the elements of this vaccination programme,  
15 including trusts, GPs and community pharmacies, had  
16 access to the Vaccine Management System and the benefits  
17 of the receipt of the information in such a prompt time  
18 were, we considered, significant.

19 The fully operational Vaccine Management System  
20 allowed for accurate and timely access to vaccine uptake  
21 data, which, in turn, allowed areas of low uptake to be  
22 identified and targeted actions to be taken.

23 In particular, the introduction of the Vaccine  
24 Management System was a key enabler of our ability to  
25 deploy into community pharmacies. It facilitated

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1 communication and the prompt updating of medical records  
2 following the vaccination.

3 Of course my Lady, Northern Ireland already had  
4 existing data recording systems, and it built on and  
5 developed from those systems to develop its dashboards  
6 and the Vaccine Management System, both of which were  
7 expanded and improved throughout the course of the  
8 vaccination programme.

9 It is hoped that these improvements will allow for  
10 a more nimble and data-driven approach in any future  
11 pandemic. Moreover, being able to communicate in  
12 a contemporaneous and transparent way with the Northern  
13 Irish public, we felt inspired hope, which, in turn, led  
14 to confidence in the system.

15 My Lady, the Department's work on vaccine rollout  
16 has left a legacy, a legacy of UK-wide cooperation and  
17 a better understanding of the importance of societal  
18 efforts at a time of emergency.

19 The Department now has a greater insight into  
20 potential barriers to the uptake of vaccines and the  
21 importance of vaccine equity.

22 There is also a legacy of technological advances,  
23 such as the VMS, which is currently used in our other  
24 vaccination programmes. Regrettably, my Lady, in  
25 current programmes, there are continuing challenges with

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1 dint of redirecting trust assets so that by  
2 8 January 2021, 90% of care homes had been visited by  
3 vaccination teams.

4 My Lady, in terms of lessons learnt, the Department  
5 considers that it has improved its understanding of how  
6 to develop -- deliver successful vaccination programmes  
7 as a result of the work that it undertook on this Covid  
8 vaccination programme.

9 It considers that it continues to learn from its  
10 experience of delivering vaccination programmes more  
11 widely, and in evidence, the Deputy Chief Medical  
12 Officer referenced the importance of providing the  
13 public with a fuller understanding of the steps taken to  
14 secure us safe vaccinations and the means by which any  
15 consequential effects of the vaccine should be put on  
16 record and collated.

17 In addition, the Department continues to develop its  
18 understanding of the behavioural and social science  
19 factors which lead to vaccine uptake.

20 It is acknowledged that the success of our  
21 vaccination programme was the best form of defence  
22 against Covid-19, and was crucially important in  
23 ensuring that Northern Ireland could return to a level  
24 of normality.

25 The practical lessons learnt from how to implement,

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1 vaccine hesitancy, but important lessons have been  
2 learned and work is ongoing to fully understand and  
3 address the multiple reasons behind this hesitancy.

4 I'd like also, my Lady, to say something about  
5 the integrated care system and the impact on the  
6 vaccination programme.

7 A key advantage of our integrated care system in  
8 Northern Ireland was that it allowed the Department to  
9 use social care and community resources more  
10 effectively, thereby vaccinating those who were  
11 housebound or in care homes.

12 A clear advantage was the increased level of  
13 co-ordination with social and health care sectors, which  
14 contributed to the development of a more efficient and  
15 better coordinated approach to the vaccination  
16 programme.

17 In the integrated care system, there were  
18 demonstrable advantages in the fact that policy  
19 colleagues were experienced in working closely together,  
20 which meant, in turn, less red tape and fewer  
21 organisational boundaries for the smooth processing of  
22 work.

23 A practical example of the benefit of the integrated  
24 care system was the speed at which the Department was  
25 able to roll out its vaccinations into care homes by

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1 swiftly and effectively, vaccination programmes, will  
2 be, undoubtedly, invaluable in any future pandemic.

3 To conclude therefore, this module of the Inquiry  
4 has been focused on vaccine rollout and it should be  
5 emphasised that the successful rollout in  
6 Northern Ireland would not have been possible without  
7 the contribution and commitment of the staff involved,  
8 and the response of the citizens of Northern Ireland.

9 The Department believes that this is an appropriate  
10 point at which to again express its sincere thanks to  
11 everyone involved for their unerring and unselfish  
12 commitment.

13 Thank you very much, my Lady.

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

16 **Closing statement on behalf of the Federation of Ethnic  
17 Minority Healthcare Organisations by PROFESSOR THOMAS KC**

18 **PROFESSOR THOMAS:** My Lady.

19 "The reality is we [cannot] change history but we  
20 can change the present. And I think that that's  
21 something very important to remember ... every day is an  
22 opportunity to rebuild trust, and ... I think Covid was  
23 a huge opportunity to try to rebuild that trust, and now  
24 is a big opportunity."

25 Dr Heidi Larson on 16 January at this Inquiry.

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1 My Lady, the evidence presented during this module  
2 has revealed undeniable failings that disproportionately  
3 impacted ethnic minority communities, including  
4 inadequate engagement, systemic inequality and  
5 bureaucratic delays.

6 FEMHO submits that these issues are emblematic of  
7 the deeper structural inequities that pervade our  
8 healthcare system and public healthcare strategies.  
9 Addressing these failings is not merely a question of  
10 fairness, but a matter of necessity.

11 One of the most glaring takeaways from this module  
12 is a lack of a coherent, national effort to engage  
13 minority ethnic communities during the vaccine rollout.

14 My Lady, government witnesses have acknowledged that  
15 health disparities and concerns about the uptake were  
16 foreseeable. Yet, despite this knowledge, there was no  
17 nationally funded coordinated campaign to address these  
18 challenges in realtime. Instead, what we had was  
19 fragmented, piecemeal efforts characterised by the  
20 government's approach which, as Dame Kate Bingham  
21 testified, "significantly hindered" progress and caused  
22 harm to the efforts that were being made across the  
23 country by individual groups and organisations.

24 My Lady, no one is denying that the task was huge.  
25 There was not only historic mistrust, but also mis- and

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1 community-driven approach.

2 You see, my Lady, it's about trust. Trust is the  
3 cornerstone of public health. Hard to build, easy to  
4 break, and essential to repair.

5 Dr Waqar, Dr Larson, and Dame Kate Bingham all  
6 underscored the importance of trust in driving vaccine  
7 confidence and uptake. You see, building trust requires  
8 more than government messaging. It demands meaningful  
9 engagement led by trusted community leaders who can  
10 bridge the gap between institutions and the people they  
11 serve.

12 Practical measures such as ensuring that tools like  
13 the Yellow Card Scheme are accessible and available in  
14 multiple languages, are also critical. Simplifying the  
15 reporting systems and tailoring communications to  
16 resonate with diverse communities. Not just  
17 recommendations. They are imperative for building  
18 trust.

19 Do you remember the full circle argument? What was  
20 clear in Module 4 is the full circle argument, broken  
21 down by Dr Larson, which FEMHO hopes will resonate with  
22 this Inquiry. It all starts with the fact that  
23 pre-existing health inequalities and historic mistrust  
24 are unaddressed, despite them being foreseeable, which,  
25 in turn, means that there is poor engagement with

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1 disinformation during the pandemic that were pressing  
2 concerns. Organisations like FEMHO stepped up because  
3 they wanted to help.

4 My Lady, you'll remember Dr Salman Waqar's mention  
5 of the Brandolini principle, or commonly known as the BS  
6 principle, which emphasises the great effort it takes to  
7 debunk misinformation, in comparison to the relative  
8 ease to creating that misinformation.

9 Healthcare workers like Dr Waqar found themselves  
10 having to do more work with less resources in order to  
11 tackle that mis- or disinformation, and build trust.

12 This fragmented approach was further compounded by  
13 the fact that private companies often stepped in where  
14 government failed. As Dr Waqar pointed out, platforms  
15 such as Facebook provided funding and support for  
16 community engagement work when that should have been  
17 a government responsibility.

18 The British Islamic Medical Association launched the  
19 BIMBA(?) myth buster series, a campaign led by trusted  
20 Muslim healthcare professionals to dispel  
21 misinformation, and low confidence within the Muslim and  
22 ethnic minority communities.

23 This initiative reached vast audiences through  
24 social media and grassroots networks and was widely  
25 praised for its cultural sensitivity and

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1 minority ethnic communities in respect of the national  
2 vaccine rollout scheme, which then causes poor diversity  
3 in clinical trials, low trust in vaccines, and low  
4 uptake by the same communities, which means sentiments  
5 hardened, and there's a general growth in vaccine  
6 hesitancy, or lack of confidence, which means government  
7 then needs to consider policies like the vaccinations as  
8 a condition of deployment to drive uptake, which might  
9 increase uptake in the short term but then has  
10 a knock-on effect of building and reinforcing distrust,  
11 which means coming back full circle, that there's an  
12 impact in years to come regarding vaccines, trust in  
13 government, and perpetuating and worsening health  
14 inequalities in our society.

15 This vicious cycle must be broken. Without systemic  
16 reform and continuous sustained meaningful engagement,  
17 my Lady, these issues will reoccur with future public  
18 health crises.

19 The issue of diversity in clinical trials. You may  
20 have seen me twitching in my seat when this was being  
21 raised by various witnesses. Let me explain why one was  
22 twitchy. It's important to clarify that outsourcing  
23 diversity to countries such as South Africa or Brazil,  
24 while providing data on certain ethnic groups, fails to  
25 address the unique challenges of mistrust, vaccine

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1 hesitancy and systemic inequities faced by minority  
2 ethnic communities in the UK. The government and  
3 vaccine companies fundamentally misunderstood the nature  
4 of low confidence, treating it as if it was a biological  
5 issue. They assumed that providing safety in black  
6 populations abroad would automatically translate into  
7 trust amongst ethnic minority communities in the UK.

8 However, my Lady, vaccine mistrust is not just about  
9 biology. It's deeply rooted in historical injustices,  
10 systemic racism and lived experience of unequal  
11 treatment in healthcare.

12 The assumption that: well, we tested it on black  
13 people in another country, therefore UK ethnic  
14 minorities should trust us, is gravely misconceived and  
15 tone deaf, because it ignores historical mistrust and  
16 structural racism in the UK healthcare, the very reason  
17 why many ethnic minorities had low confidence in the  
18 first place.

19 Secondly, it assumes that trust in one healthcare  
20 system automatically translates into historical trust in  
21 another system. That's not how it works. It conflates  
22 racial identity with shared experience when racial  
23 ethnic minorities in the UK have different social,  
24 cultural and historical contexts than in South Africa or  
25 Brazil.

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1 ethnic minority groups, healthcare workers and community  
2 leaders have made immeasurable sacrifices to help the  
3 government during the rollout. They have an enormous  
4 pride in the fact that, despite racism, they took the  
5 approach of being "We're all in this together". Yet,  
6 despite that, the government failed to take the  
7 invitation seriously, asserting that "We did all we  
8 could" when ultimately they did not.

9 We know this because the uptake was affected,  
10 diversity in clinical trials was poor, resentment for  
11 the government increased. And as a result, Covid-19  
12 impacted ethnic minority communities at a far greater  
13 rate than their counterparts.

14 The paucity of data also meant that negative trends  
15 were not being properly monitored by central government.

16 Finally, this. My Lady, the failures we have  
17 examined here are not simply historical. They are  
18 present, they are urgent, they must be addressed.  
19 Dr Waqar rightly said it all goes back to trust. Every  
20 day is, indeed, an opportunity to rebuild trust.

21 My Lady, let this Inquiry be a catalyst for  
22 transformative change, ensuring that trust is not just  
23 restored, but earned through meaningful systemic reform.

24 My Lady, the time to acknowledge is now. The time  
25 for reform is now. The time to act is now.

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1 My Lady, can I just come on to -- and I've nearly  
2 finished, a couple of additional considerations.

3 We've got to avoid the over-simplification of racial  
4 and ethnic identities. We've got to realise that while  
5 communities of colour globally may have shared  
6 experience of racism, the causes and manifestation of  
7 mistrust are deeply shaped by their local histories and  
8 social systems.

9 All of this did not happen in a vacuum, nor was it  
10 a quirk of history. It's real. It's persistent. It  
11 must end. Squeamishness around race and racism in our  
12 healthcare system has been consistently demonstrated by  
13 several witnesses and cannot continue. Whether it's  
14 a matter of vaccinations as a condition of deployment,  
15 clinical trials or data, racism is undeniably a key  
16 determinant in outcomes of the experience of black,  
17 Asian and minority ethnic communities.

18 So, my Lady, let me conclude by saying this: you  
19 will remember Health Secretary Mr Hancock acknowledging  
20 the longstanding structural racism within the healthcare  
21 system, noting that part of the work was trying to  
22 understand what to do with structural inequalities, yet  
23 in practice, this recognition did not translate into  
24 meaningful action.

25 So, to conclude, FEMHO wants an acknowledgement that

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1 Thank you.

2 **LADY HALLETT:** Thank you very much, Mr Thomas. Very  
3 grateful.

4 Mr Rawat.

5 **Closing statement on behalf of the United Kingdom Health  
6 Security Agency by MR RAWAT**

7 **MR RAWAT:** Thank you, my Lady. I make this closing  
8 statement on behalf of the United Kingdom Health  
9 Security Agency, or UKHSA, as I'm going to refer to it,  
10 today.

11 Your Ladyship is by now familiar with the role of  
12 UKHSA and the circumstances in which it was established.

13 The considerable work that UKHSA is already doing to  
14 implement the lessons that are being learned from the  
15 pandemic is set out in the statements that we have  
16 provided to the Inquiry. You have also heard in this  
17 module from Professor Harries and from Dr Ramsay.

18 I do not want to summarise that work today, but,  
19 rather, what I wish to take my time for is to touch on  
20 four themes with relevance to the future.

21 The first, which has already been alluded to today,  
22 is the importance of data preparedness and transparency  
23 in responding to future health threats and pandemics.  
24 This is a theme that we have addressed you on in  
25 previous modules.

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1 But improving the safe collation and sharing of data  
2 across the healthcare system to a point where there is  
3 a unified approach offers significant opportunity to  
4 improve health outcomes, but it must be seen in the  
5 context of similar moves in other parts of the public  
6 sector.

7 As we have pointed out before, the use of data  
8 raises important legal and ethical questions.

9 Further, and with this module in mind, where, as  
10 you've just heard, trust is central to combatting low  
11 vaccine hesitancy and promoting vaccine uptake, the data  
12 systems developed in peacetime must be sufficiently  
13 robust to maintain public trust.

14 Consideration must also be given to the potential  
15 that relaxing restrictions on data sharing during an  
16 emergency could undermine public trust, so actually  
17 having a counter effect of increasing vaccine hesitancy  
18 and/or reducing vaccine uptake.

19 The benefits of sharing data are inevitably  
20 contingent on the quality of the underlying data.  
21 Recommendations for enhanced data collection are  
22 complicated by individuals' reluctance to give personal  
23 information. And, as has been articulated during this  
24 module, a lack of robust national data in relation to  
25 certain groups, for example undocumented migrants,

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1 partners to deliver the surveillance and evaluation of  
2 immunisation programmes, which is critical to vaccine  
3 safety and confidence. The public health teams that  
4 Public Health England had embedded in the NHS have now  
5 been transferred to the NHS, but UKHSA maintains links  
6 with that expert network and with the wider public  
7 health systems in the NHS and local authorities.

8 However, as Dr Ramsay pointed out, it must be  
9 remembered that vaccination is a medical intervention  
10 delivered at specific points in time.

11 Trust is a key factor in addressing barriers to  
12 vaccine uptake within underserved communities. And so  
13 working closely with trusted organisations over the  
14 long-term is fundamental to ensuring the success of  
15 outreach activities.

16 To avoid a one-size-fits-all approach to addressing  
17 barriers to vaccine uptake, there should be a local to  
18 national public health response, building on work led by  
19 directors of public health, and emphasising the  
20 importance of those working at the local level who are  
21 likely to be more attuned to the specific needs of the  
22 communities in their area, and can build trust over the  
23 long term in partnership with those communities.

24 Finally, we should not forget that low vaccination  
25 uptake in underserved communities reflects a broader

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1 Gypsy, Roma, and Traveller communities.

2 It is, therefore, important that information sourced  
3 from local networks is not overlooked, because that  
4 risks worsening the exclusion of individuals and  
5 communities that already struggle to access healthcare  
6 services or, simply put, are not registered with a GP.

7 The second thing that we would address you on today  
8 concerns the complex question of how to improve vaccine  
9 uptake among communities who are already underserved by  
10 the healthcare system. Ensuring that vaccine uptake  
11 coverage is not only high overall, but high within such  
12 communities is essential to an effective elimination  
13 strategy.

14 This is not an issue to be left for a pandemic. It  
15 is, as Dr Ramsay put it, an issue for all time, and one  
16 which requires a concerted long-term commitment of time  
17 and resources, from multiple organisations, to lay the  
18 foundations for an effective response in a pandemic.

19 UKHSA has an important but defined role to play in  
20 addressing barriers to vaccine uptake. In delivering  
21 routine immunisation programmes, UKHSA, as PHE, that's  
22 Public Health England, did before the pandemic, seeks to  
23 publish resources that are culturally competent,  
24 targeted, available in different languages and media.

25 UKHSA works with the NHS England, MHRA and academic

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1 picture of inequalities across the health system and  
2 should not be seen in isolation. There needs to be  
3 a whole-system approach. If those who are underserved  
4 are better able to access high-quality primary care and  
5 other services in peacetime, then the likely benefit  
6 would be an increase in vaccination uptake.

7 Were this Inquiry to highlight the importance of  
8 a holistic approach to tackling health inequalities at  
9 a local level, with community services being able to  
10 offer sustained engagement through trusted workers, then  
11 that would be of real value to embedding continuity of  
12 care in the longer term.

13 My Lady, the third theme that we would address is  
14 whether more can be done to ensure that the public is as  
15 informed as possible about vaccines.

16 You have received written and oral evidence about  
17 the strategies that PHE, and now UKHSA, have deployed  
18 and do deploy to provide accurate information on the  
19 benefits and the risks of any vaccination. This  
20 includes publishing information on the gov.uk website  
21 and through the NHS, which clearly enjoys a great deal  
22 of public trust.

23 All this work ensures informed consent and promotes  
24 vaccine confidence. But it is a feature of the pandemic  
25 that a great majority of the population, some perhaps

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1 for the first time, sought out information about  
2 vaccines. They did so in an age where inaccurate  
3 information about a vaccine's effectiveness and safety  
4 can be so easily spread. And so establishing a single  
5 authoritative resource for immunisation, such as  
6 a dedicated website accessible to both the public and to  
7 healthcare professionals, would play an important role  
8 in countering misinformation.

9 Such a resource could, in a very practical way,  
10 enhance public awareness of safety signals, facilitate  
11 informed consent, and sustain vaccine confidence.

12 Recognising that consent is a process, not a one-off  
13 event, this resource would complement rather than  
14 replace the use of written materials and face-to-face  
15 conversations with healthcare practitioners, which  
16 should remain an integral resource, particularly for  
17 those facing digital exclusion.

18 Finally, my Lady, the last theme that we wish to  
19 address you on today concerns the potential  
20 recommendation which the Inquiry has explored of  
21 a national vaccines agency which, as Dame Kate Bingham  
22 explained, would sit slightly outside government, have  
23 very strong external input, and the independence and  
24 authority to be able to report directly to the  
25 Prime Minister.

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1 ability to focus just on vaccines was a strength of the  
2 VTF. Would you therefore need a separate national  
3 therapeutics agency, given that a vaccine is not always  
4 a certainty?

5 And finally, given that there are no discrete  
6 boundaries in clinical and scientific research, would  
7 a vaccines agency ultimately lead to the creation of  
8 multiple bodies, all essentially doing the same thing?

9 My Lady, the VTF was a remarkable success. It was  
10 stood up at a time when virtually everything stopped for  
11 Covid. The country's good fortune was that the  
12 political will to take risks in an emergency meant  
13 investment in a wide vaccine platform in response to  
14 a single pathogen.

15 Peacetime asks a different question, namely, are the  
16 systems in place capable of addressing multiple  
17 different threats, capable of being scaled up, and of  
18 being made even more timely in their response?

19 This is the type of system that UKHSA is already  
20 working towards and is seeking to maintain for the  
21 future. Embedding that system could save lives and  
22 protect the economy.

23 In our opening statement, we pointed to four  
24 capabilities which need to be nurtured for the future.  
25 They were: sustained research and development;

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1 It would be envisaged that this agency would have an  
2 end-to-end role.

3 In that sense, any such agency would be similar to  
4 the Vaccine Taskforce. However, whilst superficially  
5 attractive, the proposal prompts obvious questions which  
6 are not easy to answer including, for example, what  
7 budget would this new agency need? That's a question  
8 that your Ladyship put to Dr Dix a short while ago. It  
9 reflects, of course, the premise that the vehicle may be  
10 less important than the resource.

11 The VTF's initial funding was over 5 billion. UKHSA  
12 currently operates to provide all of its services,  
13 including non-infectious disease science and response  
14 and global surveillance within 3% of its original  
15 pandemic budget, a figure that, as we've pointed out  
16 before, is akin to that allocated to a moderate district  
17 hospital.

18 Second, how do you manage conflicts of interest if  
19 your external input is short-term secondment from  
20 industry, bearing in mind that relationships with  
21 industry, if poorly managed, can contribute to vaccine  
22 hesitancy?

23 Third, how do you maintain the independence of the  
24 JCVI and the MHRA?

25 Fourth, you'll recall Dr Dix explaining that the

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1 strengthening partnerships between government, industry  
2 and academia; the benefit of routine vaccination work;  
3 and the importance of surveillance and monitoring.

4 These are perhaps more prosaic than the call for  
5 a new agency, but they need to be supported because they  
6 reflect the long-term work pre-pandemic which  
7 underpinned the VTF.

8 And this is why, for example, UKHSA has improving  
9 health outcomes through vaccines as a strategic  
10 priority. It is why it undertakes funded research,  
11 often in collaboration with academia and industry  
12 partners. And an example is the funding provided by the  
13 Coalition for Epidemic Preparedness Innovations, which  
14 is an international partnership between public, private,  
15 and civil organisations, for UKHSA to develop  
16 a laboratory assay for Mpox, the first step to  
17 developing a vaccine.

18 It is why UKHSA continues to develop ongoing  
19 relationships with industry. While the Moderna  
20 Strategic Partnership may be the example that's best  
21 known to the Inquiry, in this module you've heard  
22 evidence as to how, post-pandemic, UKHSA is working with  
23 other companies, Valneva and Seqirus being examples.

24 It's why UKHSA has established the vaccine  
25 development and evaluation centre, or VDEC as it's been

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1 referred to, with a remit to support the identification  
2 of the most promising vaccine candidates and to provide  
3 pre-clinical and clinical trial testing of vaccines.

4 We note Dr Dix's view of VDEC, but its relevance as  
5 an initiative is because it goes towards strengthening  
6 relationships with industry and academia.

7 And finally, the final example I would give is that  
8 UKHSA has built a new global surveillance system and is  
9 developing a UK priority pathogen tool aligned to, and  
10 working with, the World Health Organisation.

11 My Lady, since the pandemic, UKHSA and others have  
12 sought to build systems ready to respond to a future  
13 threat. In considering the recommendation to establish  
14 a national vaccine agency, the Inquiry will want to  
15 assess the impact that such a step would have on the  
16 work that has been done and which is planned. Would  
17 such a reset undermine the progress made, and so set  
18 pandemic preparedness back?

19 There is, of course, more to be done. What can be  
20 achieved will inevitably be a function of spending  
21 priorities. It is better, however, to focus on those  
22 steps which might not make a headline, but which will  
23 improve, in the long term, the country's resilience.

24 And such steps include increasing the number of  
25 those with the science background in policy-making roles

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1 Government worked effectively, allowing decisions to be  
2 taken in extremely challenging and uncertain  
3 circumstances.

4 The fast-moving public health emergency had to be  
5 matched by rapid decision-making, reflecting the  
6 development of scientific understanding, and the spread  
7 of new variants.

8 The overarching objective of the Scottish Government  
9 was to protect the population from the harms of Covid-19  
10 and to minimise the loss of life. The vaccine rollout  
11 in the UK was the fastest in the world, and one of which  
12 we should be enormously proud.

13 Across Europe, the greatest number of lives were  
14 saved in countries such as Scotland that implemented  
15 early vaccination programmes that reached high  
16 vaccination coverage. Vaccination through increased  
17 immunity allowed governments to reopen society as  
18 Covid-19 became less of a risk for the population,  
19 bringing hope that life could potentially return to  
20 normal.

21 The Scottish Government recognises that there were  
22 many thousands of deaths and people left disabled  
23 directly or indirectly due to Covid-19, and in very rare  
24 cases, from the vaccine itself. Each one is a tragedy.  
25 And it appreciates that the clinically vulnerable

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1 in government, attracting and retaining scientists and  
2 clinicians to undertake research within government, and  
3 giving licence to the Civil Service to look for  
4 innovation and to find ways of avoiding ending up  
5 working in silos.

6 My Lady, that is the statement for UKHSA.

7 Thank you very much.

8 **LADY HALLETT:** Thank you very much for your help, Mr Rawat.

9 Ms Drysdale. I think you got moved, did you?

10 **MS DRYSDALE:** Good afternoon, my Lady. Can you hear me?

11 **LADY HALLETT:** I can, thank you.

12 **Closing statement on behalf of the Scottish Government by**

13 **MS DRYSDALE KC**

14 **MS DRYSDALE:** My Lady, I appear for the Scottish Government  
15 with my juniors Ian Halliday and Kenneth Young.

16 The Scottish Government wishes to reaffirm its  
17 commitment to assisting the Inquiry with examining what  
18 happened during the pandemic and reflecting on areas for  
19 improvement. It pays tribute to the many clinical,  
20 scientific and health and social care workers who  
21 responded to the major public health challenge.

22 Frontline health and social care workers had a much  
23 greater risk of exposure to Covid by infection due to  
24 their work but bravely continued to roll out the vaccine  
25 with support from a range of partners. The Scottish

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1 continue to feel the effects of the virus.

2 In recognising the enduring loss suffered by so  
3 many, as highlighted in the Every Story Matters report,  
4 it is important to understand everyone's unique  
5 experience of what happened.

6 The Scottish Government is committed to honouring  
7 those who lost their lives by ensuring that all  
8 available lessons and recommendations are learned in  
9 order to reduce the harm caused by a future pandemic.

10 Due to time constraints, my Lady, I am unable to  
11 address all of the topics which will be covered in full  
12 in the Scottish Government's written closing statements.  
13 Instead, in this oral closing statement, I wish to  
14 address your Ladyship on four key themes: equalities,  
15 delivery, messaging, and data.

16 Turning first to equalities. We are  
17 a multi-cultural society, and it is important that  
18 vaccine rollout reflects society. But it should also  
19 reflect a fairer society. Many underserved communities  
20 in Scotland experience poor public health in general.  
21 This makes it even more important that they access  
22 vaccination. Barriers to vaccination must be addressed  
23 if the UK is to be prepared for any future pandemic.

24 Maximising the number of people who could receive  
25 a vaccine or who could be protected from serious illness

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1 by therapeutics was an important part of the strategy in  
2 Scotland to reduce transmission and save lives.

3 The Every Story Matters report states that some  
4 contributors from minority ethnic backgrounds described  
5 how previous experiences of discrimination and racism  
6 had led them to distrust the government and the health  
7 system more broadly.

8 During the pandemic, the Scottish Government was  
9 aware that certain communities had relatively higher  
10 levels of mistrust in government, and that working in  
11 partnership with them was necessary.

12 Inequalities were routinely considered as part of  
13 decision making. The Scottish Government worked with  
14 community organisations and charities to understand  
15 concerns, and remove barriers. And since the pandemic,  
16 the Scottish Government has worked with Public Health  
17 Scotland, and partners, to ensure inclusion and  
18 equalities considerations continue to inform strategy  
19 and decision making across all of Scotland's vaccination  
20 programmes.

21 They provided for inclusion as a priority in  
22 Scotland's new 5-year vaccination and immunisation  
23 framework, a dedicated vaccines inclusion working group,  
24 permanent funding for inclusion-focused mobile  
25 vaccination units, and the ongoing collection and use of

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1 communities, recognising a high level of historic  
2 distrust of authority within these communities.

3 Partnerships were forged with local trusted figures  
4 to support engagement, and data was collected on uptake  
5 rates for GRT communities when the ethnicity data  
6 question was introduced to the Vaccine Management Tool,  
7 or VMT.

8 The Inquiry has heard evidence that a perceived lack  
9 of diversity in vaccine trials caused some members of  
10 minority ethnic communities to lack confidence in the  
11 vaccine. That underscores the need to improve the way  
12 in which public bodies across the UK work with  
13 traditionally underserved communities to build trust and  
14 confidence.

15 Part of that will, no doubt, involve a step change  
16 in the way that data is held and used, as helpfully  
17 noted by counsel for The Traveller Movement in this  
18 module.

19 Recognising the need to have in place a single  
20 national system to record details related to Covid  
21 vaccine delivery, the Scottish Government developed the  
22 Vaccine Management Tool. Ethnicity data was collected  
23 in the programme from November 2021 with the addition of  
24 a mandatory question in the VMT. From March 2021,  
25 Public Health Scotland began to publish this detailed

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1 ethnicity data to inform decisions.

2 Public Health Scotland engaged with stakeholders and  
3 undertook a health inequality impact assessment which  
4 provided recommendations to health boards. Clear  
5 direction and guidance were issued to health boards from  
6 the Scottish Government asking them to prioritise  
7 inclusive efforts. Each health board also carried out  
8 their own health inequalities impact assessment or  
9 inclusion plan, informed by their local community  
10 knowledge and engagement.

11 The Scottish Government and Public Health Scotland  
12 worked together to capture data relating to uptake  
13 inequalities. The Scottish Government has focused on  
14 ethnicity data collection through the programme, which  
15 allowed the use of realtime disaggregated data to  
16 identify trends and concerns, and target efforts towards  
17 those communities who were not accessing the vaccine.

18 Some key issues that had been raised during this  
19 module were recognised and managed in Scotland  
20 throughout the vaccine rollout. For example, the  
21 Scottish Government worked with trusted partners to  
22 alleviate concerns from refugee and asylum seeker  
23 communities with tailored messaging. In addition, in  
24 Scotland, health boards were asked to put in place  
25 outreach for Gypsy, Roma, and Traveller, GRT

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1 vaccine uptake by ethnicity and -- in areas of  
2 deprivation. This allowed both the public and decision  
3 makers to understand differences in vaccine uptake by  
4 population demographics, and it enabled the programme to  
5 respond and flex in response to realtime evidence of low  
6 uptake in underserved communities.

7 Other vaccines have since been added to the Vaccine  
8 Management Tool and the Scottish Government are  
9 committed to data improvement across all its vaccine  
10 programmes to ensure a continued focus on equalities.

11 High confidence in routine immunisation must be  
12 built. This is particularly important in underserved  
13 communities with historically low uptake of routine  
14 vaccinations.

15 Turning now to the delivery and the Barnett formula.  
16 During the pandemic, Scotland received a share of  
17 vaccines calculated on the basis of the Barnett formula.  
18 The Welsh government made a call in their opening  
19 statement for a needs-based formula for vaccine supply  
20 to the devolved nations instead.

21 At the time of the pandemic, the Scottish Government  
22 was content with the Barnett share, noting that more  
23 comprehensive modelling to inform supply was not  
24 possible in the timeframe available, and would have  
25 delayed vaccination.

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1 In general, the UK Government and UKHSA were willing  
2 to engage early and often with the devolved nations  
3 regarding supply, and were clear on decisions.

4 In terms of advance planning, it's difficult to  
5 hypothesise on the nature of a future public health  
6 emergency, and how vaccines should be distributed in  
7 that context.

8 In general, Scotland adhered to the advice of the  
9 JCVI, but as the Inquiry has heard, there were instances  
10 where this advice did not reflect the Scottish delivery  
11 approach landscape. Where this occurred, officials  
12 worked hard to develop a suitable approach, or  
13 definition, and communicate this appropriately.

14 In Scotland, health boards are responsible for the  
15 local delivery of vaccination programmes. This decision  
16 was taken as part of contract negotiations between the  
17 Scottish Government and the British Medical Association  
18 on behalf of GPs in 2018.

19 It was reasonable for the Scottish Government to  
20 divert the resource-intensive duty of mass vaccination  
21 away from GPs. This policy helped to ensure resilience  
22 in the primary care sector in Scotland.

23 The Scottish Government recognises the challenge of  
24 geography, particularly in the Highlands and Islands,  
25 and that in rural areas, people may have had to travel

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1 overall levels of vaccine uptake. Communications  
2 evolved in response to changing advice and evidence, as  
3 well as emerging insights, feedback, and research.

4 Increasing levels of fatigue, misinformation and  
5 disinformation, impacted vaccine confidence, and  
6 influenced the approach to messaging as the pandemic  
7 went on.

8 Disinformation was a continual issue over the course  
9 of the pandemic and was particularly difficult to deal  
10 with on social media. The Scottish Government took an  
11 effective approach of repeating factual statements that  
12 countered this without being drawn into direct  
13 confrontation with the publishers. Trusted medical  
14 professionals were often used to deliver these messages,  
15 recognising high levels of public trust in the NHS.

16 In addition, there was a dedicated team leader in  
17 the vaccine policy team responsible for managing  
18 disinformation, liaising with partners in Scotland, but  
19 also making connections with other UK nations. The  
20 former First Minister took a central, visible role in  
21 public messaging.

22 Vaccination was promoted from an early stage, as  
23 a positive intervention that would support easing of  
24 restrictions.

25 The Scottish Government has already begun its work

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1 longer distances to access vaccination.

2 Mobile units were made available to reach these  
3 communities, and health boards used their local  
4 knowledge and realtime uptake data to pivot their  
5 approach to ensure suitable clinic availability. In  
6 addition, health boards worked with local partnerships  
7 and charities to mobilise volunteers and free accessible  
8 transport options to get people to their appointments.

9 The Scottish Government recognised that attending  
10 a mass vaccination centre would not be suitable for  
11 everyone. A range of measures were put in place by  
12 health boards to ensure that the vaccine reached  
13 everyone. Work is ongoing with partners to ensure that  
14 all current and future vaccination programmes are fully  
15 accessible, no matter where in the country some one  
16 lives.

17 Decisions taken regarding delivery, such as the  
18 vaccination of care home staff, at the same time as care  
19 home residents, led to higher uptake among care home  
20 workers in Scotland, but it is difficult to compare  
21 uptake, as there were only marginal differences in the  
22 vaccination programmes across the UK. The uptake  
23 figures for the four nations are broadly in alignment.

24 Turning now to messaging. Public health messaging  
25 in Scotland was broadly effective, demonstrated by the

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1 with partners to identify areas for improvement and  
2 embed learning into its vaccination programmes.

3 In January 2024, responsibility for national  
4 oversight of all vaccination programmes in Scotland was  
5 transferred to Public Health Scotland.

6 Finally, my Lady, turning to data. Throughout this  
7 module, the Inquiry heard evidence to the effect that  
8 the lack of accessible data hampered vaccine delivery  
9 across all four nations. At the start of the programme,  
10 there were challenges regarding accessible and publicly  
11 available supply data, which impacted the Scottish  
12 Government's ability to communicate appropriately with  
13 the public and build and maintain trust in the  
14 programme. This later improved as supply became  
15 steadier.

16 The Scottish Government worked with partners to  
17 improve its programme data throughout the course of the  
18 rollout to ensure that it was able to plan its resources  
19 and approach appropriately. Its future pandemic  
20 preparedness programme of work has identified data as  
21 a priority area for improvement.

22 My Lady, in conclusion, the Scottish Government  
23 wishes to thank all those who have given evidence during  
24 Module 4, and to pay tribute to all those in the NHS and  
25 across society who served others during the pandemic by

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1 developing, delivering and administering vaccines and  
2 therapeutics.  
3 The Scottish Government is wholeheartedly committed  
4 to assisting the Inquiry in fulfilling its terms of  
5 reference and identifying findings and recommendations.  
6 It is determined to emerge from the public health crisis  
7 with the a stronger and fairer society, building on the  
8 common purpose within the vaccination and therapeutic  
9 pandemic response in Scotland.

10 Now that we have emerged from this tough challenge,  
11 there is an opportunity to renew our country, building  
12 a fairer society with more equitable access to  
13 healthcare. The Scottish Government has laid strategic  
14 foundations to prepare its vaccination, and therapeutic  
15 systems for the next pandemic, to improve routine  
16 immunisation programmes, and to put it in a strong  
17 position to respond to new threats.

18 **LADY HALLETT:** Thank you, Ms Drysdale.

19 Mr Stanton.

20 **Closing statement on behalf of the British Medical  
21 Association by MR STANTON**

22 **MR STANTON:** Thank you, my Lady.

23 My Lady, the closing oral statements of the British  
24 Medical Association is as follows. The BMA's position  
25 remains as stated at the outset of these hearings: that  
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1 This use of existing infrastructure and delivery of  
2 vaccines at a local level was highly effective, and by  
3 the end of October 2021, 71% of vaccines in England had  
4 been administered by GPs and their teams and community  
5 pharmacies.

6 The Inquiry was told that many people felt more  
7 comfortable and had greater levels of trust in receiving  
8 their vaccination from their local GP rather than at  
9 a vaccine centre. GPs have substantial experience of  
10 delivering vaccinations, and have existing knowledge of  
11 and relationships with their patients, particularly  
12 elderly patients.

13 This, coupled with the proximity of GPs to their  
14 local populations, helped to overcome barriers to  
15 access.

16 In addition, GPs have the experience to address  
17 questions or concerns about the vaccine and to encourage  
18 uptake in the local communities.

19 And as confirmed by the UKHSA, being able to receive  
20 a vaccine in a familiar environment can support public  
21 confidence.

22 My Lady, turning to barriers to uptake. The Inquiry  
23 has heard a substantial volume of evidence on  
24 disparities in vaccination uptake amongst different  
25 population groups, including ethnic minority  
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1 the Covid-19 vaccination programme was one of the  
2 biggest successes of the pandemic, as clearly  
3 demonstrated by the estimate of the UKHSA that, as at  
4 September 2021, vaccination in the UK had prevented more  
5 than 24.3 million infections and over 123,000 deaths.

6 The BMA also recognises and commends the speedy  
7 development and authorisation of the vaccine, which took  
8 place without compromising safety.

9 However, the BMA's interests in this module  
10 primarily relate to vaccination rollout and deployment,  
11 and in particular, the following: the role of general  
12 practice in delivering the vaccination programme,  
13 barriers to vaccine uptake, workforce planning and  
14 capacity, data sharing, and vaccination as a condition  
15 of deployment.

16 In respect of the role played by general practice,  
17 the BMA considers that GPs and their practice teams made  
18 a major contribution to the success of the vaccination  
19 programme.

20 The BMA proactively made the case in England that  
21 the vaccination programme should be delivered by general  
22 practice, and the Inquiry heard from Dame Emily Lawson  
23 that, in England, GPs were the right model, particularly  
24 for the most at-risk priority groups, including care  
25 home residents and the elderly.  
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1 communities, migrants, Gypsy, Roma, and Traveller  
2 communities, disabled people, and those living in  
3 deprivation.

4 These disparities highlighted longstanding problems  
5 of inclusion within UK healthcare systems, and it was  
6 well known before the pandemic that there was a historic  
7 mistrust of the healthcare system and vaccines within  
8 certain communities.

9 A 2016 report of Public Health England on flu  
10 vaccination showed lower uptake by people from ethnic  
11 minority backgrounds than for people with white British  
12 or white Irish backgrounds. And this trend was also  
13 seen in the lower rates of Covid-19 vaccine uptake  
14 amongst ethnic minorities. Again, with vaccine uptake  
15 highest amongst those from a white ethnic background.

16 The Inquiry also heard that deprivation was a factor  
17 in lower uptake in all groups, with vaccine uptake  
18 higher in areas of greater affluence, something the BMA  
19 highlighted in its fifth Covid-19 review report.

20 People from ethnic minority and deprived communities  
21 had worse health outcomes before the pandemic, and had  
22 a higher likelihood of becoming infected with, and  
23 experiencing severe symptoms from, Covid, not least  
24 because of wider health inequalities.

25 Disabled people were also at significantly greater  
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1 risk from Covid, and from dying as a result of  
2 infection.  
3 With this in mind, the BMA submits that there should  
4 have been greater consideration of these groups when  
5 planning the vaccine rollout.

6 Professor Van-Tam's witness statement reflects this  
7 position, and sets out that:

8 "It is well known that vaccine uptake tends to be  
9 lower in marginalised, deprived, and ethnic minority  
10 communities. It was therefore foreseeable that  
11 a similar pattern would be observed when it came to  
12 delivery of the COVID-19 vaccines, as indeed it was. It  
13 is ... therefore arguable that more should have been  
14 done in the planning phase to consider this."

15 The mechanisms of the programme also, on occasion,  
16 caused barriers to vaccination. For example, although  
17 disabled people were a focus of prioritisation, the less  
18 than full identification of people living with  
19 a learning disability and the lack of clarity on the  
20 level at which a learning disability provided priority  
21 eligibility created a barrier in accessing vaccination  
22 for this vulnerable group.

23 This must be addressed in advance of any future  
24 pandemic to ensure that the main means of offering  
25 vaccination in a mass vaccination programme does not

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1 needs to be resourced."

2 Misinformation and disinformation also contributed  
3 to vaccine hesitancy, and the Inquiry has heard about  
4 these issues from a number of witnesses in these  
5 hearings, including the Director General with overall  
6 responsibility for the Counter Disinformation Unit, who  
7 told the Inquiry that: disinformation is defined as the  
8 deliberate creation and dissemination of false  
9 information, which is intended to deceive and mislead.  
10 And misinformation is the same, but without the  
11 deliberate intent.

12 During the pandemic, the BMA ran its own social  
13 media campaign to address vaccine hesitancy, and called  
14 on the UK Government to take more action to tackle  
15 misinformation online.

16 It goes without saying, then, that the BMA entirely  
17 rejects the assertion made by the former Minister for  
18 Equalities, Kemi Badenoch, in her oral evidence, that  
19 the BMA was itself responsible for misinformation.

20 The background circumstances to this issue are that  
21 the BMA raised legitimate concerns in June 2020 within  
22 a number of letters to Ms Badenoch and the Secretary of  
23 State for Health and Social Care, following publication  
24 of the Public Health England review into inequalities  
25 and disparities.

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1 rely on self-identification.

2 The Inquiry also heard of physical barriers  
3 preventing vaccine uptake, such as the distance to  
4 a vaccination site, the cost of transport, and  
5 difficulties or concerns for the clinically vulnerable,  
6 disabled, elderly, or housebound from attending  
7 a vaccine centre.

8 The lack of an NHS number also presented issues for  
9 people in the homeless population, the Gypsy, Roma, and  
10 Traveller communities, and vulnerable migrants.

11 The BMA recognises that efforts were made to address  
12 vaccine hesitancy and to overcome barriers to assessing  
13 vaccines, but more still needs to be to instill  
14 confidence.

15 Evidence before the Inquiry supports ongoing  
16 engagement with marginalised and underserved communities  
17 which has been lacking.

18 The disparities in access and uptake to the vaccine  
19 laid bare the disparities in access to healthcare more  
20 broadly, and highlight an important area for governments  
21 across the UK to prioritise for urgent improvement.

22 As the Inquiry's experts in vaccine delivery and  
23 disparities warned:

24 [As read] "We cannot be complacent. We have to be  
25 continuously promoting uptake of vaccinations. And it

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1 And my Lady, you heard evidence on this issue in  
2 Module 2.

3 The BMA had anticipated that the review would  
4 address why there was such disproportionate deaths and  
5 serious illness in healthcare workers from ethnic  
6 minority backgrounds. However, when the review was  
7 published, it failed to address the staggeringly higher  
8 proportion of deaths amongst healthcare workers from  
9 ethnic minority backgrounds.

10 In response to Ms Badenoch's criticisms,  
11 Professor Banfield, the BMA's chair of UK Council,  
12 issued an immediate public response on Monday of this  
13 week which concluded:

14 "To suggest the BMA was spreading misinformation at  
15 this time is highly disingenuous. All we were doing was  
16 asking the government to be transparent about how and  
17 when it was planning to take action to save lives and  
18 address racial inequalities."

19 In respect of workforce planning and capacity, the  
20 BMA's view is that general practice was the right  
21 delivery vehicle for Covid vaccination. However, the  
22 BMA remains concerned that insufficient consideration  
23 was given to workforce planning in connection with the  
24 vaccination programme, and that delivery of the  
25 programme further reduced the already limited workforce

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1 capacity in general practice, with GPs and other  
2 healthcare workers required to work additional hours to  
3 administer vaccinations whilst still continuing to  
4 deliver Covid and non-Covid care.

5 During the pandemic, the BMA engaged with  
6 NHS England and the Department of Health and Social  
7 Care, to address the increasing demands on general  
8 practice, the rising workloads and workforce shortages,  
9 and make clear that general practice was at breaking  
10 point, and there were simply too few GPs.

11 Against this background, the comments made in the  
12 published witness statement of the former Secretary of  
13 State for Health, Sir Sajid Javid, that the BMA sought  
14 to take commercial advantage of the vaccination scheme  
15 are shameful and offensive, and expose complete  
16 ignorance of the reality for GPs on the ground,  
17 including the overwhelming demand, the lack of capacity,  
18 and the abuse faced by GPs and their staff whilst they  
19 did their best to manage unmanageable workloads.

20 The vaccination programme was substantial additional  
21 work that general practice delivered in the national  
22 interest, requiring the existing or additional staff to  
23 take on increased hours, often at weekends. It did not  
24 result in GPs being paid twice, as alleged, and the  
25 efficiency with which GPs delivered vaccines was more

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1 considers that mandating vaccination is not the right  
2 approach, and would worsen the existing recruitment and  
3 retention crisis within health and social care, as seen  
4 when the policy was implemented for a short period of  
5 time within social care in England, which caused  
6 significant reductions to the workforce.

7 Covid-19 vaccines have been very successful at  
8 controlling serious disease and death, but they do not  
9 prevent transmission. And Professor Sir Chris Whitty,  
10 while acknowledging that VCOD was a political decision,  
11 expressed his scepticism that it was a good idea, and  
12 told the Inquiry that mandation has not got a very happy  
13 history.

14 He also highlighted that doctors have a clear  
15 professional responsibility to protect patients by  
16 having vaccinations, but said that there is a big  
17 difference between responsibility and mandating it so  
18 that you lose your job.

19 A similar view was held by Dame Jenny Harries, who  
20 advised in February 2021 that there was no evidence that  
21 the policy would have more benefit than harm.

22 In conclusion, my Lady, while there is no doubt that  
23 the Covid vaccination programme was a success, there are  
24 lessons to be learned from this experience, and from  
25 vaccination programmes before it, that can lead to

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1 cost effective than costs per dose at mass vaccination  
2 centres.

3 My Lady, on the question of data sharing, access to  
4 GP data is subject to a number of checks and balances.  
5 These are put in place to preserve the integrity of the  
6 doctor-patient trust relationship, and to ensure that  
7 GPs uphold their obligations as data controllers under  
8 GDPR.

9 However, the BMA was broadly supportive of measures  
10 put in place to support the UK's pandemic response which  
11 lowered the threshold on access to GP data. The Inquiry  
12 heard evidence that such measures should be brought back  
13 to enable better sharing of health data. The BMA agrees  
14 that improved data sharing is essential to providing  
15 safe, high-quality healthcare, and to enable healthcare  
16 services to respond to emergencies, such as a future  
17 pandemic.

18 However, great care must be taken to safeguard  
19 patient confidentiality.

20 Finally, my Lady, on the issue of vaccination as  
21 a condition of deployment (VCOD), the Inquiry has heard  
22 differing views on the merits of this policy. The BMA's  
23 position is that it strongly urges doctors and frontline  
24 healthcare workers to be vaccinated, and uptake amongst  
25 doctors of the Covid-19 vaccine was high, but the BMA

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1 increased uptake and reduced disparities, which will in  
2 turn further reduce the risk of infection and save more  
3 lives.

4 My Lady, thank you to you and your team for  
5 facilitating the core participation of the BMA at the  
6 Inquiry.

7 **LADY HALLETT:** Thank you very much, Mr Stanton.

8 Ms Domingo, I won't cut you off before the break as  
9 I did last time.

10 **Closing statement on behalf of the National Pharmacy  
11 Association by MS DOMINGO**

12 **MS DOMINGO:** Thank you, my Lady.

13 This is the closing statement on behalf of the  
14 National Pharmacy Association.

15 Over the past three weeks the Inquiry has heard  
16 evidence from many sources of the vital role played by  
17 community pharmacy in the delivery of the Covid-19  
18 vaccination programme, and of the efforts made by the  
19 National Pharmacy Association on behalf of its members  
20 to advocate for an increased role for community pharmacy  
21 in supporting vaccine delivery.

22 The NPA welcomes the Inquiry's scrutiny of the  
23 rollout of the vaccination programme, and particularly  
24 those areas where there are lessons to be learnt for the  
25 future.

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1 This statement for the NPA seeks to address two  
2 broad points arising from the evidence heard in this  
3 module. First, the key role that community pharmacy  
4 played in the success of the vaccination programme and  
5 the need for early involvement of community pharmacy in  
6 planning and delivery for future vaccination programmes.  
7 And, secondly, the role of community pharmacy in  
8 addressing health inequalities, overcoming barriers to  
9 vaccination, encouraging vaccine uptake and countering  
10 vaccine hesitancy.

11 Primary care, including community pharmacy teams,  
12 were crucial to the successful delivery of the Covid-19  
13 vaccination programme, and all four UK nations relied on  
14 community pharmacy to differing extents in ensuring that  
15 vaccines were readily available throughout the country.  
16 Community pharmacy teams have helped to protect and save  
17 the lives of tens of millions of people in the UK.

18 Given its years of experience and expertise in  
19 delivering annual flu vaccinations, and given the reach  
20 and resources of the approximately 13,000 community  
21 pharmacies embedded in communities across the UK,  
22 community pharmacy is ideally equipped to deliver  
23 a vaccination programme.

24 The Inquiry has heard that the Covid-19 vaccination  
25 programme benefited from the infrastructure already in  
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1 1,000 doses a week, and this approach was devised to  
2 protect as many people as quickly as possible in the  
3 fairest way possible.

4 However, the very first Covid-19 vaccine delivery  
5 plan, issued by DHSC on 11 January 2021, emphasised that  
6 local vaccination services, including community pharmacy  
7 sites, provided the largest number of sites, supported  
8 the country's highest-risk individuals, and delivered  
9 vaccination to people unable to attend vaccination  
10 centres, including reaching vulnerable groups such as  
11 the homeless.

12 This document recognised that community pharmacies  
13 are integral parts of local communities and will be  
14 accessible and approachable places from which to deliver  
15 vaccination.

16 The NPA submits that the balance reached in the  
17 early part of the vaccination programme, prioritising  
18 large vaccination centres in favour of a higher number  
19 of local sites, was wrong. A more balanced approach  
20 that relied on existing health infrastructure, including  
21 the extensive network of community pharmacies across the  
22 country would that have ensured broader, more equitable  
23 access to the vaccine at an earlier stage, and could  
24 have been achieved, had community pharmacy been  
25 consulted and involved earlier in the planning process.  
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1 place for the delivery of routine immunisation  
2 programmes, and that programmes delivered at local level  
3 have proved highly effective.

4 However, as the Inquiry has also heard, community  
5 pharmacy was not involved in the initial phases of the  
6 rollout, in large part due to the programme requirements  
7 in England that vaccination sites administer at least  
8 1,000 doses per week and remain open 12 hours a day,  
9 seven days a week.

10 The NPA voiced concerns that community pharmacy was  
11 under-utilised in the early days of the rollout, and  
12 evidence before the Inquiry shows that in January 2021,  
13 the Prime Minister also questioned whether enough was  
14 being done through community pharmacies.

15 Amongst reasons put forward for not including  
16 community pharmacy from the outset were the  
17 difficulties transporting and storing the Pfizer  
18 vaccination, and while the NPA well understood these  
19 challenges, by early January 2021 the Oxford-AstraZeneca  
20 vaccine was available and was very suitable for  
21 community pharmacy to deliver. The requirement of 1,000  
22 vaccines per week was, in the NPA's view, no longer  
23 required, and risked creating new health inequalities.

24 It has also been suggested that it was supply  
25 constraints which demanded that vaccine sites deliver  
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1 As a final point on the role of pharmacists in  
2 vaccine delivery, and as mentioned in the NPA's opening  
3 statement, the NPA asks the Inquiry to take account of  
4 the impact of delivering the vaccination programme in  
5 a system that was already stretched to breaking point by  
6 the pandemic.

7 Healthcare workers and community pharmacy and  
8 general practice provided crucial vaccination services  
9 on top of existing commitments, and any future  
10 vaccination programmes must ensure that experienced  
11 health professionals have sufficient capacity to deliver  
12 the programme in a safe and sustainable way.

13 The second broad area relates to vaccine uptake,  
14 barriers and hesitancy. The Inquiry has heard of the  
15 benefits of working at local level through general  
16 practice and community pharmacy, including high levels  
17 of patient registration, the ability to rapidly identify  
18 clinical at-risk groups, and value in being able to  
19 receive a vaccine in a familiar environment which  
20 supports public confidence.

21 The Inquiry's expert in vaccine hesitancy,  
22 Professor Larson, told the Inquiry that access was a big  
23 issue, and to quote:

24 "The more we can try to engage locally, and again,  
25 that doesn't have to wait and shouldn't wait for another  
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1 crisis, whether it's through a local GP or a pharmacy,  
 2 the more we can bring vaccines closer to people is only  
 3 an asset."  
 4 Many witnesses have described the trust relationship  
 5 that exist at a community level, and GPs and community  
 6 pharmacists have been described as by far the most  
 7 trusted health professionals in their communities.  
 8 Approximately 50% of the NPA's membership are from  
 9 ethnic minority backgrounds, and their role as trusted  
 10 healthcare professionals at the heart of their  
 11 communities allowed them to respond to the needs and  
 12 concerns of their patients, addressing health  
 13 inequalities and vaccine hesitancy within their  
 14 communities. Their ability to debunk myths and  
 15 misconceptions improved vaccine uptake, particularly in  
 16 patients who expressed scepticism about the vaccination.  
 17 Community pharmacies are disproportionately located  
 18 in poorer areas, and they play a particularly important  
 19 role in deprived and rural communities, which often have  
 20 less access to other healthcare services, and where  
 21 there are increased barriers to accessing a vaccine  
 22 centre.  
 23 Community pharmacies are accessible without an  
 24 appointment, and 99.8% of the population in areas of  
 25 highest deprivation have access to a community pharmacy

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1 the national booking system appointment system.  
 2 The NPA believes that the significance of vaccine  
 3 hesitancy and other barriers to vaccine uptake were not  
 4 fully appreciated early enough. Barriers to vaccination  
 5 need to be understood and addressed at a community  
 6 level, and again, the early involvement of community  
 7 pharmacy and planning could have better identified these  
 8 issues, and allowed greater scope for the positive role  
 9 that community pharmacy can play.  
 10 To conclude, my Lady, the Inquiry has heard that  
 11 throughout the relevant period, community pharmacy  
 12 delivered just under 21% of all Covid vaccinations in  
 13 England, and in the recent winter campaign for flu and  
 14 Covid, community pharmacy delivered over 40% of  
 15 vaccinations.  
 16 As highlighted by Dame Lawson, the role that  
 17 pharmacy plays in vaccination, particularly in areas  
 18 which are underserved by both primary and secondary  
 19 care, is absolutely vital.  
 20 The NPA believes there is substantial scope for  
 21 community pharmacy to play a greater role in vaccination  
 22 planning and delivery, which will benefit future  
 23 pandemic preparedness.  
 24 Thank you.  
 25 **LADY HALLETT:** Thank you very much, Ms Domingo. We will

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1 within a 20-minute walk.  
 2 Community pharmacies have tried and tested  
 3 mechanisms of reaching out to patients to reduce vaccine  
 4 inequity in local populations, as well as being  
 5 innovative in delivering patient care.  
 6 The NPA's witness statement in this module included  
 7 the following account from a member pharmacy that had  
 8 set up a process with their local director of public  
 9 health to vaccinate individuals from marginalised  
 10 communities.  
 11 The pharmacy team recognised the importance of  
 12 vaccinating people from inclusion health groups, given  
 13 they are already experiencing significant health  
 14 inequalities, and are at higher risk of poor outcomes  
 15 should they contract Covid-19.  
 16 Inclusion health groups comprised people who might  
 17 struggle to access mainstream healthcare, and include  
 18 vulnerable migrants, asylum seekers, refugees, people  
 19 experiencing homelessness, sex workers, Gypsy, Roma,  
 20 Traveller communities, and people struggling with  
 21 addiction.  
 22 The walk-in model was particularly useful for  
 23 helping including health populations who are typically  
 24 not registered with a GP, and have no NHS number or  
 25 access to the Covid-19 vaccine as they are unable to use

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1 take our break now. I shall return at 3.25.  
 2 **(3.07 pm)**  
 3 **(A short break)**  
 4 **(3.24 pm)**  
 5 **MR JACOBS:** My Lady, can you hear me?  
 6 **LADY HALLETT:** Not quite.  
 7 **MR JACOBS:** Let's try again.  
 8 **LADY HALLETT:** Got you. Yes.  
 9 **Closing statement on behalf of the Traveller Movement by MR**  
 10 **JACOBS**  
 11 **MR JACOBS:** My Lady, the Traveller Movement is grateful to  
 12 you for the opportunity to participate in this module of  
 13 the Inquiry. Public inquiries are important because  
 14 they are capable of catapulting significant but perhaps  
 15 neglected issues into public consciousness, and into the  
 16 minds of institutions which hitherto failed to act  
 17 appropriately when needed. And as a result of its  
 18 participation in your inquiry, the Traveller Movement  
 19 believes that the sands have shifted insofar as there is  
 20 now an institutional awareness and public understanding  
 21 that Roma, Gypsies and Travellers were largely abandoned  
 22 in the vaccination programmes and, importantly, that  
 23 they were, in many ways, statistically invisible, and  
 24 not properly captured, certainly in England, in census  
 25 records and other national data.

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1 It was uncontentious during the rollout in  
2 December 2020 that the Traveller communities were  
3 a health inclusion group. And that means that by virtue  
4 of social exclusion, poor health outcomes, and a high  
5 risk of missing out on vaccination, they were  
6 particularly vulnerable.

7 Yet it's clear from the limited data that we have  
8 and the compelling evidence given before you by  
9 Ms MacNamara on 16 January that not enough was done to  
10 address the significantly low uptake of vaccines that  
11 ensued.

12 My Lady, the evidence over the last three weeks has  
13 confirmed that the level of institutional failure  
14 towards the three GRT communities was indeed  
15 significant.

16 You will recall that the director of the health --  
17 of the public health programmes at the UK Health  
18 Security Agency, Dr Ramsay, stated in evidence on  
19 21 January, in answer to questions from ourselves, that,  
20 apart from a single workshop, she was not aware of any  
21 concerted effort at national level to ensure the  
22 inclusion of GRT and targeting of GRT into the  
23 vaccination programme.

24 Furthermore, my Lady, on 27 January, Kemi Badenoch,  
25 the Minister for Equalities at the time of the vaccine

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1 live as a result of local authorities failing to meet  
2 spatial planning requirements.

3 I gave examples in my opening submissions of  
4 discrimination during the pandemic: deaths occurring  
5 because ambulances were required to wait for police  
6 escorts before entering sites, and heavy police presence  
7 at funerals.

8 You will recall that Ms MacNamara told you, in her  
9 evidence on 16 January, about cases where police were  
10 sent to sites to stop residents going out to buy fuel  
11 for generators, those very generators which were used to  
12 power the refrigerators on sites that stored medication.

13 My Lady, I echo what Mr Thomas KC told you earlier,  
14 it's about trust. Trust is vital. The fundamental  
15 problem with the authority's approaches to the GRT  
16 communities is that prior to the pandemic, only very  
17 limited steps were taken to proactively engage to  
18 address mistrust and lack of cooperation, so by the time  
19 of the vaccine rollout in December 2020, as Ms MacNamara  
20 put it so well, the flood had already started and it was  
21 too late to build the ark.

22 And that chimes, my Lady, with the evidence of  
23 Dr Chantler on 27 January, and she said there needs to  
24 be an ability to build trust and relationships, so that  
25 you don't have to suddenly gather people together.

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1 rollout, was asked again by ourselves about the lack of  
2 targeted initiatives such as pop-up clinics or bespoke  
3 community engagement in respect of Travellers.

4 And she said that it was her understanding that  
5 there were GRT-based activities, but that of all the  
6 groups that the government was trying to reach, this was  
7 the most difficult group.

8 Ms Badenoch went on to say that the lack of  
9 engagement with Travellers might have been down more to  
10 the fact that GRT were difficult to reach, rather than  
11 simply because nothing was done.

12 Significantly, she clarified that she might be able  
13 to explain this, but not as a minister, but from her  
14 experience as a constituency MP, where she had noted  
15 that there was a hostility to state bodies within the  
16 communities.

17 My client is keen to impress upon the Inquiry that  
18 the underlying reason why some members of the Traveller  
19 community appear to be hostile or reluctant to interact  
20 with the state lies in the fact that discrimination and  
21 marginalisation necessarily breeds distrust and  
22 non-cooperation., and this particularly applicable in  
23 a number of pockets of chronic exclusion around the UK,  
24 such as unregistered sites, where, as we've already  
25 stated, approximately 10,000 Travellers are forced to

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1 My Lady, the way to generate trust is through  
2 effective community engagement, and the two are very  
3 much connected, and equally important. Ms MacNamara  
4 confirmed that mobile health services for the GRT  
5 community are no longer in existence, and that this  
6 important outreach should be reinstated because it had  
7 been crucial to building the relationships with  
8 communities that are so needed at times of health  
9 crisis, for example.

10 Ms MacNamara went on to say that the mobile health  
11 services, when in existence, had allowed people to have  
12 someone they could go to with health concerns or issues,  
13 who they could build up a relationship of trust and  
14 confidence with. She stated that these services might  
15 have proved very useful when the vaccinations were  
16 rolled out, because questions about vaccinations would  
17 have been dealt with by health professionals, who the  
18 Travellers knew and trusted, and in circumstances where  
19 the Travellers would be more familiar with the  
20 healthcare system.

21 Dr Richardson said, on 28 January, that it is  
22 important that the message is transmitted by the right  
23 messenger, and my client couldn't agree more.

24 My Lady, you will recall that misinformation was  
25 a significant issue for the GRT community. Ms MacNamara

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1 told the Inquiry that rates of child mortality and  
2 miscarriage are high in these communities, and that  
3 rumours spread to the effect that vaccines could lead to  
4 infertility in children, and -- sorry, to infertility,  
5 and autism in children.

6 These rumours spread quickly through what is  
7 traditionally an oral community and went unchecked, and  
8 it's important to note that a community which suffers  
9 from digital exclusion and literacy issues is not only  
10 less able to receive vaccine invitations by letter or  
11 look at government alerts on the Internet, but will also  
12 be unable to access government messaging so as to  
13 counter misinformation.

14 My Lady, I spoke earlier in relation to the evidence  
15 about the lack of any meaningful initiatives at national  
16 level to ensure the inclusion of GRT, and targeting GRT  
17 into the vaccination programmes, the evidence that was  
18 given by the Director of Public Health Programmes.

19 Regrettably, it was the case that local  
20 interventions were also sparse, particularly in England.  
21 Aside from local programmes at the Appleby Horse Fair  
22 and an initiative in Shropshire involving a well-known  
23 TV figure, there doesn't appear to be any evidence that  
24 much was done at a local level in England.

25 Witnesses have pointed to the Community Champions  
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1 contrast between data capture in Scotland and in England  
2 is shown at pages 58 and 59 of the expert report of  
3 Dr Kasstan-Dabush and Dr Chantler. My Lady, of course  
4 I don't have time to put all this on the screen, but  
5 you'll note at page 59, when you come to analyse the  
6 report, that there's a table containing the Public  
7 Health Scotland data where GRT are recorded as the  
8 highest unvaccinated group, as I've said, at 55%  
9 unvaccinated and the least likely group to receive at  
10 least one dose.

11 Yet on the preceding page, if you go back in the  
12 report, you'll see the data from England that fails to  
13 refer to the GRT groups at all. These communities are  
14 nowhere in sight as far as the English data is  
15 concerned.

16 And Dr Chantler helpfully confirmed in his evidence  
17 on Tuesday that in England, healthcare records do not  
18 routinely record membership of certain health inclusion  
19 groups.

20 And we have heard this in other evidence. The  
21 government's final report on progress to address the  
22 Covid-19 health inequalities, or the quarterly review,  
23 you might recall, dated December 2021, so a year before  
24 the rollout, that confirms -- and it's INQ000089747, at  
25 page 124 -- the vaccination estimates for Gypsy, Roma  
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1 Scheme, but the Traveller Movement maintains that this  
2 initiative did not address the problem of low vaccine  
3 uptake notwithstanding that local authorities had an  
4 awareness, of course, of where the Traveller sites, or  
5 some of them at least, were located.

6 The situation was handled much better in Scotland,  
7 as Ms Drysdale KC on behalf of the Scottish ministers  
8 has set out in her submissions today. We note that  
9 Mr Grieve told the Inquiry, on 28 January, that the  
10 Scottish Government's approach was to respond to  
11 feedback that they received from particular communities.

12 And there is evidence in a February 2022 Scottish  
13 Government document entitled "Inclusive vaccinations",  
14 phase I of the Covid-19 vaccination programme,  
15 INQ000376293, that the National Health Service in  
16 Scotland worked with local authorities and ambulance  
17 services and visited Traveller sites in the Forth Valley  
18 and the Boswell Fair to deliver vaccination.

19 My Lady, I turn, perhaps as I must, to the issue of  
20 data. The Traveller Movement's position is that  
21 problems of lack of trust and lack of engagement were  
22 compounded by the fact that GRT, which as we've said,  
23 constitute possibly up to 1% of the UK population, are  
24 statistically invisible, and particularly in England.

25 Now, as I pointed out in my opening submissions, the  
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1 and Irish Traveller populations are not available as NHS  
2 systems do not have these categories available to  
3 choose.

4 So it was out in the open.

5 The same report recommends, at pages 134 and 136  
6 that it was a high priority next step to improve  
7 ethnicity coding and health datasets amongst other  
8 things to allow information for the GRT groups to be  
9 presented. Yet it appears, of course, that this  
10 recommendation has not been implemented.

11 Dame Emily Lawson accepted in her evidence,  
12 answering Mr Keith King's Counsel on 28 January, that we  
13 would not find any figures relating specifically to GRT  
14 in the NHSE documentation, and she confirmed that GRT  
15 are not in the NHS Data Dictionary.

16 Dame Emily also said in her evidence that ethnicity  
17 data was in the process of being updated, but you will  
18 recall that Ms MacNamara also said on the 16th that her  
19 organisation, the Traveller Movement, for whom I act,  
20 has been calling for such inclusion since 2012.

21 My Lady, it is just unacceptable that this situation  
22 is permitted to continue, and we say that if the Inquiry  
23 makes any recommendation in relation to GRT, and we hope  
24 there will be more than that, but if it makes any one  
25 recommendation, it must emphatically recommend that the  
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1 NHS changes its data recording procedures to include the  
2 GRT communities.

3 It is self-evident, of course, that data capture has  
4 a strong bearing on vaccine uptake. You will recall  
5 that Ms MacNamara told the Inquiry that without proper  
6 data capture, GRT community members would not have  
7 received NHS text messages that were sent out to  
8 vulnerable communities during the pandemic. And  
9 Dr Kasstan-Dabush referred to GRT in his evidence on  
10 28 January, and he said that you need an NHS number to  
11 be called up in the first place.

12 One would have thought it quite obvious, really.

13 TM's uncontroversial position is that without  
14 inclusion in NHS data, people are going to be overlooked  
15 in local and national health strategies and delivery.  
16 And that's what happened in the Covid pandemic and it  
17 will happen again, if not addressed.

18 There's another issue to which Ms MacNamara referred  
19 in her evidence which I want to address briefly, which  
20 is that GRT are no longer provided with handheld medical  
21 records. Now, this was a measure that addressed the  
22 longstanding problem of inclusion in healthcare that GRT  
23 face, where, for example, GRT members relocate  
24 frequently between sites or between houses. And we ask  
25 you to recommend that the system of providing handheld

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1 with the GRT communities, restore specialist health  
2 visitor outreach services, and capture high-quality data  
3 describing family ethnic groups, the mistakes that were  
4 made -- and they undoubtedly were made -- around  
5 vaccination in the Covid-19 pandemic, will be carried  
6 through to any future pandemic.

7 My Lady, the Traveller Movement ask that you  
8 recommend that these measures are implemented by policy  
9 makers now. Dr Kasstan-Dabush told the Inquiry, on  
10 28 January, that there is a need to create an agenda for  
11 change in partnership with underserved groups, and my  
12 client emphatically agrees.

13 Furthermore, these problems don't just arise when  
14 there is a pandemic on the horizon.

15 As Mr Stanton on behalf of the BMA stated before the  
16 afternoon break: Dr Chantler told the Inquiry in her  
17 evidence that we cannot be complacent. She said we have  
18 to be continually promoting uptake of vaccinations and  
19 this needs to be resourced.

20 Now finally, my Lady, your Inquiry represents  
21 a once-in-a generation opportunity to address vaccine  
22 inequality within these three highly-marginalised and  
23 vulnerable communities.

24 And we submit, or the Traveller Movement submits,  
25 that the Inquiry must make robust recommendations to

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1 records for members of the GRT communities is restored.  
2 These records would make it easier to register with  
3 a GP. They might break the pattern of Travellers being  
4 turned away from surgeries.

5 GP registration is, of course, important. As  
6 Ms Stephenson of counsel put to Ms MacNamara on  
7 16 January, the invitations to vaccinate were linked to  
8 GP registration. If you're excluded from the system,  
9 you're just not going to get the information. It's  
10 noteworthy that many GRT members did not have an NHS  
11 number during the pandemic, and that in itself amounted  
12 to an impediment to obtaining a vaccination dose.

13 In conclusion, my Lady, I would repeat what I said  
14 in my opening submissions: there are three actions which  
15 would have been effective to improve immunisation uptake  
16 amongst the GRT communities. These are, firstly,  
17 maintaining trust within the Traveller groups locally;  
18 secondly, specialist health attendances on GRT; and  
19 thirdly, high-quality data.

20 And these are effectively the recommendations that  
21 we seek. Having heard the detailed evidence over the  
22 last three weeks, it is even clearer that these measures  
23 are needed.

24 It should now be uncontentious that unless the  
25 authorities take appropriate steps to establish trust

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1 ensure GRT engagement, and inclusion in the future.

2 I repeat Ms MacNamara's very apt analogy: you can't  
3 build the ark after the flood has happened, and we say  
4 that building process must start now.

5 Unless I can assist further, those are my  
6 submissions.

7 **LADY HALLETT:** Thank you very much indeed for your help,  
8 Mr Jacobs.

9 Ms Parsons, are you over there?

10 **Closing statement on behalf of the Covid-19 Bereaved  
11 Families for Justice Cymru by MS PARSONS**

12 **MS PARSONS:** My Lady, I make this closing statement on  
13 behalf of the Covid-19 Bereaved Families for  
14 Justice Cymru.

15 By way of introduction, as the Inquiry is aware,  
16 a priority of the Covid-19 Bereaved Families for  
17 Justice Cymru group is to scrutinise where the Welsh  
18 Government discharged its duty to protect the lives of  
19 people in Wales.

20 This closing statement flags key concerns of the  
21 group in relation to that issue. It will focus in  
22 particular on the delivery of vaccinations in the first  
23 few months of the programme to the most vulnerable  
24 groups in Wales.

25 It is important, when considering these issues, to

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1 remember what a devastating period this was, with care  
2 homes in Wales experiencing 465 Covid-19-related deaths  
3 in January 2021 alone, and, at times, as many as  
4 20 deaths a day.

5 Vaccinations in Wales commenced on 8 December 2020.  
6 However, by 16 February 2021, over two months later,  
7 only 82% of care home residents in Wales had been  
8 vaccinated.

9 Whilst at first blush that might seem a high  
10 proportion, in fact, it was significantly below some of  
11 the other phase I priority groups. This was despite the  
12 JCVI having identified care home residents as the most  
13 vulnerable group, and the first priority group on the  
14 list.

15 The source of this information is the Welsh  
16 Government's vaccination update.

17 That's at INQ000410143.

18 This update also demonstrates that during  
19 February 2021, up to the 16th of that month, almost no  
20 vaccines were delivered to care home residents.

21 Time was of the essence for many vulnerable people  
22 in Wales, as powerfully described by the group's  
23 co-lead, Sam Smith-Higgins, from whom, my Lady, you  
24 heard earlier this month.

25 She told the Inquiry about her fears for her  
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1 of our vaccinators standing around with nothing to  
2 do ..."

3 This bizarre statement was roundly criticised, and  
4 it might be thought to be an off-script comment made in  
5 error. However, it was, in fact, the policy of the  
6 Welsh Government, as seen from the ministerial advice to  
7 the First Minister, Mr Drakeford, on 24 November 2020.

8 That is at INQ000361639.

9 That ministerial advice stated as follows:

10 [As read] "Given the constraints around  
11 transportation of the Pfizer vaccine to care homes, it  
12 is recommended that the vaccine is not used in care  
13 homes for the first four weeks of delivery."

14 This policy, my Lady, was also contrary to the JCVI  
15 priority cohorts and to the approaches taken in other UK  
16 countries, as can be seen from the Cabinet Office  
17 meeting minutes of 12 January 2021, and those minutes  
18 are at INQ000088889.

19 The minutes read as follows:

20 [As read] "300,000 doses had been delivered to Wales  
21 but short of 90,000 had been used so far. The press  
22 have picked up that this was down to the Welsh  
23 Government. It would be useful to have regular  
24 publication of how many vaccines had been delivered.  
25 The Welsh Government's approach was slightly different  
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1 73-year old father, who was admitted to hospital in  
2 January 2021 for cancer-related treatment and was  
3 immune suppressed and vulnerable.

4 Ms Smith-Higgins made efforts to secure a vaccine  
5 for her father prior to his admission but was told this  
6 was not possible. Tragically, just three weeks after  
7 being admitted to hospital, he died from  
8 a Covid-19-related infection acquired in hospital.

9 So, against that backdrop, my Lady, the key  
10 concerns.

11 Key concern number 1: the Welsh Government's  
12 decision to deliberately slow the rate of vaccine  
13 delivery and its failure to vaccinate in accordance with  
14 JCVI priority cohorts.

15 The group's members are extremely concerned at the  
16 decision of the Welsh Government to intentionally slow  
17 the delivery of vaccines in January 2021 to vulnerable  
18 people, and the group requests, my Lady, that the  
19 Inquiry gives this matter careful consideration.

20 The former First Minister, Mark Drakeford, made  
21 a public statement on 18 January 2021 explaining that  
22 vaccinations in Wales would be staggered because,  
23 I quote:

24 "... it would be logistically very damaging to try  
25 to use all of that in the first week and then have all  
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1 to other nations, as it had prioritised NHS staff for  
2 the Pfizer vaccine."

3 And, my Lady, you heard the anger and confusion that  
4 this decision, the decision to delay the vaccination to  
5 vulnerable, had caused people in Wales.

6 Ms Smith-Higgins told you in her evidence:

7 "... the vaccinations had started coming out on  
8 December ... and I was a carer for an 85-year old, my  
9 mother ... and so I expected her to be ... vaccinated  
10 relatively soon, but as December went through, I was  
11 tweeting like mad everybody, MPs, MSs, head of NHS,  
12 saying: What is going on? Why hasn't my mother been  
13 vaccinated? And it soon became apparent that actually,  
14 in Wales, they were focusing on the healthcare workers  
15 and not ... aged or the most vulnerable.

16 "By 11 January, Cardiff and Vale Health Board  
17 tweeted that up to date, up to 11 January, they had  
18 vaccinated 12,300 people, of which [just] 69 were in  
19 care homes and only 75 were over 80."

20 The group wishes to make clear that they take  
21 absolutely no issue whatsoever with the prioritisation  
22 of frontline healthcare workers as advised by the JCVI,  
23 but that wasn't what happened in Wales, with significant  
24 numbers of administrative staff vaccinated before the  
25 vulnerable.  
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1 Ms Smith-Higgins refers in her witness statement to  
2 one such example, a relative in her fifties with no  
3 underlying health conditions who worked in an  
4 administrative department of one of the Welsh health  
5 boards and who received her vaccination as early as  
6 December 2020.

7 The concern and anger about this issue was amplified  
8 by the history of neglect of care homes in Wales during  
9 the pandemic. This was epitomised, my Lady, by the  
10 evidence of the former First Minister, Mark Drakeford,  
11 in Module 2B, when he told the Inquiry, and I quote:

12 "There is no single register of where every care  
13 home in Wales is located."

14 This of course begs the question: how was  
15 vaccination progress being managed and monitored among  
16 this most vulnerable priority group when the government  
17 didn't even know of their existence?

18 The group, many of whom witnessed the death of their  
19 loved ones from Covid-19, want to know how many deaths  
20 could have been prevented if the Welsh Government hadn't  
21 delayed the vaccination in December 2020 and  
22 January 2021? They want to know how many deaths could  
23 have been prevented if the Welsh Government hadn't  
24 prioritised non-frontline healthcare workers over older  
25 people and the vulnerable.

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1 a vaccine-to-person model, when it would have been so  
2 obviously a disadvantage to those who were vulnerable  
3 and/or who could not travel.

4 The group believes that trusted healthcare  
5 professionals such as GPs and community pharmacists who  
6 are embedded within communities and easily accessible  
7 were insufficiently utilised by the Welsh Government in  
8 the delivery of vaccines compared with other UK  
9 countries.

10 The group believes that this was a missed  
11 opportunity by the Welsh Government.

12 The group also believes that the difficulties of  
13 storing and transporting the Pfizer vaccine, while real,  
14 are too often relied upon to explain away poor  
15 performance or justified poor decisions. The  
16 Oxford-AstraZeneca vaccine became available at the  
17 beginning of January 2021 and was widely used in Wales  
18 from this time, as can be seen from a Wales Covid-19  
19 vaccination programme daily situation report.

20 That's at INQ000505456.

21 That is a daily situation report of 29 January 2021,  
22 and it records that some 138,000 AstraZeneca vaccines  
23 had been delivered by end of January 2021.

24 The ministerial statement of the former Minister for  
25 Health and Social Services, Vaughan Gething, in his

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1 Key concern number 2, my Lady: overreliance on  
2 a small number of mass vaccination centres, despite the  
3 geographical and demographic challenges of Wales.

4 The group is concerned at the decision of the Welsh  
5 Government to heavily rely on delivery through larger  
6 vaccination centres. This decision is particularly  
7 difficult to understand, given the geography of Wales,  
8 with many rural and remote communities, and also the  
9 demographic of Wales, which, as explained by  
10 Dr Richardson in her oral evidence, is an older  
11 population, with greater healthcare needs than other  
12 parts of the UK.

13 My Lady may recall the evidence of Sam Smith-Higgins  
14 when she told the Inquiry that the mass vaccination  
15 centres in Wales covered huge geographical areas  
16 requiring lengthy journeys by car, bus or several buses.

17 She told the Inquiry:

18 "... for people who have been ... shielding for  
19 months and months and months, to suddenly have to take  
20 an hour-and-a-half journey within the same health board  
21 to then stand outside for an hour-and-a-half queueing to  
22 get into a sports centre, it [just] wasn't the best  
23 thought out ..."

24 The group wants to know why the Welsh Government  
25 used this model, a person-to-vaccine model, rather than

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1 statement made on 4 January 2021, described the  
2 AstraZeneca vaccine as a game changer.

3 He said as follows in his statement:

4 [As read] "Members will be aware of the widely  
5 reported benefits of this latest vaccine. It is cheaper  
6 and supply will be more plentiful. However, crucially,  
7 it presents significantly fewer logistical challenges  
8 than the Pfizer vaccine, with storage at normal fridge  
9 temperatures. As NHS capacity continues to build over  
10 the coming weeks, we will be able to get the vaccine to  
11 where it is needed in every part of Wales. Much more  
12 flexible and mobile deployment models will be activated.  
13 Every care home will be within reach, and this priority  
14 group will be a key focus for the NHS over coming  
15 weeks."

16 In these circumstances, my Lady, the group submits  
17 that it is clear that the issues experienced in storing  
18 and transporting the Pfizer vaccine cannot be used to  
19 justify poor decisions and performance such as the  
20 overreliance on mass vaccination centres and the delays  
21 in vaccinating the most vulnerable.

22 Key concern number 3, communications.

23 The group's experience of Welsh Government is that  
24 it is strong on rhetoric and weak on delivery. And they  
25 submit that this was also a feature of the delivery of

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1 the vaccination programme.

2 The first milestone of the Welsh Government strategy

3 was not based on the number of vaccines delivered, but

4 on the number of invitations issued to JCVI priority

5 groups 1 to 4 for their first dose vaccinations.

6 Vaughan Gething announced, on 12 February 2021, that

7 this first milestone had been met. There are many

8 things wrong with using a meaningless metric, such as

9 the number of invitations issued, as a milestone,

10 including, as already indicated, the fact that at the

11 date the achievement announced, only 82% of care home

12 residents had received their first dose of the vaccine.

13 However, its lack of substance is best illustrated by

14 the experience of Ms Smith-Higgins, as she explained in

15 her witness statement: an invitation was sent out to her

16 father one week after his death; no doubt an invitation

17 which helped the Welsh Government meet its milestone.

18 Further, measuring achievement in such a superficial

19 way takes no account of the difficulties experienced by

20 the many who did not receive their invitation, or who

21 received an invitation but experienced difficulties

22 booking and travelling to an appointment, or, as in the

23 case of many care home residents, those who were still

24 waiting for their vaccination to be administered at the

25 point the Welsh Government announced it had met its

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1 And I turn to my concluding remarks, my Lady.

2 I have already identified the concerns that the Bereaved

3 Families for Justice Cymru invite you to consider, but

4 may I say this by way of conclusion: the group is

5 conscious of the need for the Inquiry to deliver its

6 work within a reasonable timeframe. However, it has

7 been disappointed at the limited time spent in this

8 module on issues specific to Wales. As we know you are

9 aware, my Lady, the Inquiry's proceedings take a very

10 significant toll on the families who are engaged, and

11 this is particularly so for families in Wales who have

12 to contend with a government that has exhibited in

13 earlier hearings a remarkable ignorance about the issues

14 for which they were responsible, whose actions do not

15 match their words, and prominent members of which have

16 destroyed potentially relevant information.

17 The group remains wholly committed to your Inquiry,

18 and looks forward to working with your Inquiry team in

19 future modules to hold decision makers in Wales to

20 account.

21 My Lady, thank you.

22 **LADY HALLETT:** Thank you, Ms Parsons.

23 Mr Weatherby.

24 Closing statement on behalf of Covid-19 Bereaved Families

25 for Justice UK by MR WEATHERBY KC

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1 milestone.

2 And there were also communication problems in

3 relation to the vaccine themselves. The Audit Wales

4 report, reported on the rollout of the vaccination

5 programme in Wales, and identified a number of problems.

6 That's at INQ000066528.

7 By way of example only, there were problems with

8 identical letters inviting people for their first and

9 second doses, and there were problems with the clarity

10 of the invitations themselves, which used English and

11 Welsh interchangeably over several pages of information,

12 making it very difficult to understand.

13 Those are the communication difficulties.

14 Turning, my Lady, to the fourth point --

15 **LADY HALLETT:** I'm afraid you're going to have to take it

16 very quickly, because you're substantially over time and

17 I've got to be fair to everyone. I'm sorry, Ms Parsons.

18 **MS PARSONS:** My Lady, I will in that case wrap up by

19 referencing one more concern about the policy before

20 concluding, and that was that the policy adopted, was to

21 proceed to vaccinate the next priority cohort, once only

22 50% of the vaccination had been achieved in a higher

23 priority group, which may explain, perhaps, why, by

24 mid-February 2021, there remained so many care home

25 residents still to be vaccinated.

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1 **MR WEATHERBY:** Thank you.

2 Through our opening submissions, the Covid Bereaved

3 Families for Justice UK families have been clear to

4 highlight the fact that this Inquiry should learn

5 lessons from what went right, as well as from failures,

6 but the Module 4 evidence has shown that even where

7 there were successes, there were shortcomings, and even

8 where things went right this time, there are stark

9 lessons going forward, very stark lessons.

10 And behind many of the perceived successes, there is

11 underlying evidence of a lamentable lack of planning and

12 preparedness and resilience, and whilst it is right to

13 note -- still right to note great efforts to save lives

14 from a standing start, history will repeat itself if we

15 do not set those efforts against the reality that the

16 United Kingdom and its four nations was so remarkably

17 unready. And next time, a standing start may produce

18 very different results. As we well know, the

19 development of vaccines and therapeutics for the next

20 Disease X may well be very different.

21 Nadhim Zahawi likened the UK approach to building

22 a plane whilst flying it; if ever there was an analogy

23 which cautioned "Don't do it again", that was it.

24 And similarly, we submit, the perspective of Yvonne

25 MacNamara from the Traveller Movement about which you've

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1 been reminded only a few minutes ago by Mr Jacobs, that  
2 you can't build an ark after the flood has started. The  
3 plane and the ark need to be built now, outside of an  
4 emergency.

5 I anticipate all of us will recognise the importance  
6 of the evidence of Dame Kate Bingham underlined by that  
7 of the "phenomenal" Dr Dix, who played a central role in  
8 the initial period of the VTF.

9 A bottom line has been to caution that as the  
10 pandemic eased, the UK, in many respects, relaxed back  
11 to where it was in January 2020, and this conclusion  
12 rests not only on Kate Bingham and Dr Dix, but on  
13 several other witnesses.

14 Only on Wednesday, Lord Bethell, minister during the  
15 pandemic, gave the following alarming assessment. His  
16 words, and I quote:

17 "Frustratingly ... I think we are in a worse shape  
18 today than we were five years ago. The NHS is clearly  
19 under a huge amount of pressure in terms of capacity,  
20 the workforce are under pressure, and there's been  
21 a drop-off on recruitment. International surveillance  
22 of viruses is not where it could or should be. In terms  
23 of the institutions of resilience, UKHSA, for instance,  
24 should be a national agency with heft and resources, and  
25 I'm disappointed that it has been denuded in the way it

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1 limitations of that this morning.

2 Kate Bingham told us that there should be no need  
3 for taskforces. Competent government, she said, should  
4 maintain readiness and capabilities for vaccines and  
5 therapeutics. She identified not only the complete  
6 absence of planning in this area but the suspicion of  
7 industry from within the Civil Service, a lack of  
8 science and technology skills possessed by those  
9 recruited via its fast-track graduate entry scheme and  
10 a risk-averse culture as key problems. Better not to  
11 try than to fail, lest you be criticised, seemed to be  
12 the accepted working practice.

13 And these were views largely echoed by Eddie Gray  
14 from the Antivirals Taskforce.

15 Kate Bingham brought a wealth of relevant and  
16 crucial experience to the VTF, a team of seasoned  
17 experts to hit the ground running. However, as she  
18 laments, and we heard this morning, that once she'd  
19 left, her successor soon followed her out of the door  
20 because of the lack of support from civil servants, and  
21 the industry experts were dispensed with too, which  
22 "reflected incredibly badly on the UK". Her words, not  
23 mine.

24 She commented that thereafter there has been  
25 a concentration on one platform, which is bad for the UK

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1 has been.

2 "Local Resilience Forums remain a shadow  
3 organisation ... I could go on ..."

4 Kate Bingham reminded us that Covid was the seventh  
5 pandemic of this century, yet there was no UK Government  
6 plan for development, manufacture, supply and rollout  
7 and little consideration of vaccines at the DHSC beyond  
8 flu.

9 A key initiative that could have made a significant  
10 difference, as we heard earlier, was the Vaccines  
11 Manufacturing and Innovation Centre, conceived in 2017,  
12 to onshore vaccine manufacture, and expressly to supply  
13 manufacturing capacity during a pandemic.

14 It had not progressed by the onset of the pandemic  
15 despite the allocation of hundreds of millions of pounds  
16 of public money. By the time the project was abandoned,  
17 it had not contributed a single vaccine dose, with its  
18 publicly-funded centre sold off to a private US  
19 healthcare company and then mothballed.

20 From the evidence, it's unclear how much of the  
21 public funding has been recovered, but it's a salutary  
22 example of abject governmental failure. We are told the  
23 Moderna Innovation and Technology Centre will become  
24 operational later this year, more than five years from  
25 the onset of the pandemic, and we heard about the

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1 going forward. Contracts with smaller vaccine  
2 producers, including Valneva, Novavax, were cancelled,  
3 causing losses of jobs in Scotland and Darlington,  
4 a move which Kate Bingham described as not only  
5 inexplicable, but "improper" -- again, her word not  
6 mine -- and driven by cost cutting to the detriment of  
7 industry relations for the future, a view underlined by  
8 Dr Dix today.

9 The failure to take up the Evusheld cocktail left  
10 the UK to be the only western country not to  
11 prophylactically protect its immunosuppressed.

12 This was forthright evidence from two key figures in  
13 the vaccine response. Not all of it is accepted by  
14 those involved, of course, both regarding Evusheld and  
15 the cancelled contract. But her views and those of  
16 Dr Dix are compelling.

17 She proposes that there should be a vaccine tsar --  
18 this time my word not hers -- working alongside the  
19 responsible minister, with similar status and access to  
20 the National Security Adviser, and she and Dr Dix call  
21 for the vaccine agency. We endorse the thrust of those  
22 proposals.

23 But moreover, we call for a clear, published  
24 UK Government vaccine and therapeutic plan to cover  
25 development, resourcing, manufacture, supply and

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1 rollout, and we also propose that there should be  
2 similar overarching plans in each of the devolved  
3 administrations to ensure that there is both full  
4 cooperation and proper protection of devolved powers.

5 We fully recognise the importance of planning  
6 remaining flexible, because the characteristics of the  
7 next pandemic and its effects may be very different to  
8 this one, but there are also constants and themes which  
9 will arise: a need to identify the vulnerable, the  
10 imperative to combat consequences of discrimination, the  
11 infrastructure of both supply and delivery of vaccines  
12 and drugs, prioritisation, protection of key workers,  
13 and so forth.

14 The Inquiry has heard a deal of evidence regarding  
15 inequalities and different vaccine percentages across  
16 different groups. We endorse and follow the submissions  
17 made by Mr Thomas King's Counsel earlier, amongst  
18 others. The problems should not be seen as hesitancy or  
19 one of so-called "hard to reach" communities. The  
20 problem is systemic, and must be addressed and solved or  
21 mitigated systemically.

22 There are two key points to vaccine coverage. The  
23 first is safety and efficacy, and the second, access.  
24 There has been somewhat complex evidence regarding  
25 diversity of clinical trials. Dr Waqar gave evidence

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1 pharmaceutical company, despite the fact that it had  
2 only been trialled on adults, and which resulted in dire  
3 consequences.

4 Given the evidence, and particularly from the MHRA,  
5 we do not suggest that the Covid trials were unsafe, but  
6 we do say this Inquiry should focus on the evidence of  
7 work to be done, and that should be taken seriously.

8 In our view, there should be a requirement before  
9 authorisation that clear evidence of trial diversity  
10 must be produced and published. Trial diversity must  
11 mean that, to the greatest extent possible, the  
12 trialists should be representative of the population  
13 within which the trial takes place.

14 Where there are barriers to that, and we know there  
15 are real barriers, for example involving pregnant women  
16 or those where there are issues of consent, the  
17 applicants for authorisation must set out the  
18 limitations of their trials.

19 If there was a clear public requirement for a higher  
20 standard of diversity before authorisation will be  
21 granted, then those designing and operating and  
22 resourcing the trials will solve or mitigate issues such  
23 as ethical diversity, which are not intractable.

24 We submit this Inquiry should recommend such  
25 a public diversity requirement.

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1 that there has been a historical problem with the lack  
2 of diversity in trials. Big pharma insists that the  
3 Covid trials were fully diverse, and point to trials  
4 elsewhere which ensured that there were sufficient  
5 non-white participants and people with different ethnic  
6 groups involved.

7 The expert Professor Prieto-Alhambra gave figures  
8 which show that participants in the UK AstraZeneca  
9 trials were disproportionately white, with the same  
10 caveat: that diversity was improved by other non-UK  
11 trials.

12 Meanwhile, Kate Bingham comments that the Cabinet  
13 Office were not prepared to front a publicity campaign  
14 to ensure sufficiently diverse volunteers in the UK,  
15 whilst the MHRA opined that the trials were satisfactory  
16 in terms of diversity but there remained work to be  
17 done.

18 There are notorious cases of drugs deployed having  
19 been tested against other demographics which have gone  
20 catastrophically wrong. Diversity of testing is  
21 universally recognised as a necessary precursor to  
22 authorisation. It's not only about confidence. For  
23 example, a quick Google of open source material reveals  
24 a case within the last 30 years regarding the use of  
25 a novel drug to treat children in Nigeria by a major

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1 Requiring diversity for safety and efficacy purposes  
2 overlaps with and leads on to the second point of  
3 confidence. If UK clinical trials do not reflect the  
4 whole community, if individuals cannot see "people like  
5 us", there will be an inevitable adverse perception by  
6 those that are thereby marginalised, irrespective of  
7 whether that lack of diversity is mitigated by trials  
8 taking place elsewhere.

9 The evidence of experts Professor Evans and  
10 Professors Chantler and Kasstan-Dabush was that,  
11 ultimately, trust in marginalised communities is  
12 a structural and historical issue. But as well as  
13 tackling those fundamental whole-system problems,  
14 confidence can and must be addressed to reduce the  
15 coverage gap.

16 This is not done by projecting the problem back on  
17 marginalised individuals, by describing them as  
18 "hesitant" or "hard to reach"; it's done by proper  
19 planning, both in terms of a more general strategy to  
20 combat health inequalities, but by specific pandemic  
21 planning itself.

22 It's well known, as I've touched upon, that there  
23 are real adverse prior examples from around the world  
24 occurring disproportionately away from the wealthiest  
25 nations, and historical memory was acknowledged amongst

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1 others, by Dr Gillian Richardson, the SRO from Wales.  
 2 Disparities of coverage can be mitigated by systemic  
 3 planning to identify the issues ahead of the emergency,  
 4 working with people and organisations from within those  
 5 communities, before the emergency arrives, ensuring not  
 6 only that vaccines and drugs are safe and efficacious  
 7 for all, but ensuring that they're seen to be so with  
 8 clear public messaging, and planning ahead of time to  
 9 message and supply those new treatments in ways in which  
 10 and places appropriate to those communities, ensuring  
 11 also that intersectional issues are recognised and  
 12 addressed, including language and literacy barriers.  
 13 And finally, I turn to evidence from the bereaved  
 14 themselves. As in other modules, you've heard that  
 15 evidence before you it is undeniably powerful. Jean  
 16 Rossiter was the first Module 4 witness. She and her  
 17 family lost their son Peter, an otherwise healthy  
 18 39-year-old teacher and key worker.  
 19 She raises two particular issues. Firstly,  
 20 prioritisation and secondly dosage intervals.  
 21 As a matter of logic, had Peter been vaccinated  
 22 earlier or had his second dose earlier, as manufacturer  
 23 recommended, his chances of contracting and succumbing  
 24 to Covid would have been exponentially reduced.  
 25 Although we've heard justifications for

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1 Sara Meredith's son Daniel, seven years old, had  
 2 complex needs. Sara campaigned and spoke with MPs and  
 3 peers to have vulnerable children prioritised for  
 4 vaccination. Sadly, Daniel contracted Covid shortly  
 5 after receiving his first vaccine dose too late, and  
 6 died.  
 7 Each of those cases, and more, illustrate the  
 8 real-life consequences of a failure to plan for  
 9 a pandemic and the real-life consequences of decisions  
 10 which left particularly vulnerable people unprotected  
 11 until too late. The families look forward to your  
 12 recommendations to ensure that next time others do not  
 13 find themselves in the same position. Thank you very  
 14 much.  
 15 **LADY HALLETT:** Thank you, Mr Weatherby.  
 16 Mr Wilcock.  
 17 **Closing statement on behalf of Northern Ireland Covid**  
 18 **Bereaved Families for Justice by MR WILCOCK KC**  
 19 **MR WILCOCK:** My Lady, as you know, I represent Northern  
 20 Ireland Covid Bereaved Families for Justice, along with  
 21 Mary-Claire McDermott and instructed by PA Duffy  
 22 Solicitors.  
 23 In opening this module, your counsel, Mr Keith  
 24 King's Counsel, stated that the evidence you will hear  
 25 in this module overwhelmingly suggests that the

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1 prioritisation and dosage intervals which amounted to  
 2 a policy to do the greatest good with limited supplies,  
 3 there are two points. Firstly, those limitations of  
 4 supply might have been much reduced had there been  
 5 proper planning and resilience in onshore manufacturing.  
 6 And secondly, there was recognition that some key  
 7 workers should be prioritised whilst others were not.  
 8 And there were differences of approach with respect to  
 9 certain sectors, for example care home staff in England,  
 10 and in Scotland.  
 11 It's not hard to understand Jean's distress and  
 12 frustration at the effect of those decisions, not only  
 13 her loss. In Jean's statement, not only in the oral  
 14 evidence she gave, there are accounts of others within  
 15 the Covid Bereaved Families for Justice group.  
 16 I'll mention simply two. Winifred Partington, aged  
 17 82, died in hospital unvaccinated in March 2021. She'd  
 18 been in hospital for some months, and despite receiving  
 19 vaccination letters to her home, and despite the  
 20 hospital being a vaccination centre, inpatient  
 21 vaccination did not start until five days before she  
 22 tested positive. The family are understandably  
 23 distressed and frustrated that she would have been  
 24 vaccinated if she'd been at home, yet not in hospital  
 25 with the additional risks that that brought.

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1 UK Covid-19 vaccines successfully protected the people  
 2 of the UK against a virus that was killing and liable to  
 3 kill hundreds of thousands of people. He was right.  
 4 He was also right to observe that this remarkable  
 5 achievement was built on the UK's formidable science and  
 6 clinical research infrastructure, including those who  
 7 volunteered for vaccine clinical trials.  
 8 Northern Ireland Bereaved Families for Justice echo  
 9 the calls of the many witnesses you have heard urging  
 10 you to recognise the importance of maintaining and  
 11 strengthening this infrastructure in peacetime, so to  
 12 speak, so that the UK scientific and biomedical research  
 13 centre receives the funding necessary to ensure that it  
 14 is sufficiently resourced and robust to continue  
 15 experimental research of vaccines and therapeutics, so  
 16 that we might be as well prepared as we can be when we  
 17 are inevitably next at risk to the as-yet-unknown  
 18 pathogen X.  
 19 My Lady, as Mr Weatherby presaged, those who do not  
 20 learn from history are doomed to repeat it. And in that  
 21 context, it was incredibly disappointing to those  
 22 I represent to hear both Lord Bethell and Dr Dix tell  
 23 you in different ways that the UK now is in worse shape  
 24 today, in many ways, in terms of vaccine resilience,  
 25 than it was five years ago.

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1 My Lady, with those general remarks, and making  
2 clear that we adopt the general submissions you have  
3 heard from Mr Weatherby King's Counsel, can I return to  
4 some of the evidence you have heard in relation to  
5 Northern Ireland, which, given its inevitable reliance  
6 on the UK's greater scale, research capacity and  
7 purchasing power, related more to rollout than it did to  
8 the development and national supply of the Covid  
9 vaccines.

10 Although the only evidence the Inquiry was able to  
11 hear directly during this module about Northern Ireland  
12 came from Dr Naresh Chada, Northern Ireland's Deputy  
13 Chief Medical Officer, we know and make clear to those  
14 listening to these remarks that you will also bear in  
15 mind the plethora of other written evidence you have  
16 received during the course of this module relating to  
17 the provision of vaccines and therapeutic medications in  
18 the north of Ireland.

19 And they include the extensive witness statement of  
20 the ever-present Chief Medical Officer, Professor  
21 Sir Michael McBride, and the former head of the Northern  
22 Ireland Covid-19 vaccination programme,  
23 Dr Patricia Donnelly.

24 And we accept that there were no easy or  
25 straightforward answers to a number of challenges that  
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1 vaccine, Dr Chada stated that he did not think that the  
2 Northern Irish programme was particularly constrained by  
3 that. It was only just a matter of a week or two.

4 Now, of course, we know what he was trying to say  
5 and what he meant. But you have heard from our witness,  
6 Fiona Clarke, that even that short timescale continues  
7 to haunt those who lost loved ones who could only have  
8 been fully vaccinated outside that short period he  
9 described.

10 In his written statement to the Inquiry, Dr Chada  
11 explained that his initial input into the vaccination  
12 programme was in the context of Northern Ireland not  
13 then having a permanent Senior Medical Officer lead for  
14 vaccinations within the Department of Health. You will  
15 recall Dr Dix's evidence to you this morning about the  
16 need for someone in government to fully understand  
17 vaccines. We suggest that this reasoning might equally  
18 be thought to apply to the Northern Ireland Department  
19 of Health.

20 In July 2020 the Northern Ireland Covid-19  
21 Vaccination Programme Oversight Board was established to  
22 set the direction and oversee the progress of planning  
23 and ultimately the implementation for a future Covid-19  
24 vaccination programme.

25 As a director general of the Department for  
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1 the rollout of the vaccination programme in Northern  
2 Ireland faced. And we also accept that many of these  
3 challenges were successfully faced and overcome.  
4 Vaccination centres were established, and processes were  
5 put in place that allowed vaccines to be distributed to  
6 these centres as well as GPs and community pharmacies.

7 You will have noted Dr Chantler's specific approval  
8 during the course of her expert evidence of Northern  
9 Ireland's "very novel approach of a twin-track approach  
10 ... whereby different priority groups could either go to  
11 the trust or to the GP surgery at the same time".

12 That said, the approach we urge upon the Inquiry,  
13 and other Core Participants from the north of Ireland is  
14 not simply to comment or congratulate themselves on the  
15 considerable efforts that were undeniably made by those  
16 involved in the Northern Irish vaccination programme,  
17 but to examine whether the rollout of that programme  
18 could have been improved as far as Northern Ireland was  
19 concerned, in order to hopefully learn the lessons to  
20 stop history repeating itself, and put those involved on  
21 the front foot, rather than the back foot, when, sadly,  
22 those efforts will again be required in the future.

23 My Lady, this isn't just a topic for academic study.  
24 In describing the difficulties caused by the fact that  
25 GP practices were initially unable to handle the Pfizer  
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1 Business, Energy and Industrial Strategy,  
2 Ms Alexandra Jones, told you, this didn't ensure more  
3 than limited Irish involvement in the early phase of the  
4 UK Vaccine Taskforce at around the same time.

5 My Lady, will recall that Ms Jones told you that  
6 although there were "conversations" that were happening  
7 within the devolved administrations, we didn't join them  
8 up because of the inevitable growing pains of  
9 establishing a Vaccine Taskforce.

10 And Ms Jones offered this to you as something she  
11 would specifically want to learn from in the future.

12 But back to the Oversight Board. Whilst both  
13 Dr Chada and Dr Donnelly were participants in the  
14 Oversight Board, it was not until October 2020 that  
15 Dr Donnelly was appointed as the head of the vaccination  
16 programme to oversee and drive the planning and  
17 operation and delivery of the programme. And  
18 furthermore, in his evidence to you, Dr Chada stated  
19 that even then, he and Dr Donnelly had to work with what  
20 he described as "a relatively small core team of people  
21 in the department to try to get the vaccination  
22 programme up and running."

23 And Dr Chada told you, and we have seen nothing to  
24 indicate to the contrary, that notwithstanding the small  
25 infrastructure, he and Dr Donnelly really worked quite  
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1 well together. But the question we ask the Inquiry to  
2 consider is whether the system might have worked better  
3 had it been on the front foot from the outset, and not  
4 on the back foot because of the lack of vaccination  
5 lead, and the, perhaps, surprisingly late appointment of  
6 Dr Donnelly as head of the vaccination programme many  
7 months after, it must have been clear, that  
8 a vaccination programme was inevitably going to be  
9 necessary.

10 And perhaps as an example of the Northern Irish  
11 Public Health Authority being on the back foot in terms  
12 of their vaccination plans in 2020, the Inquiry will  
13 recall Dr Chada's uncertainty as to whether Northern  
14 Ireland ever had its own public vaccine plan, and his  
15 acceptance that, given the significance of communication  
16 in vaccine delivery, such a written document, which is  
17 there and available for people to see, is -- perhaps an  
18 understatement -- really important.

19 Dr Chada also explained that prior to the pandemic,  
20 Northern Ireland had no single IT system that captured  
21 vaccination data. This necessitated the development of  
22 the Vaccine Management System, which although  
23 operational by early December 2020, required what  
24 Dr Chada described as "quite a lot of refinement and  
25 development and improvement of its capabilities to

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1 You know from your travels that Northern Ireland has  
2 some of the most socially deprived areas in the  
3 United Kingdom. Plainly, as Professor Sir Chris Whitty  
4 told you, bringing data together in this area is vital,  
5 but so is transparency, particularly given  
6 Dr Kasstan-Dabush's observations to you for the need for  
7 alignment of how data is collected and stored if we are  
8 going to be able to identify trends and/or evaluate  
9 success in this area on a UK-wide basis.

10 My Lady, before I finish, can I deal with one  
11 discrete topic which affects the whole of the UK. My  
12 Lady has heard evidence in relation to Parliament's  
13 Vaccine Damage Payment Scheme. It is unfortunate that,  
14 as we understand the evidence, Parliament has not  
15 revisited the threshold and the amount of the award of  
16 this scheme since 2007. It certainly seems to those  
17 I represent, that Ms Scott from the Vaccine Injured  
18 Bereaved UK had a point when she described the scheme as  
19 it presently stands as not fit for purpose.

20 And accordingly, we urge you to consider carefully  
21 how your Ladyship can best, most effectively reflect  
22 this similar evidence for the need for reform in this  
23 area that you heard from Lord Sharma and other  
24 witnesses, notwithstanding the obvious point that,  
25 plainly, the Parliamentary origin of the scheme and the

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1 ensure timely access to timely and reliable uptake  
2 data."

3 Now, Dr Donnelly, in her written statement, I seek  
4 to remind you, described the lack of such a system at  
5 the beginning of the vaccine programme as "a major  
6 drawback", and your Ladyship will recall that  
7 immediately after Dr Chada gave evidence, Dr Chantler  
8 described to you how having these systems in place was  
9 extremely crucial. We ask your Ladyship to bear those  
10 points in mind when considering some of the submissions  
11 your Ladyship heard earlier on this afternoon from the  
12 Department of Health about this system.

13 In relation to data, you heard Dr Chantler repeat to  
14 you what other witnesses have sadly told you in relation  
15 to other modules: we don't have as much access to  
16 evaluations under the Northern Ireland devolved  
17 administration as we do in relation to the other three.  
18 It's a recurring theme.

19 In spite of these data, and we submit therefore,  
20 transparency limitations, Dr Chada gave a relatively  
21 positive review of the work that the Northern Ireland  
22 low uptake group were able to do in dealing with low  
23 uptake among identified occupational groups, ethnic  
24 minorities, and areas of social deprivation in Northern  
25 Ireland.

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1 fact that it may be thought questions on the extent and  
2 detail of it are inevitably political questions  
3 involving both Parliament and the payment of public  
4 monies.

5 But in conclusion, we say that the three issues of  
6 Northern Ireland's relationship and input into UK-wide  
7 bodies, the effect of the historical, systemic and  
8 structural failings within Northern Ireland's political  
9 and health systems you are all too aware, and the  
10 weaknesses of its data collection systems, have all  
11 featured in previous modules you have dealt with and,  
12 I dare say, may feature in modules to come.

13 At this stage, in relation to this module, I'm  
14 conscious that we will be lodging written submissions at  
15 a later stage, which will include suggested  
16 recommendations for the future. That is all I now  
17 propose to say on behalf of the Northern Ireland Covid  
18 Bereaved Families for Justice. We are very grateful for  
19 the opportunity of addressing you.

20 **LADY HALLETT:** Thank you very much indeed, Mr Wilcock.

21 Ms Mitchell, if you'd like to go tonight, I'm very  
22 happy to sit until quarter to.

23 **DR MITCHELL:** My Lady might be not be surprised to know THAT  
24 it's not going to take me to quarter to.

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1 **Closing statement on behalf of the Scottish Covid Bereaved**

2 **by DR MITCHELL**

3 **DR MITCHELL:** I present these submissions as instructed by  
4 Aamer Anwar & Company on behalf of the Scottish Covid  
5 Bereaved. The Scottish Covid Bereaved understand how  
6 lucky we are to have this module on vaccines. Our  
7 collective experience would look very different had  
8 a Covid vaccine not be found.

9 Given we don't know what the next pandemic will be,  
10 we can only hope that we will find a vaccine for  
11 Disease X, but hope isn't necessary, however, to ensure  
12 that, when the time comes, there are processes and  
13 procedures in place to ensure that the vaccines are  
14 developed and deployed at a pace to those who require it  
15 most first, and the rest of society as soon as possible  
16 thereafter.

17 In order for that to be done, there are various  
18 recommendations that the Scottish Covid Bereaved will  
19 make in writing to the chair. Before then, we wish to  
20 make the following four points.

21 One, at the outset of the Inquiry there was  
22 discussion about the use of the term "vaccine hesitancy"  
23 and it was suggested that "vaccine scepticism" might be  
24 a better term. Having listened to the experts, we  
25 suggest that the best term is that of "vaccine

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1 them vulnerable to Disease X, be it age, gender, race,  
2 physical or learning disability or any other definable  
3 data source that we can identify.

4 Data must be harnessed as a valuable vaccine and  
5 therapeutic tool.

6 Three, the Chair has remarked on occasion that so  
7 many interactions and decisions come down to individual  
8 relationships with people rather than governmental  
9 structures. We saw that perhaps no more clearly than  
10 when Dame Kate Bingham explained how she had navigated  
11 the governmental process.

12 Whilst, alas, we cannot ensure that everyone who  
13 governs is competent, we can listen to experts like  
14 Dame Kate Bingham and Dr Clive Dix, who are, about how  
15 best to prepare for the next pandemic.

16 It may come as no surprise that the Scottish Covid  
17 Bereaved support the idea of a national vaccine agency  
18 and having someone in government who understands  
19 vaccines.

20 We hear the concerns about cost and independence of  
21 government, but we also know that from all the  
22 innovations, and speedy changes that occurred forced by  
23 the necessity of a pandemic, that where there is  
24 a public will, there is a political way.

25 Four, in relation to barriers to uptake, in addition

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1 confidence", which people may have to a greater or  
2 lesser extent. Some members of the Scottish Covid  
3 Bereaved, for example, were not confident that they had  
4 enough information to make informed decisions about the  
5 vaccine. In particular, those with pre-existing health  
6 conditions or pregnant women. Concern was also  
7 expressed about vaccinating younger people.

8 We don't know what Disease X will be, but we can be  
9 sure that the best inoculation we have against it at  
10 present is education. With education and engagement,  
11 vaccine confidence may be fostered. In doing so,  
12 misinformation and disinformation that abounds in  
13 relation to Covid vaccines may be challenged.

14 It is imperative that prior to the next pandemic as  
15 much as possible is done in relation to public health  
16 messaging to ensure that the public has confidence in  
17 vaccines and the system of dispersal of vaccines in  
18 a fair way, which protects the most vulnerable first and  
19 the least vulnerable last, to protect us all in the  
20 process.

21 Two, a further important issue, a recurring one, is  
22 the need to provide data systems. It stands to reason  
23 that, in order to provide vaccines and therapeutics such  
24 as antivirals, pending vaccines to the most vulnerable,  
25 we must be able to quickly identify whatever might make

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1 to fostering confidence we will make recommendations  
2 about vaccines and therapeutics might be best delivered  
3 in Scotland, bearing in mind its rural and island  
4 communities. Perhaps providing a good practical example  
5 of public will leading to a political way that I  
6 forementioned, the Chair may be pleased to hear that  
7 since the evidence given by Melanie Newdick on behalf of  
8 the Scottish Covid Bereaved, routine vaccine delivery is  
9 to be restored to Highland GPs, trusted and local  
10 healthcare providers, following an intervention by the  
11 Health Secretary.

12 In conclusion, science can and hopefully will  
13 provide an effective vaccine come the next pandemic, but  
14 vials of vaccines and antivirals will be useless unless  
15 they are used, and in order to do so, we must ensure  
16 that we have confidence in them, and trust in those who  
17 provide and administer them. The recommendations of the  
18 Scottish Covid Bereaved will focus on how to ensure that  
19 we are best placed to foster these sentiments in all  
20 communities to inoculate us from the next pandemic.

21 These are the submissions on behalf of the Scottish  
22 Covid Bereaved.

23 **LADY HALLETT:** Thank you very much indeed, Ms Mitchell, and  
24 thank you for telling me about the intervention of the  
25 Health Secretary. That's one good thing that's come out

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1 of this Inquiry so far. So thank you very much indeed.  
 2 **DR MITCHELL:** Indeed, my Lady, and I think the Scottish  
 3 Covid Bereaved were delighted that such a practical  
 4 effect has happened immediately, and people may be  
 5 protected as a result of that in the future.

6 **LADY HALLETT:** Thank you.  
 7 Very well, I shall rise now and return at 10.00  
 8 tomorrow morning, please.

9 **(4.34 pm)**  
 10 **(The hearing adjourned until 10.00 am the following day)**

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<b>MR KEITH: [8]</b> 1/4 1/8 13/22 25/20 31/18 34/24 40/23 102/12	<b>1,000 doses [1]</b> 154/8 <b>1.3 million [1]</b> 9/17 <b>1.45 [2]</b> 102/13 102/17		<b>8 December [1]</b> 176/8 <b>8 December 2020 [2]</b> 108/10 173/5 <b>8 January 2021 [1]</b> 111/2 <b>8.3 [1]</b> 37/25 <b>80 [1]</b> 176/19 <b>82 [3]</b> 173/7 181/11 194/17 <b>84 [1]</b> 6/6 <b>85-year [1]</b> 176/8	
<b>MR MANSELL: [4]</b> 68/8 68/14 80/23 97/19	<b>10 [1]</b> 54/14 <b>10 February 2021 [1]</b> 76/2 <b>10,000 Travellers [1]</b> 162/25		<b>9</b>	
<b>MR RAWAT: [1]</b> 120/7	<b>10.00 [3]</b> 1/2 209/7 209/10	<b>2</b>	<b>90 [1]</b> 111/2 <b>90,000 [1]</b> 175/21 <b>99.8 [1]</b> 157/24	
<b>MR STANTON: [1]</b> 141/22	<b>101 [1]</b> 9/15 <b>11 [1]</b> 176/16 <b>11 January [1]</b> 176/17 <b>11 January 2021 [1]</b> 155/5 <b>11.01 [1]</b> 41/5 <b>11.20 [2]</b> 41/4 41/7 <b>12 [2]</b> 50/13 181/6 <b>12 hours [1]</b> 154/8 <b>12 January 2021 [1]</b> 175/17 <b>12,300 people [1]</b> 176/18 <b>12.43 [1]</b> 102/15 <b>123,000 deaths [1]</b> 142/5 <b>124 [1]</b> 167/25 <b>13,000 [1]</b> 153/20 <b>134 [1]</b> 168/5 <b>136 [2]</b> 61/25 168/5 <b>138,000 AstraZeneca [1]</b> 179/22 <b>15 [2]</b> 72/10 74/10 <b>15 December 2024 [1]</b> 1/13 <b>16 [1]</b> 50/22 <b>16 February 2021 [1]</b> 173/6 <b>16 January [4]</b> 112/25 161/9 163/9 170/7 <b>1600 [1]</b> 9/14 <b>16th [2]</b> 168/18 173/19 <b>17 March 2022 [1]</b> 88/6 <b>17 November 2020 [1]</b> 100/7 <b>174 [1]</b> 105/23 <b>18 January 2021 [1]</b> 174/21 <b>18 May [1]</b> 54/3 <b>18 months [1]</b> 89/4 <b>18 November 2024 [1]</b> 41/15	<b>2 years [1]</b> 89/4 <b>20 [1]</b> 11/3 <b>20 deaths [1]</b> 173/4 <b>200 [3]</b> 71/6 72/9 74/9 <b>200,000 [1]</b> 46/17 <b>2001 [1]</b> 69/22 <b>2007 [1]</b> 203/16 <b>2011 [1]</b> 33/13 <b>2012 [2]</b> 105/24 168/20 <b>2016 [1]</b> 144/9 <b>2017 [1]</b> 186/11 <b>2018 [1]</b> 137/18 <b>2020 [29]</b> 8/14 8/15 8/18 21/24 27/11 32/2 43/16 69/2 69/9 71/24 74/12 85/15 87/19 92/21 100/7 107/24 108/10 147/21 161/2 163/19 173/5 175/7 177/6 177/21 185/11 199/20 200/14 201/12 201/23 <b>2021 [41]</b> 8/16 22/1 39/8 49/7 49/10 50/2 50/3 50/7 50/10 50/15 61/7 69/10 75/16 76/2 77/23 87/19 111/2 135/23 135/24 142/4 143/3 151/20 154/12 154/19 155/5 167/23 173/3 173/6 173/19 174/2 174/17 174/21 175/17 177/22 179/17 179/21 179/23 180/1 181/6 182/24 194/17 <b>2022 [13]</b> 22/1 24/12 46/16 54/2 54/6 57/24 58/5 59/6 61/7 66/12 81/21 88/6 166/12 <b>2023 [1]</b> 43/18 <b>2024 [3]</b> 1/13 41/15	<b>3</b>	
<b>MR WAGNER: [2]</b> 35/3 37/17	<b>10,000 [3]</b> 1/2 209/7 209/10	<b>2B [1]</b> 177/11	<b>3.07 [1]</b> 160/2 <b>3.24 [1]</b> 160/4 <b>3.25 [1]</b> 160/1 <b>30 [1]</b> 19/7 <b>30 January 2025 [1]</b> 1/1 <b>30 May [1]</b> 54/6 <b>30 years [1]</b> 190/24 <b>300 metric tonnes [1]</b> 26/7 <b>300,000 [1]</b> 175/20 <b>39 and [1]</b> 42/25 <b>39-year-old [1]</b> 193/18	
<b>MR WEATHERBY: [1]</b> 184/1	<b>101 [1]</b> 9/15 <b>11 [1]</b> 176/16 <b>11 January [1]</b> 176/17 <b>11 January 2021 [1]</b> 155/5 <b>11.01 [1]</b> 41/5 <b>11.20 [2]</b> 41/4 41/7 <b>12 [2]</b> 50/13 181/6 <b>12 hours [1]</b> 154/8 <b>12 January 2021 [1]</b> 175/17 <b>12,300 people [1]</b> 176/18 <b>12.43 [1]</b> 102/15 <b>123,000 deaths [1]</b> 142/5 <b>124 [1]</b> 167/25 <b>13,000 [1]</b> 153/20 <b>134 [1]</b> 168/5 <b>136 [2]</b> 61/25 168/5 <b>138,000 AstraZeneca [1]</b> 179/22 <b>15 [2]</b> 72/10 74/10 <b>15 December 2024 [1]</b> 1/13 <b>16 [1]</b> 50/22 <b>16 February 2021 [1]</b> 173/6 <b>16 January [4]</b> 112/25 161/9 163/9 170/7 <b>1600 [1]</b> 9/14 <b>16th [2]</b> 168/18 173/19 <b>17 March 2022 [1]</b> 88/6 <b>17 November 2020 [1]</b> 100/7 <b>174 [1]</b> 105/23 <b>18 January 2021 [1]</b> 174/21 <b>18 May [1]</b> 54/3 <b>18 months [1]</b> 89/4 <b>18 November 2024 [1]</b> 41/15	<b>3</b>	<b>4</b>	<b>A</b>
<b>MR WILCOCK: [1]</b> 195/19	<b>10.00 [3]</b> 1/2 209/7 209/10	<b>1945 [1]</b> 26/6 <b>1950s [1]</b> 26/8 <b>1960s [1]</b> 26/9	<b>4 January 2021 [1]</b> 180/1 <b>4.34 [1]</b> 209/9 <b>40 [1]</b> 159/14 <b>400 community [1]</b> 104/9 <b>44 weeks [1]</b> 42/23 <b>45-50 [1]</b> 42/25 <b>465 [1]</b> 173/2 <b>48 hours [1]</b> 27/15	<b>Aamer [1]</b> 205/4 <b>abandoned [2]</b> 160/21 186/16 <b>ability [12]</b> 75/3 81/24 83/17 93/1 102/1 106/25 108/24 127/1 140/12 156/17 157/14 163/24 <b>abject [1]</b> 186/22 <b>able [33]</b> 4/5 4/21 33/23 38/25 47/12 47/12 47/25 48/8 60/12 61/16 63/3 64/15 95/5 103/19 105/4 107/17 108/1 108/12 109/11 110/25 124/4 124/9 125/24 140/18 143/19 156/18 162/12 165/10 180/10 197/10 202/22 203/8 206/25 <b>abounds [1]</b> 206/12 <b>about [108]</b> 7/12 8/9 9/7 11/8 16/17 18/7 21/22 21/25 23/23 24/11 30/7 34/3 34/14 35/8 37/1 37/5 38/22 38/24 42/23 43/14 45/2 49/2 49/10 51/3 55/2 56/17 57/5 57/11 58/11 62/11 63/11 66/21 67/9 70/10 70/20 71/9 73/25 74/18 75/20 78/2 79/3 79/8 81/18 82/1 82/13
<b>MS DOMINGO: [1]</b> 152/12	<b>10.00 [3]</b> 1/2 209/7 209/10	<b>1945 [1]</b> 26/6 <b>1950s [1]</b> 26/8 <b>1960s [1]</b> 26/9	<b>5</b>	
<b>MS DOUGLAS: [2]</b> 65/20 67/19	<b>101 [1]</b> 9/15 <b>11 [1]</b> 176/16 <b>11 January [1]</b> 176/17 <b>11 January 2021 [1]</b> 155/5 <b>11.01 [1]</b> 41/5 <b>11.20 [2]</b> 41/4 41/7 <b>12 [2]</b> 50/13 181/6 <b>12 hours [1]</b> 154/8 <b>12 January 2021 [1]</b> 175/17 <b>12,300 people [1]</b> 176/18 <b>12.43 [1]</b> 102/15 <b>123,000 deaths [1]</b> 142/5 <b>124 [1]</b> 167/25 <b>13,000 [1]</b> 153/20 <b>134 [1]</b> 168/5 <b>136 [2]</b> 61/25 168/5 <b>138,000 AstraZeneca [1]</b> 179/22 <b>15 [2]</b> 72/10 74/10 <b>15 December 2024 [1]</b> 1/13 <b>16 [1]</b> 50/22 <b>16 February 2021 [1]</b> 173/6 <b>16 January [4]</b> 112/25 161/9 163/9 170/7 <b>1600 [1]</b> 9/14 <b>16th [2]</b> 168/18 173/19 <b>17 March 2022 [1]</b> 88/6 <b>17 November 2020 [1]</b> 100/7 <b>174 [1]</b> 105/23 <b>18 January 2021 [1]</b> 174/21 <b>18 May [1]</b> 54/3 <b>18 months [1]</b> 89/4 <b>18 November 2024 [1]</b> 41/15	<b>5 billion [1]</b> 126/11 <b>5 June [1]</b> 28/20 <b>5-year [1]</b> 133/22 <b>5.26 [1]</b> 35/12 <b>5.29 [1]</b> 35/12 <b>5.39 [1]</b> 35/19 <b>5.69 [1]</b> 38/23 <b>50 [3]</b> 42/25 157/8 182/22 <b>55 [2]</b> 62/1 167/8 <b>58 [1]</b> 167/2 <b>59 [2]</b> 167/2 167/5		
<b>MS DRYSDALE: [2]</b> 130/10 130/14	<b>10.00 [3]</b> 1/2 209/7 209/10	<b>1945 [1]</b> 26/6 <b>1950s [1]</b> 26/8 <b>1960s [1]</b> 26/9	<b>6</b>	
<b>MS MURNAGHAN: [2]</b> 102/20 102/23	<b>101 [1]</b> 9/15 <b>11 [1]</b> 176/16 <b>11 January [1]</b> 176/17 <b>11 January 2021 [1]</b> 155/5 <b>11.01 [1]</b> 41/5 <b>11.20 [2]</b> 41/4 41/7 <b>12 [2]</b> 50/13 181/6 <b>12 hours [1]</b> 154/8 <b>12 January 2021 [1]</b> 175/17 <b>12,300 people [1]</b> 176/18 <b>12.43 [1]</b> 102/15 <b>123,000 deaths [1]</b> 142/5 <b>124 [1]</b> 167/25 <b>13,000 [1]</b> 153/20 <b>134 [1]</b> 168/5 <b>136 [2]</b> 61/25 168/5 <b>138,000 AstraZeneca [1]</b> 179/22 <b>15 [2]</b> 72/10 74/10 <b>15 December 2024 [1]</b> 1/13 <b>16 [1]</b> 50/22 <b>16 February 2021 [1]</b> 173/6 <b>16 January [4]</b> 112/25 161/9 163/9 170/7 <b>1600 [1]</b> 9/14 <b>16th [2]</b> 168/18 173/19 <b>17 March 2022 [1]</b> 88/6 <b>17 November 2020 [1]</b> 100/7 <b>174 [1]</b> 105/23 <b>18 January 2021 [1]</b> 174/21 <b>18 May [1]</b> 54/3 <b>18 months [1]</b> 89/4 <b>18 November 2024 [1]</b> 41/15	<b>6,000 [1]</b> 79/8 <b>60 weeks [1]</b> 42/25		
<b>MS PARSONS: [2]</b> 172/12 182/18	<b>101 [1]</b> 9/15 <b>11 [1]</b> 176/16 <b>11 January [1]</b> 176/17 <b>11 January 2021 [1]</b> 155/5 <b>11.01 [1]</b> 41/5 <b>11.20 [2]</b> 41/4 41/7 <b>12 [2]</b> 50/13 181/6 <b>12 hours [1]</b> 154/8 <b>12 January 2021 [1]</b> 175/17 <b>12,300 people [1]</b> 176/18 <b>12.43 [1]</b> 102/15 <b>123,000 deaths [1]</b> 142/5 <b>124 [1]</b> 167/25 <b>13,000 [1]</b> 153/20 <b>134 [1]</b> 168/5 <b>136 [2]</b> 61/25 168/5 <b>138,000 AstraZeneca [1]</b> 179/22 <b>15 [2]</b> 72/10 74/10 <b>15 December 2024 [1]</b> 1/13 <b>16 [1]</b> 50/22 <b>16 February 2021 [1]</b> 173/6 <b>16 January [4]</b> 112/25 161/9 163/9 170/7 <b>1600 [1]</b> 9/14 <b>16th [2]</b> 168/18 173/19 <b>17 March 2022 [1]</b> 88/6 <b>17 November 2020 [1]</b> 100/7 <b>174 [1]</b> 105/23 <b>18 January 2021 [1]</b> 174/21 <b>18 May [1]</b> 54/3 <b>18 months [1]</b> 89/4 <b>18 November 2024 [1]</b> 41/15			
<b>MS WILLIAMS: [3]</b> 41/9 41/13 65/14	<b>10.00 [3]</b> 1/2 209/7 209/10	<b>1945 [1]</b> 26/6 <b>1950s [1]</b> 26/8 <b>1960s [1]</b> 26/9		
<b>PROFESSOR THOMAS: [5]</b> 37/22 40/7 99/18 101/19 112/18	<b>101 [1]</b> 9/15 <b>11 [1]</b> 176/16 <b>11 January [1]</b> 176/17 <b>11 January 2021 [1]</b> 155/5 <b>11.01 [1]</b> 41/5 <b>11.20 [2]</b> 41/4 41/7 <b>12 [2]</b> 50/13 181/6 <b>12 hours [1]</b> 154/8 <b>12 January 2021 [1]</b> 175/17 <b>12,300 people [1]</b> 176/18 <b>12.43 [1]</b> 102/15 <b>123,000 deaths [1]</b> 142/5 <b>124 [1]</b> 167/25 <b>13,000 [1]</b> 153/20 <b>134 [1]</b> 168/5 <b>136 [2]</b> 61/25 168/5 <b>138,000 AstraZeneca [1]</b> 179/22 <b>15 [2]</b> 72/10 74/10 <b>15 December 2024 [1]</b> 1/13 <b>16 [1]</b> 50/22 <b>16 February 2021 [1]</b> 173/6 <b>16 January [4]</b> 112/25 161/9 163/9 170/7 <b>1600 [1]</b> 9/14 <b>16th [2]</b> 168/18 173/19 <b>17 March 2022 [1]</b> 88/6 <b>17 November 2020 [1]</b> 100/7 <b>174 [1]</b> 105/23 <b>18 January 2021 [1]</b> 174/21 <b>18 May [1]</b> 54/3 <b>18 months [1]</b> 89/4 <b>18 November 2024 [1]</b> 41/15			
<b>THE WITNESS: [5]</b> 40/13 40/22 68/5 102/6 102/8	<b>101 [1]</b> 9/15 <b>11 [1]</b> 176/16 <b>11 January [1]</b> 176/17 <b>11 January 2021 [1]</b> 155/5 <b>11.01 [1]</b> 41/5 <b>11.20 [2]</b> 41/4 41/7 <b>12 [2]</b> 50/13 181/6 <b>12 hours [1]</b> 154/8 <b>12 January 2021 [1]</b> 175/17 <b>12,300 people [1]</b> 176/18 <b>12.43 [1]</b> 102/15 <b>123,000 deaths [1]</b> 142/5 <b>124 [1]</b> 167/25 <b>13,000 [1]</b> 153/20 <b>134 [1]</b> 168/5 <b>136 [2]</b> 61/25 168/5 <b>138,000 AstraZeneca [1]</b> 179/22 <b>15 [2]</b> 72/10 74/10 <b>15 December 2024 [1]</b> 1/13 <b>16 [1]</b> 50/22 <b>16 February 2021 [1]</b> 173/6 <b>16 January [4]</b> 112/25 161/9 163/9 170/7 <b>1600 [1]</b> 9/14 <b>16th [2]</b> 168/18 173/19 <b>17 March 2022 [1]</b> 88/6 <b>17 November 2020 [1]</b> 100/7 <b>174 [1]</b> 105/23 <b>18 January 2021 [1]</b> 174/21 <b>18 May [1]</b> 54/3 <b>18 months [1]</b> 89/4 <b>18 November 2024 [1]</b> 41/15			
'				
<b>'I [1]</b> 90/14 <b>'I think [1]</b> 90/14				
-				
<b>-- and [1]</b> 171/4				

<p><b>A</b></p> <p><b>about...</b> [63] 82/14 85/9 85/20 87/3 87/15 87/17 87/21 87/24 89/13 89/17 90/8 90/22 90/22 91/4 92/18 93/16 94/19 94/21 96/1 96/21 97/20 98/10 98/23 99/3 101/5 103/11 105/12 106/7 107/22 110/4 113/15 115/2 117/8 124/15 124/16 125/1 125/3 143/17 147/3 148/16 157/16 162/1 163/9 163/14 164/16 165/15 173/25 177/7 182/19 183/13 184/25 186/25 190/22 197/11 199/15 202/12 205/22 206/4 206/7 207/14 207/20 208/2 208/24</p> <p><b>abroad</b> [1] 117/6</p> <p><b>absence</b> [4] 9/2 63/15 63/23 187/6</p> <p><b>absent</b> [1] 64/6</p> <p><b>absolutely</b> [14] 31/9 61/23 73/24 74/21 77/4 84/10 85/22 90/19 93/6 93/9 98/25 98/25 159/19 176/21</p> <p><b>abuse</b> [1] 149/18</p> <p><b>academia</b> [5] 93/7 97/1 128/2 128/11 129/6</p> <p><b>academic</b> [2] 122/25 198/23</p> <p><b>accept</b> [2] 197/24 198/2</p> <p><b>acceptance</b> [1] 201/15</p> <p><b>accepted</b> [3] 168/11 187/12 188/13</p> <p><b>accepts</b> [2] 20/3 20/8</p> <p><b>access</b> [46] 31/16 38/16 43/3 43/9 43/22 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