IN THE UK COVID-19 INQUIRY

MODULE 4

CLOSING STATEMENT ON BEHALF OF

CLINICALLY VULNERABLE FAMILIES ('CVF')

A. INTRODUCTION

1. This is the closing statement of Clinically Vulnerable Families ('**CVF**'). CVF was founded in August 2020 and currently represents those who are clinically vulnerable ('**CV**'), clinically extremely vulnerable ('**CEV**') and the severely immunosuppressed,[1] as well as their households, across all four nations (collectively referred to as '**Clinically Vulnerable**'). This group of vulnerable individuals were, and remain, at higher risk of severe outcomes from the disease, such as greater mortality[2] and long Covid,[3] than the greater population.

2. The vast majority of people who died in the pandemic were vulnerable and there are still hundreds of people, mostly Clinically Vulnerable, dying each week from Covid-19. The emergency phase of the pandemic may have passed, but for Clinically Vulnerable people the pandemic is by no means over. Many vulnerable individuals continue to shield and lead limited lives to this day and in a world in which continually evolving Covid-19 variants pose an ongoing and insufficiently mitigated threat, Clinically Vulnerable people – more than any other group – continue to need the protection of the Covid-19 vaccine, prophylactics and therapeutics. This is why the Inquiry, and Module 4 in particular, is so important to many Clinically Vulnerable people.

3. CVF is grateful that the Inquiry requested and obtained written and oral evidence from CVF. CVF, through this evidence, has sought to provide a voice to a large group of people who have been largely forgotten since the inaptly named 'Freedom Day'. Considered in total, the evidence in Module 4 has highlighted the uneven impact of the pandemic on Clinically Vulnerable people, with the gap ever widening between healthy people for whom the vaccine programme provided a route out of the pandemic and the Clinically Vulnerable who were either completely left behind, or not sufficiently protected by the vaccine and therapeutics programme. As to recommendations, there is an urgent need to restore trust and confidence that the lives and wellbeing of all Clinically Vulnerable people matter, and that their distinct concerns and needs will be addressed, both now and in a future pandemic.

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[1] These terms are used as they were during the acute stage of the pandemic according to the contemporaneous government definitions. Where CEV is referred to below, that category should be taken to include the severely immunosuppressed.
[2] Information from the Office for National Statistics titled Pre-existing conditions of people who died due to Covid-19, England and Wales, Quarter 1 (January to March) 2023, dated 25/04/2023 [INQ000408875].
[3] All data from the Office for National Statistics relating to Prevalence of ongoing Symptoms following coronavirus (COVID-19) infection in the UK: 30 March 2023, dated 30/03/2023 [INQ000408796].

4. Throughout this module, CVF has shared the experiences and perspectives of Clinically Vulnerable people in order to demonstrate the impact the vaccine and therapeutics programme had on them, which is distinct from the impact it had on other vulnerable groups. It is hoped that in doing so the Inquiry will understand why one of CVF's central recommendation proposals is for equality legislation to be strengthened, including through recommending that clinical vulnerability be included as a distinct protected characteristic. Throughout this statement CVF also proposes a number of targeted recommendations on issues specifically impacting all Clinically Vulnerable people and which are designed to assist the Inquiry.

5. This statement addresses CVF's concerns in relation to the following five topics: (1) vaccine delivery, (2) vaccination of children, (3) prophylactics, (4) antivirals, and (5) the overall approach to vaccines compared to therapeutics.

B. VACCINE DELIVERY

6. The initial roll out of the Covid-19 vaccination programme was full of promise. For many Clinically Vulnerable people, particularly those who were still shielding,[4] the vaccine offered reassurance, safety, and the first opportunity to see a way back to normal life. At this time no one knew how much protection the new vaccines might offer.

7. Overall the vaccine programme must be celebrated for the hundreds of thousands of lives saved and the millions of people protected from severe illness as a result.[5] The dedication and tireless efforts of all those involved in the development, procurement and delivery of the Covid-19 vaccine must also be recognised. Covid-19 vaccines continue to protect millions of people: the virus has been surging this Winter and the vaccination programme, though it is more limited than CVF would like it to be, is one of the most important tools available to reduce serious illness and death. CVF is keen to ensure we do not lose sight of, or take for granted, the critical importance of the Covid-19 vaccine, and vaccination programmes generally, to the public health of the UK.

8. However, whilst recognising the central role played by Covid-19 vaccines in protecting the UK population, CVF submits there were clear failings in the delivery of the vaccine, many of which could have been avoided had the needs of Clinically Vulnerable people been considered from the outset.

Eligibility

9. CEV and CV people were, rightly, amongst the first to receive a vaccination and CVF welcomed their inclusion in the priority cohorts, although CVF submits that CV people should have been prioritised immediately after CEV people, rather than behind those aged over 65 years of age.

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[4] This includes CEV people who were formally shielding as well as those who were informally shielding, including both CV people and healthy people who were protecting a vulnerable household member.
[5] Report from UK Health Security Agency, 'COVID-19 vaccine surveillance report', dated 30/09/2021 [INQ000223938].

10. However, as contributions to Every Story Matters (**'ESM'**) illustrate, many CV and CEV people questioned why other members of their household were not offered a vaccine sooner, and prioritised ahead of younger age groups, once CV and CEV people had received a vaccine. They propose that vaccinating household contacts of Clinically Vulnerable people would have reduced their chances of catching Covid-19.[6] While CVF welcomed the prioritisation of household contacts of severely immunosuppressed people, which came later in the vaccine rollout,[7] CVF submits that this did not go far enough in protecting CV people who are not immunosuppressed, particularly given the evidence that the Covid-19 vaccines succeeded in reducing transmission of the virus, at least against the earlier variants.[8] CVF submits that household contacts of CEV and CV people should have been offered a vaccine in a cohort which **immediately followed** the CEV and CV cohorts, and ahead of otherwise healthy age groups, in order to reduce transmission to Clinically Vulnerable people, whilst not delaying the vaccination of CEV and CV people.

11. The Inquiry heard from Professor Wei Shen Lim and Clive Dix that the protection offered by the Covid-19 vaccines, particularly mRNA vaccines, wanes after 5-6 months.[9] Professor Wei Shen Lim also confirmed that Covid-19 had not transitioned into a seasonal virus like influenza.[10] In light of this evidence, CVF submits that Clinically Vulnerable people must continue to be prioritised for vaccination going forward. CVF is deeply concerned that Clinically Vulnerable people who are not immunosuppressed will be prevented from accessing the Covid-19 vaccine from the Autumn of 2025[11] and submit that this will remove protection from millions of people who, due to risk factors such as health or age, remain vulnerable to Covid-19.

12. Dame Kate Bingham,[12] Sir Munir Pirmohamed[13] and Clive Dix[14] have all emphasised the importance of not relying on one particular vaccine format, such as mRNA, and that it is "*very important*" to develop "*a portfolio of vaccines with different routes of administration*", both intramuscular and nasal.

13. Proposed recommendations: (a) ongoing eligibility for Covid-19 vaccination should be reviewed in consultation with organisations who represent Clinically Vulnerable people to consider whether the current proposals provide adequate protection for Clinically Vulnerable people most at risk of severe outcomes from Covid-19, including Clinically Vulnerable children (see further below). (b) Work to identify and procure a diverse Covid-19 vaccine portfolio must be maintained, particularly the search for more robust vaccines that provide a broader and longer-lasting immunity.

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[6] Every Story Matters [INQ000474465/35-36].
[7] JCVI letter regarding considerations on COVID-19 vaccination of adult household contacts of severely immunosuppressed adults, dated 24/03/2021 [INQ000354494].
[8] Professor Prieto-Alhambra [7/90/2-10], [INQ000474703_0026].
[9] Professor Wei Shen Lim [8/119/16-19] and Clive Dix [12/86/2-3].
[10] [8/119/20-22].
[11] JCVI statement on COVID-19 vaccination in 2025 and spring 2026, 14 November 2024.
[12] [6/56/14-23].
[13] [11/183/16-25].
[14] [12/85/23-25] to [12/86/1-6].

14. Many of CVF's members reported confusion around their eligibility for priority vaccination. There were CEV people who were not automatically called for vaccination because they had not been recorded as CEV or the coding had not worked. Many more CV people (who were not CEV) were never officially identified and were therefore left doubting their own eligibility. CVF are concerned that these systems issues, in combination with a lack of clarity in the communications to vulnerable people, both in terms of wider public messaging and direct communications, resulted in CV and CEV people not being sufficiently aware of their status and therefore not receiving the protection of the vaccine as early as they should have done, all the while continuing risk-taking behaviours.

15. This became an even greater issue when it came to the administration of vaccine boosters and third primary doses for severely immunosuppressed people. CVF is concerned that the ever-changing eligibility[15] for vaccine boosters caused significant confusion, both among Clinically Vulnerable people whom the boosters were intended to protect and also within the health services providing these vital doses. As CVF member Juliet has explained "*I never get invited for [a booster], even though I'm eligible. Each one has been a fight to find out what is going on and when I can book one.*"[16] There was even less awareness in general practices of the third primary dose programme. For CVF member Catherine, the confusion delayed her third dose considerably and she eventually received it weeks after she should have done.[17]

16. Given the deficiencies in the data systems in operation at the start of the pandemic, it can be no surprise that CVF's members experienced these difficulties. Professor Sir Chris Whitty acknowledged that "*we entered the pandemic with a very large amount of data in a very fragmented state. And part of the problems we had in the first three to four months was that corralling the data, so you can link different bits of data together, was extremely difficult*".[18] He explained that there has always been a difficulty in linking up general practice data with secondary care data which is *"not good for patient treatment"*.[19] Dame Emily Lawson agreed that they *"didn't have entirely robust data at least initially."*[20] It would appear that little progress has been made in this regard: Matt Hancock considered that "*it's a very complicated area, and, frankly, it could do with a huge amount of improvement."*[21] It was particularly concerning to hear Professor Sir Chris Whitty say that *"we have slipped backwards since our time in the pandemic in terms of bringing data together"*.[22]

[15] CVF, Annex A [INQ000474526_0119].
[16] CVF, §38 [INQ000474526_0017].
[17] CVF, §49 [INQ000474526_0022].
[18] [5/49/5-9].
[19] [5/50/24-25] to [5/51/1-2].
[20] [9/168/7].
[21] [3/95/7-9].
[22] [5/50/1-3].

17. Proposed recommendation: CVF urges the Inquiry to make robust recommendations regarding the urgent need to dedicate time, motivation and resource to improving both the quality of healthcare data and easy, secure access to healthcare data.

Practical barriers to access

18. A significant feature of the initial rollout of the Covid-19 vaccine was the use of large vaccination centres. Many CVF members found the centres unsafe for Clinically Vulnerable people, with some members even contracting Covid-19 as a consequence. CVF are concerned that patients who were eligible for vaccination did not come forward, or did not obtain a vaccination as early as they should have done, because of their concerns about the risks of such centres.

19. CVF was particularly concerned about the severe crowding, the lack of ventilation and the poor air quality in the buildings used. These are critical factors for an airborne virus such as Covid-19 and therefore any failure to make safe the very buildings that vulnerable people had to visit in order to receive protection from the virus was unacceptable. CVF members also found that both staff and other patients were constantly removing their masks while inside the vaccination centres. As CVF member Vicky describes *"it was very scary as was very busy, masks constantly being removed. Waiting room was packed. No windows or doors open – I left without waiting 15 minutes and waited outside instead as felt unsafe."*[23] Lara Wong stressed in her oral evidence that "*this was a population who had been shielded, they had lived very limited lives, or they had shielded themselves informally, and so this was their first kind of exposure to a particular risk, and so heading into these environments was very concerning for many of CVF's members*". While there were some good examples, she said it was a "*postcode lottery*".[24]

20. Dr Kasstan-Dabush and Dr Chantler have confirmed that mass vaccination sites "*were not always suitable, and possibly not safe, for a number of vulnerable cohorts in the JCVI prioritisation list.*"[25] The experts agreed that "*clinically vulnerable people were likely to have heightened concerns about attending mass vaccination centres due to risk of transmission in places of higher footfall.*"[26]

21. Many CVF members also had to travel significant distances to vaccination centres and a pressing concern, particularly for those who had been shielding, was the risk of contracting Covid-19 associated with travelling long distances to be vaccinated, either from public transport or in the close confines of a car where they were being driven by someone who was potentially infected. CVF member Julie found that *"as a non-driver in a semi-rural area, I found it very difficult to get my first vaccine. When I discussed the issue with my GP surgery, I was told that it would be ok to travel for nearly an hour on a crowded bus to get the vaccine."*[27] As one contributor to ESM noted, *"we found that our small, isolated*

[23] CVF, §31 [INQ000474526_0014].
[24] [3/48/13-23].
[25] Dr Kasstan-Dabush and Dr Chantler, §99(b) [INQ000474623_0031].
[26] Dr Kasstan-Dabush and Dr Chantler, §250 [INQ000474623_0076].
[27] CVF, §50 [INQ000474526_0022].

village played against us, we'd have to take long bus journeys or multiple buses to get to the vaccination centre, coming into contact with more and more people."[28]

22. The former Minister for Covid-19 vaccine deployment, Nadhim Zahawi, gave oral evidence that he was not aware of the concerns about vaccine centres and suggested *"we go back and learn exactly how we can do better for the clinically most vulnerable in a pandemic"*.[29] But earlier in his evidence, he agreed that when the vaccine programme was being designed, the priority was "*efficiency and scale*".[30] CVF submits that in doing so, the programme overlooked the risks faced by Clinically Vulnerable people when trying to access a vaccine. This may be connected to the failures to appreciate early on in the pandemic that the virus was airborne.

23. Dame Emily Lawson acknowledged that some high-priority patients, such as the very elderly, would not attend large hospitals because of accessibility or transport issues, and genuine concerns about risk of infection in a large hospital given their vulnerability.[31] However, she failed to explain why these considerations were not applied equally to all Clinically Vulnerable people who – being at highest risk of severe outcomes from Covid-19 – held the same concerns about risk of infection at hospitals and large vaccination sites.

24. When asked what steps could and should have been taken to ensure the safe delivery of vaccines to Clinically Vulnerable people, expert Dr Ben Kasstan-Dabush said "*I think it's the identification, crucially [of] that vulnerable cohort and the triaging, them to the locations that make most sense i.e. not a mass vaccination centre, a primary care or an outreach site, for example, with quieter hours or hours for reduced footfall, longer appointment times.*"[32] Dr Kasstan-Dabush said that the priority of the vaccine delivery programme was to get everything up and running at pace, and while there had been consideration of social distancing, "*things got omitted and overlooked*".[33]

25. Proposed recommendations: CVF invites the Inquiry to reflect the specific experiences of Clinically Vulnerable people in relation to this important issue in its report, and to make recommendations to ensure that future pandemic responses appropriately prioritise Clinically Vulnerable people by (a) planning for which groups are likely to be Clinically Vulnerable in potential pandemics and (b) planning how such groups can safely access vaccinations by conducting appropriate risk and equality impact assessments, (c) ensuring that impact assessments for any pandemic or epidemic include the Clinically Vulnerable as a group which must be considered, which would most clearly be mandated by including the Clinically Vulnerable as a protected characteristic in the Equality Act 2010, though this could also be achieved, in this narrow context, by setting a requirement that institutions consider the Clinically Vulnerable in impact assessments.

[28] Every Story Matters [INQ000474465/41].
[29] [9/127/7-9].
[30] [9/97/2-4].
[31] [9/155/16-22].
[32] [10/205/19-24].
[33] [10/206/11-14].

C. VACCINATION OF CHILDREN

26. On 19 July 2021, the first cohorts of children were offered a Covid-19 vaccine. These were 12–15-year-olds with particular underlying health conditions and children aged 12 years and over who were household contacts of immunosuppressed people.[34] The offer was extended to all 12–15-year-olds on 13 September 2021,[35] eight months after the first adult was vaccinated. Children aged 5 to 11 years old with the same underlying health conditions, or with immunosuppressed household contacts, were offered a vaccine on 22 December 2021,[36] over a year after the first adult was vaccinated. The offer was extended to all 5–11-year-olds on 16 February 2022.[37] Children aged 6 months to 4 years old in a clinical risk group were offered a vaccine on 6 April 2023.[38] Children who were aged under 5 in September 2022 without specific underlying health conditions have never been offered a vaccine.

27. As CVF's founder, Lara Wong explained "*the risk to children impacts on the Clinically Vulnerable household, but there are also, obviously, Clinically Vulnerable children, who we very often did not hear about. There was a suggestion in the media that clinically vulnerable children did not exist, to an extent, or that children were not at risk. And there were children who were at risk, there were children who died, and it's really important to understand that.*"[39]

28. The vaccination of children is of particular importance to CVF due to:
    a. the impact on Clinically Vulnerable children at higher risk of severe outcomes from Covid-19, and
    b. the impact on households, i.e. healthy children who have Clinically Vulnerable parents, siblings, and household contacts.

29. The children that CVF are concerned about were not protected by the 'earlier' vaccine offers on 19 July 2021, 22 December 2021 and 6 April 2023 (if the latter dates could ever be considered 'early') either because they were CV but did not have the particular conditions listed in the Joint Committee on Vaccination and Immunisation ('**JCVI**') advice, or because their household contacts were not immunosuppressed. Instead, protection did not arrive for them until universal offers were made to 12–15-year-olds and 5–11-year-olds. In the case of under 5-year-olds in this category, they were never even given the option. CVF members were particularly worried about their children returning to school in September 2021 without being vaccinated, as the Government had mandated compulsory school attendance.

[34] JCVI statement on COVID-19 vaccination of children and young people aged 12 to 17 years, dated 19/07/ [INQ000354522].
[35] Universal vaccination of children and young people aged 12 to 15 years against COVID-19, dated 13/09/2021 [INQ000257035].
[36] JCVI Statement on COVID-19 vaccination of children and young people: 22 December 2021 [INQ000257219].
[37] JCVI Statement on vaccination of children aged 5 to 11 years old, dated 16/02/2022 [INQ000257287].
[38] COVID-19 vaccination of children aged 6 months to 4 years: JCVI advice [INQ000412435].
[39] [3/56/13-20].

30. CVF is deeply concerned about the lack of consideration of these children by all bodies involved in the decision making in this area, from the JCVI and the Office of the Chief Medical Officer ('**OCMO**') to the Department of Health and Social Care ('**DHSC**') and Health Ministers.

Eligibility of children for vaccines

31. CVF members like Mary despaired that the government had prioritised healthy 18-year-olds over their vulnerable children: *"I had a massive battle to try and get my clinically vulnerable son his vaccine as he was 14. .... I wrote to everyone in authority I could think of and got nowhere."*[40] Another CVF member reported that *"despite assurances that children were less affected by the virus, our friends suffered the heartbreaking loss of a child with the same genetic condition as my daughter. This tragedy, which we believe was potentially preventable with earlier vaccination, highlights the unacceptable delay in administering vaccines to children, over a year after healthy adults had the chance to have been vaccinated two or even three times.... This period was especially stressful, with vulnerable under-12s without vaccination, yet required to attend school. ... The government's apparent disregard for clinically vulnerable children's safety during this critical time was both alarming and disappointing."*[41]

32. CVF's concerns are shared by Covid-19 Bereaved Families for Justice UK who have raised questions about the prioritisation of Clinically Vulnerable children following the tragic death from Covid-19 of a 7-year-old child with complex health needs. His mother had advocated for vulnerable children to have access to the vaccination as early as adults, only to be told that children are not adversely affected.[42]

33. CVF submits that the decision-making around the vaccination of children was exceptionally cautious and often out of step with the approach taken by other countries. It was also inexplicably slow: the JCVI provided its initial advice on 2 December 2020 against the vaccination of children[43] but did not advise again until summer 2021.[44]

34. As Sir Sajid Javid has explained, the government unequivocally accepted the advice of JCVI on whether to vaccinate children, until September 2021 when he sought the advice of the Chief Medical Officers of all four nations.[45] CVF submits that the JCVI's singular focus on the potential risks from the vaccine vs the potential benefit of the vaccine to the individual child was too narrow. Instead, what was missing from the JCVI and CMOs' consideration was the impact on Clinically Vulnerable children at higher risk of severe outcomes from Covid-19 (not just those with severe neuro-disabilities, Down's Syndrome, underlying conditions resulting in immunosuppression, and those with severe learning disabilities),[46]

[40] CVF, §143 [INQ000474526_0062].
[41] CVF, §170 [INQ000474526_0077].
[42] [1/82/10-22].
[43] Paper from JCVI titled Advice on priority groups for COVID-19 vaccination, dated 02/12/2020 [INQ000234638_0005].
[44] Draft paper from Joint JCVI titled Statement on Childhood vaccination of children and young people aged 12-17 years, dated 07/07/2021 [INQ000387481].
[45] Sir Sajid Javid, §87 [000474381_0029].
[46] i.e. those children who were prioritised in July 2021: JCVI statement on COVID-19 vaccination of children and young people aged 12 to 17 years, dated 19/07/2021 [INQ000354522].

the risks of sequelae (long Covid), and the impact on Clinically Vulnerable parents, siblings, and household contacts of healthy children. This was despite there being was growing evidence in 2021 of both long Covid in children[47] and the effect of the vaccine on reducing transmission.[48]

35. A false dichotomy between the risks of mild, self-resolving myocarditis from vaccination in children and not being vaccinated[49] was used to caution against the vaccination of children. The appropriate comparison should have been with the more severe myocarditis caused by the virus itself. CVF is concerned that this misleading narrative, which was amplified by the media, contributed to a decline in public confidence not just in the Covid-19 vaccine but it has left a harmful legacy damaging the childhood vaccination programme more broadly.

36. CVF is also concerned that there still, to this day, appears to be some confusion around the issue of children's vaccination, with witnesses in the Inquiry suggesting that Clinically Vulnerable children and households *were* considered. Sir Sajid Javid suggested that the benefit to protecting clinically extremely vulnerable household contacts was taken into account in August 2021,[50] but this was the offer to over 12-year-olds who had an immunosuppressed household member, which is a smaller group. Similarly, while children and young people aged 12 years and over with particular underlying health conditions were offered a vaccine from 19 July 2021,[51] this did not include all Clinically Vulnerable children.

37. Professor Wei Shen Lim explained that when using a vaccine in a pandemic you either "*target people directly with a vaccine and protect those people, or use the indirect benefits of a vaccine by targeting people who might be responsible for transmission, and therefore indirectly protect those most at risk themselves.*"[52] Dame June Raine has observed that "*despite younger age groups generally experiencing less severe disease following infection ... those age groups still carried and spread the virus*".[53] Professor Wei Shen Lim went on to explain that the indirect model has "*two prerequisites*" to achieve the indirect benefit, namely a vaccine that will effectively reduce transmission and a high degree of vaccine uptake within that population. CVF submits that the Inquiry should be asking why, when there was evidence that the vaccine did reduce transmission, and there was reason to believe that uptake would be reasonably high,[54] the indirect protection model not applied in the case of children.

38. In the event, the factor which ultimately caused a change of approach to children was education, and the wider public health benefit of the vaccine in reducing disruption to education. CVF invites the Inquiry to consider, if education was a key consideration, why was this not considered sooner for children in

[47] Updated statement from the JCVI regarding COVID-19 vaccination of children and young people aged 12 - 17 years, dated 04/08/2021 [INQ000401363_0002].
[48] Sir Chris Whitty, §6.55 [INQ000474401_0050].
[49] See Professor Wei Shen Lim's evidence that emerging reports of myocarditis in Europe was "*very relevant*" to the JCVI's assessment of the risk-benefit balance to be drawn for 12 to 15-year-olds [8/96/9-12].
[50] [8/61/20-25] to [8/62/1-3].
[51] JCVI statement on COVID-19 vaccination of children and young people aged 12 to 17 years, dated 19/07/2021 [INQ000354522].
[52] [8/80/2-10].
[53] Dame June Raine, §217 [INQ000474337_0065].
[54] In England 58.6% of 12–15-year-olds had had one dose by 26 June 2022, see Dr Kasstan-Dabush and Dr Chantler, §170 [INQ000474623_0052].

Clinically Vulnerable households, particularly when school absences among Clinically Vulnerable families were disproportionately higher than those of other severely impacted groups.[55]

39. Proposed recommendation: CVF agrees with Dr Kasstan-Dabush and Dr Chantler that "*the flexibility to invoke broader evidence and criteria is integral to making appropriate recommendations when required*".[56] CVF recommends that the remit of JCVI should be extended beyond the current individual risk-benefit analysis so that it may consider the broader evidence outlined above. Alternatively, there must be processes in place which require decision-makers to take into account such evidence, even if the JCVI may not.

Delivery of vaccines to children

40. Once the vaccine was eventually offered 12–15-year-olds in September 2021, CVF members then experienced multiple difficulties in actually accessing a vaccine for their child. CVF agrees with Dr Kasstan-Dabush and Dr Chantler's conclusion that "*school-age children were disadvantaged in areas of the UK that relied (at least initially) on school-based delivery only.*"[57] This was a particular barrier to access for children in Clinically Vulnerable households who had no safe option but to homeschool in order to avoid entering the high-risk school environment. But there were further problems once delivery was extended beyond schools: the option for GP surgeries to 'opt out' of providing the vaccine to children and the requirement that vaccination centres be 'green lit' for children created additional hurdles and reduced the available options. CVF notes the positive lessons to be learned from the vaccine programme for children in Scotland, which provides an example of how the rollout to children could have been done better.[58]

41. Dr Kasstan-Dabush and Dr Chantler have also suggested that "*the language of 'non-urgent offers'*"[59] in respect of 5–11-year-olds "*indicated a softer recommendation for parents to consider.*"[60] They have proposed that further investigation is required to assess whether the language may have influenced parental decision-making and risk perceptions.[61]

The impact upon vaccine uptake

42. CVF submits that it is highly likely that the delays in decision-making around children, combined with the discouraging language used once the vaccines were approved for children, contributed to the lower uptake among children.[62] Low uptake is of great importance to both Clinically Vulnerable children and Clinically Vulnerable adults, whose safety was in part dependent on a highly vaccinated population.

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[55] CVF, §145 [INQ000474526_0066].
[56] Dr Kasstan-Dabush and Dr Chantler, §70 [INQ000474623_0025].
[57] Dr Kasstan-Dabush and Dr Chantler, §251 [INQ000474623_0076].
[58] Derek Grieve [10/48/1-5], Dr Kasstan-Dabush [10/166/13-25] to [10/167/1-7].
[59] Dr Kasstan-Dabush and Dr Chantler, §371(a) [INQ000474623_0106].
[60] Dr Kasstan-Dabush and Dr Chantler, §275 [INQ000474623_0083].
[61] Dr Kasstan-Dabush and Dr Chantler, §148 [INQ000474623_0043].
[62] Dr Kasstan-Dabush and Dr Chantler, §170 [INQ000474623_0052].

43. Professor Larson has observed a general decline in routine childhood immunisation levels,[63] and therefore CVF submits that the management of Covid-19 vaccination for children has had a much wider negative impact upon children's health.

44. Proposed recommendations: (a) A primary course of Covid-19 vaccines should be made available to all children as part of the paediatric programme via the NHS, and any subsequent doses should be accessible privately for children and infants aged 6 months and above; and (b) there must be a comprehensive investigation into uptake of routine childhood vaccinations and efforts made to restore public confidence in the benefits of all standard childhood vaccinations.

D. PROPHYLACTICS

45. For those who are immunosuppressed and unable to mount an effective response to vaccination, non-vaccine prophylactic treatment was, in effect, their vaccine.

46. It is important for the Inquiry to recognise that this is a significant number of people. As many as 1.8 million people in the UK are immunosuppressed.[64] Catherine Little, former Second Permanent Secretary to the Treasury, put the figure at 1.7 million,[65] which was repeated in the closing statement made on behalf of the Treasury.[66] The All-Party Parliamentary Group on Vulnerable Groups to Pandemics has stated that the government's own figures suggest there are 1.2 million people in this category.[67]

47. AstraZeneca developed a prophylactic – Evusheld – which helped to reduce the chances of infection and severity of Covid-19 in people who have had an unsatisfactory immunological response to Covid-19 vaccination or who are severely immunosuppressed. It was approved by the Medicines and Healthcare products Regulatory Agency ('**MHRA**') as safe and effective however it was not procured by the government. It was instead subjected to a prolonged National Institute for Health and Care Excellence ('**NICE**') approvals process, in stark contrast to the process of rapid assessment adopted for the Covid-19 vaccines.

48. In CVF member Melanie's words, "*I am part of the cohort that cannot respond to vaccination. When Evusheld was approved by MHRA I was elated but devastated afterwards when I realised that NICE hadn't yet approved it. I still feel let down, ignored and dismissed.*" CVF member Sally has similarly described feeling "*totally abandoned.*"[68]

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[63] Professor Heidi Larson, §39 [INQ000474705_0016], [3/139/8-11], [3/141/1-11].
[64] CVF, §14 [INQ000474526_0009].
[65] Catherine Little, §200 [INQ000474557_0053].
[66] [13/70/9-12].
[67] Report by All-Party Parliamentary Groups on vulnerable groups to pandemics, titled Forsaken But Engaged, December 2023 [INQ000417415-0002].
[68] CVF, §87 [INQ000474526_0038].

49. As a result, Evusheld has not been available at any time from the NHS, unlike its availability in other OECD countries. CVF submits that the lack of access to Evusheld in the UK has left severely immunosuppressed patients significantly unequal when compared to immune competent persons: they have not been given access to a prophylactic that would give them the same protection as someone who is successfully immunised. This has had substantial life-changing effects on CVF members' lives. They are often unable to partake in 'normal' life in the way that successfully vaccinated people can. This has affected many areas such as work, education, and socialising. It can even affect their basic needs such as buying food, collecting medicine and attending medical appointments. CVF members like Sally have been left with an unenviable choice of "*playing Russian Roulette with hospital appointments trying to second guess whether not getting treatment and tests is more dangerous than potentially getting Covid.*"[69]

50. While Evusheld became less effective in respect of later variants of Covid-19, it still maintained some level of efficacy. CVF submits that there was a significant period of time in late 2020 and most of 2021 when, had it been available, it would have saved the lives of immunosuppressed people and enabled basic freedoms that others take for granted. The delays that resulted from the protracted decision-making process robbed immunosuppressed people of the opportunity to acquire this protection against earlier variants of the virus.

51. CVF agrees with Dame Kate Bingham's conclusion regarding the government's decision on Evusheld: "*by far the most significant harm was caused to hundreds of thousands of immunocompromised members of the UK public. The effect was that UK was the only Western country not to protect its immunocompromised people using long-acting antibodies. It is very plausible that this decision cost lives and condemned many more people to suffer through long term shielding*".[70] Dame Kate considered that it was not acceptable to allow very vulnerable people to go into situations where there was a high risk of contracting Covid-19 with the only reassurance offered – that we will treat you if you catch it.[71] She felt in fact that the UK had not followed one of the Vaccine Taskforce's three goals: "*our original mandate ... was to protect the UK against SARS-CoV-2. And that wasn't just to protect those people who could respond to a vaccine, but to protect all those people, including the immunocompromised*".[72]

52. CVF was alarmed by the evidence of Professor Sir Chris Whitty and Professor Jonathan Van-Tam who suggested that Evusheld became less important because immunosuppressed people received some benefit from vaccine in the end,[73] and that there were in any event antivirals available for treating Covid-19 infection.[74] First, immunosuppressed people will never achieve the same level of protection from vaccination as the immunocompetent population. Secondly, any protection which is achieved is in any event cumulative, so that the protection offered after one dose at the start of rollout would not have

[69] CVF, §87 [INQ000474526_0038].
[70] Dame Kate Bingham, §38.13 [INQ000474406_0043].
[71] [6/52/13-21].
[72] [6/21/19-25].
[73] Professor Sir Chris Whitty [5/114/7-9], Professor Jonathan Van-Tam [5/182/20-23].
[74] Professor Jonathan Van-Tam [5/180/8-10].

offered anywhere near equivalent protection to that which a healthy person would have gained. Thirdly, Professor Van-Tam's flippant observation in relation to antivirals ("*history speaks for itself, that those immunosuppressed patients can access treatment, whereas those of us who don't those kind of conditions can't*") betrays a total ignorance of the fundamental problems CVF has identified with access to antivirals in practice.

53. In response to the argument that the vaccine rollout had been effective, we know from the experts that whilst the vaccine reduced transmission – it did not totally block transmission. As Dame Kate Bingham said, *"the fact that the vaccine rollout had been effective doesn't stop people without an immune system getting infected."*[75] To put it simply, immunosuppressed people still needed prophylactics.

54. A number of reasons were put forward by the CMOs for why they did not recommend advance purchase of Evusheld, including its short shelf life, the need to keep giving it over again, and apparent difficulties with administration.[76] Clive Dix explained why he did not believe any of those reasons were valid, before concluding: "*I actually feel most of those are excuses, and the actual reason that it wasn't purchased was cost.*"[77]

55. Some witnesses suggested there was simply no clinical data to demonstrate the effectiveness of Evusheld. But as Dame Kate Bingham explained, this did not seem to be a problem in relation to vaccines, which were supported in development "*before we knew whether or not these vaccines would work.*"[78] CVF invites the Inquiry to consider why a comparable approach was not taken to Evusheld. The expert evidence of Professor White is that there may have been a window of opportunity for Evusheld to provide the vital protection immunosuppressed people needed and if pharmacometric testing had been explored, the outcome might have been different.[79] Professor White was very critical of using laboratory tests to inform decision-making and has called for pharmacometric analysis to be carried out to calibrate laboratory tests before they are relied upon.[80]

56. Professor Sir Chris Whitty accepted that "*had Evusheld been available and licensed in early 2021, even with vaccination I think it would have had at least some niche use*".[81] In light of the size of the immunosuppressed population, and for the reasons set out above, CVF submits that Evusheld would have had far more than "some niche use" and considers that the use of the word "niche" may betray the unfortunate minimisation of the needs of immunosuppressed people.

57. Matt Hancock was asked whether prophylactics were generally forgotten after the decision not to make an advance purchase of Evusheld. Mr Hancock replied: "*Far from it. We continued to push for this, and*

[75] [6/52/11-13].
[76] Sir Jonathan Van-Tam [5/180/17-25], Professor Sir Chris Whitty [5/112/4-22] and [5/114/25] to [5/115/1-2].
[77] [12/88/20/21].
[78] [6/28/14-16].
[79] [12/25/1-5].
[80] [12/18/9-17].
[81] [5/116/3-5].

I remember regarding this decision as a decision "not now", rather than a decision "not ever".[82] CVF invites the Inquiry to consider whether in fact the government did continue to push for prophylactics.

58. The reality is that for the immunosuppressed, no adequate solution has ever been offered and 5 years on and there is still no plan and very little in terms of treatment access or options. It seems that the current 'plan' is that they are to be offered indefinitely a vaccine that offers less, if any, protection for them,[83] unless there is work ongoing to identify a suitable prophylactic, of which there is no clear evidence. There appears to be a real risk that immunosuppressed people are to be condemned to a future of annual vaccinations that do not offer full protection, combined with ongoing shielding and non-pharmaceutical measures.

59. Proposed recommendation: the government must devise a holistic, comprehensive plan for the protection of immunosuppressed people against Covid-19 that includes a fully resourced investigation to (a) identify and procure a prophylactic that is effective against Covid-19, and (b) understand and consider the impact and effectiveness of ongoing, bi-annual vaccinations for immunosuppressed people, noting that they are the only group to receive this many vaccines.

E. ANTIVIRALS

Issues with the antivirals procured

60. Lara Wong made clear in her oral evidence that some of the antivirals procured are not suitable for many Clinically Vulnerable people; notably Paxlovid which has many contraindications to medicines which immunosuppressed patients commonly take.[84]

61. Sir Munir Pirmohamed said that it is "*very important*"[85] to develop a diverse portfolio of antivirals (and vaccines), having recognised earlier in his evidence that "*patients who were particularly vulnerable to severe effects from Covid were the elderly, vulnerable, and they maybe on other drugs*".[86] Professor White has also explained combinations of antiviral drugs are less vulnerable to resistance or loss of effectiveness against emerging variants of a virus.[87]

62. Given that the "*entire focus*" of the procurement of antivirals was said to be to "*help those in high risk groups*", and to provide a "*valuable tool for those who could not be vaccinated or who were still at particular risk*",[88] CVF considers that this oversight is difficult to explain and ultimately left many of

[82] [3/89/19-21].
[83] Although, unlike flu, household contacts of severely immunosuppressed people no longer qualify for Covid-19 vaccines.
[84] [3/51/21-25].
[85] Sir Munir Pirmohamed [11/184/1].
[86] Sir Munir Pirmohamed [11/176/25] to [11/177/1-2].
[87] §7.11 [INQ000474743_0093].
[88] Sir Sajid Javid, §264 [INQ000474381_0076].

the people to whom the antivirals were directed unable to obtain the benefit of their protection from severe illness.

63. Proposed recommendation: work to identify and procure antivirals which are effective and suitable for treating Covid-19 in Clinically Vulnerable people continues, and that this issue is expressly factored into the mandate of any future taskforce or committee tasked with obtaining antivirals.

Eligibility for antivirals

64. CVF is concerned that the list of people eligible for therapeutics has always been and continues to be particularly limited, especially given the underlying conditions and age profile of people admitted to hospital and sadly dying of Covid-19.

65. Contributors to ESM expressed confusion about who was and was not eligible for treatment. Some understood themselves to be eligible based on information they had received from the NHS during the pandemic. However, when they contacted the NHS they were told that they were not eligible for treatment. Those who experienced this felt angry but also scared about what might happen to them as their infection progressed. "*I felt very cross and disappointed when I learned that respiratory patients are not eligible for anti-viral medications. They were sent numerous letters telling them to shield yet were not considered ill enough to warrant anti-viral. All our friends were back to enjoying some sort of normality but still we were scared to mix much in fear of the effect Covid would have on a vulnerable person. I wrote to numerous politicians… asking them to fight for anti-virals for people with chest conditions. This was useless.*"[89]

66. Proposed recommendation: CVF submits that there should be an urgent expansion of provision to those identified by NICE over a year ago.[90] This is a pressing need because there are still vulnerable people who would benefit from antiviral medicine but are not receiving it because they are not currently eligible.

Deployment of antivirals

67. CVF has sought to demonstrate that the Covid-19 antiviral pathway is fraught with access issues and barriers which have prevented many vulnerable people from receiving the lifesaving treatment that they need. It is significantly more restrictive when compared to other medications like influenza antivirals, which can simply be prescribed by a GP.

68. The system set up for providing antivirals to those who needed them was intended to "*ensure that treatments were delivered quickly following symptom onset since GP practices did not need to confirm*

[89] Every Story Matters [INQ000474465/48-49].
[90] ID6262: Nirmatrelvir plus ritonavir for treating COVID-19 (Partial Rapid Review of TA878) recommends an expansion to people aged 70 years and over, with a body mass index of 35 kg/m2 or more, with diabetes, or with heart failure.

eligibility or discuss treatment options."[91] However, in practice, the burden has been on the patient – who would almost certainly have been experiencing Covid-19 symptoms or risking imminent illness – to secure the medication, all within a system which was and is not currently fit for purpose. CVF members describe GPs referring to 119, 119 referring to 111, and 111 referring back to 119 or the GP. Even if eventually referred to the Covid-19 Medical Decisions Unit ('**CMDU**'), people have been dismayed to find that the Unit is closed over weekends or bank holidays. Contributors to ESM reported similarly frustrating experiences, often resulting in missed opportunities to benefit from the medication.[92]

69. Professor Nicholas White has confirmed that antiviral drugs are *"most effective as soon as people felt ill and were diagnosed with Covid-19 in the community"*, explaining that an early effective treatment could prevent severe illness and hospitalisation.[93] Lord Bethell also stressed the importance of swift delivery of antivirals: "*you need to get them to them very, very quickly, for instance on a motorbike, the moment that they test positive*" because "*once your nose is running and you're coughing it's probably too late. The medicine can't get in early enough.*" For this reason, Lord Bethell reflected that "*within the NHS we could have been more creative about test, trace and treat*", noting that there are ways of using data and home diagnostics to spot people much earlier on. He also suggested making antivirals available for moments of outbreak. When asked by CVF to reflect on the existing system of providing antivirals, he agreed that a 5-day window is "*not a great way of running an antivirals programme*".[94]

70. CVF members have also reported issues with the assessments undertaken by the CMDUs: people who were eligible as per the eligibility list who may have been referred via multiple doctors or healthcare professionals were not offered treatment at the clinical decision point, either because the decision-maker did not know that a condition really qualified people as higher risk, or because the person was not exhibiting sufficiently severe symptoms or, indeed, their symptoms had become too severe due to delays, leading to advice that they should go to hospital. This is despite the guidance for antivirals being clear that they should be given as rapidly as possible to eligible people. It has been said that the way antivirals work is in fact "*incompatible with a symptom led approach*",[95] i.e. the approach usually adopted in the NHS. CVF submits that not being ill enough should never have been a barrier to treatment because the sooner you are treated the better. CVF reports real examples among their members where things went wrong in respect of access to antivirals, in some cases with tragic consequences.[96]

71. NHS England has explained that a system of routine reporting of CMDU triage outcomes was put in place which found that only around 25% of triaged patients were treated.[97] CVF invites the Inquiry to

[91] Clara Swinson, §179 [INQ000474335_0058].
[92] Every Story Matters [INQ000474465/49-50].
[93] Professor Nicholas White §5.2 INQ000474743_0042].
[94] Lord Bethell [11/50/1-14], [11/51/15-18], [11/72/3-4].
[95] Lord Bethell, §68 [IN0000474434_0023].
[96] CVF, §63 [INQ000474526_0029].
[97] Gareth Arthur, §181, INQ000474328_0047.

consider whether in fact the systemic problems in obtaining antivirals via the pathway set up by NHS England were the reason for these statistics.

72. More recently, in 2023, there was a change in commissioning and eligible people who contracted Covid-19 are now required to contact their GP practice, NHS 111 or hospital specialist. It is the experience of many CVF members that obtaining a GP appointment within the tight 5-day timeframe is very challenging, and in some cases impossible, through lack of access to primary care.

73. CVF is also concerned that eligible patients have had no ability to obtain antivirals 'in advance', for example ahead of high-risk activities such as travelling abroad, or bank holiday weekends (where experience has shown that CMDUs have been closed).

74. CVF do not believe that the process of accessing antivirals was, or is, fit for purpose. Systems for recording patients' eligibility for antivirals (and the lateral flow tests required to demonstrate Covid-19 infection) must be implemented now as an urgent priority, for example by including a flag on eligible patients' digital health care record and providing prescription cards that they can show to demonstrate their eligibility.

75. CVF agrees with the observations of the former Chair of the Antivirals Taskforce, Eddie Gray, that we know who are likely to be the most vulnerable to a future pandemic and those people could be "*identified in advance and if possible, given antivirals immediately upon declaration of pandemic for use in case of infection.*"[98]

76. Given the serious failings outlined above, CVF takes particular issue with the assertion made in the oral closing submission of HM Treasury that "*need turned out to be far lower than anticipated by DHSC and 4.98 million doses costing over £3 billion went unused*".[99] If doses did indeed go unused, CVF submits that this is not because there was not a need for them among Clinically Vulnerable people, but rather the delivery system failed so significantly that vital doses ended up being wasted. CVF submit there is a great danger in taking the evidence of the Treasury at face value when there is clearly an enormous disconnect between the policies designed and the real lived experience of Clinically Vulnerable people. How can it be that antivirals are sitting unused, while Clinically Vulnerable people were unable to obtain them? With tragic consequences in some cases. CVF submits that such a wastage is a damning indictment on the government.

77. Eddie Gray told the Inquiry he wanted to ensure that "*the people who we'd bought [antivirals] for were the people who got them*" and was even concerned that they got to a point in the process "*where people*

[98] Eddie Gray, §93 [INQ000474342_0033].
[99] [13/70/1-3].

on the vulnerable list needed the courses and we'd run out".[100] The reality could not be further from this ambition.

78. Proposed recommendations: (a) antivirals must be made accessible to those who need them the most, rapidly and comprehensively. There should be an immediate change to the system so that Clinically Vulnerable people are flagged as eligible (both digitally and via a physical card) and provided with antivirals immediately on communication of a positive test. (b) NHS clinicians responsible for administering Covid-19 antivirals must receive training on this approach to prescribing, which is different from the usual NHS 'symptom-led approach.'

F. OVERALL APPROACH TO VACCINES COMPARED TO THERAPEUTICS WAS WRONG

79. CVF has submitted from the outset of this module that a critical mistake the government has made during the pandemic was to overbalance its attention on vaccines at the expense of therapeutics and prophylactics. There is now direct evidence that therapeutics and prophylactics were deprioritised from witnesses such as Dame Kate Bingham, Clive Dix, Sir Sajid Javid and Eddie Gray. CVF submits that this is also clearly evident from the lived experiences and outcomes identified in the preceding paragraphs. The therapeutics and prophylactics programme were the poor relation of the vaccines programme – and this was not good enough.

80. What is clear following the evidence in this module is that the vaccination programme was given the highest possible priority, independence and funding and whilst the delivery programme had its flaws, Dame Kate Bingham, Clive Dix and others essentially demonstrated what should be considered the gold standard of independence and impact. The contrast with the therapeutics programme was stark – although there were some successes, there was none of the world-beating vim and vigour of the vaccines programme. The therapeutics programme was slower, more bureaucratic, and more limited. The result was that people who could not benefit from the vaccine programme, notably the immunosuppressed, were left behind.

81. In respect of prophylactics, Dame Kate Bingham is an independent and trusted voice, she had no reason to defend decisions if they were not the right ones. She "*absolutely felt"* that "*the issue of prophylactic development was being left behind*".[101] Damningly, she said *"the government, was following a very clear two-tiered strategy where the clinically vulnerable immunocompromised patients were being deprioritised in favour of those who were able to receive vaccines*".[102] She felt this was "*manifestly wrong, both ethically and morally, but also, it did not follow the goals that we'd been set, which was to protect the entire population*". She said that "*there was zero appetite in the Department of Health to actually consider how these patients would be treated*" and that "*it was cheaper to let these clinically*

[100] [11/108/5-12].
[101] [6/21/22-24].
[102] [6/49/18-25].

vulnerable individuals, who were already shielding, to stay shielding at home, and then if they were to be infected, they would be treated with drugs".[103] Clive Dix agreed, explaining that said that the Vaccine Taskforce had "*a very entrepreneurial way of going about things*" and getting things done, but prophylactic antibodies "*started to be looked at in a very different way ... [with] less enthusiasm*".[104] CVF submits that in contrast to independent witnesses like Dame Kate and Clive Dix, there is an element of motivated reasoning in the evidence of the CMOs when they effectively say, with the benefit of hindsight, 'it wouldn't have worked anyway, so it turns out the decision we made was the correct one'.

82. When it came to the procurement of antivirals, Eddie Gray spoke of his frustration with the process for getting funding approved, the struggle to "*get the right people to make the decision*" and the "*timeliness*" of that decision, which was "*as slow as previous occasions*".[105] Sir Sajid Javid described "*a big battle with the Treasury and Number 10*", explaining that the volume of antivirals secured was "*a lot less than [he] had wanted*".[106] He said that by June 2021 *"there was less focus on ... having something other than vaccines."*[107] He contrasted the difference in funding positions for vaccines - which had an "*almost unlimited budget*" - and antivirals which had no overarching budget.[108] This meant that he had to seek specific approval from the Treasury in respect of the procurement of oral antivirals, only to have his clinical case questioned by Treasury officials.[109] Sir Sajid reflected "*I saw firsthand the approach to funding the vaccine and the willingness to take risks did not even last the length of the pandemic."*[110]

83. Government witnesses have stated that once it became clear there would be an "*effective vaccine*", this did "*change the context*" for other preventative treatments.[111] What these witnesses failed to acknowledge is that "*effective vaccine"* only meant effective for the majority, and the needs of the minority – a not insignificant minority – were forgotten. CVF submits that downplaying the role of prophylactics and therapeutics in a vaccinated population risks further marginalising those at highest risk. It fails to account for the reality that immunosuppressed people remain vulnerable despite vaccination (which is why vaccines are offered to them still) and depend on antivirals as an additional layer of protection.

84. The attitudes to prophylactics and therapeutics displayed during Module 4 serve to exacerbate health inequalities for Clinically Vulnerable people. The grim reality is, to this day, no prophylactic treatment has been procured by the government, the oral antivirals which were procured for treatment are not suitable for many of the Clinically Vulnerable people they are aimed at, and there are huge problems accessing the antivirals in practice. If the same creativity, independence and appetite for risk had been applied to therapeutics and prophylactics as were applied to vaccines, things may well have been

[103] [6/50/3-11].
[104] [12/90/21-25] to [12/91/1-2].
[105] [11/107/1-18].
[106] [8/42/9-11].
[107] [8/41/1-10].
[108] [8/48/14-24].
[109] [8/41/21-25].
[110] §23 [INQ000474381 _0009].
[111] Clara Swinson [4/67/6-12].

different. Helen Knight, the Chief Executive of NICE, reflected that in the event of another pandemic, "*the system as a whole would need to do more to develop therapeutics*" for the highest risk patients.[112]

G. CONCLUSION

85. CVF's concerns are linked by a common theme: the inescapable reality that the disproportionately severe impact of Covid-19 on Clinically Vulnerable people, and associated decision-making, were insufficiently considered and mitigated. Clinically Vulnerable were often overlooked, their needs underappreciated, their voices not heard. For many Clinically Vulnerable people, 'Freedom Day' never came and they continue to feel the effects and continue to live in the shadow of the virus today.

86. Lord Bethell said frankly that there was no plan for the immunosuppressed at the beginning[113] despite it being clear enough that they were going to be particularly gravely impacted by a virus that affected the immune system. And it was already known at the beginning of this pandemic, that the likely vaccine candidate would be the one which relied on a person's immune system to fight back against Covid-19, one which would not work well for immunosuppressed people. CVF urges the Inquiry to consider, how can we ensure Clinically Vulnerable people's needs are not overlooked again?

87. It is for these reasons that CVF considers it is essential that Clinically Vulnerable people be identified as a specific group/protected characteristic, both under the Equality Act 2010 and in the Inquiry's Equalities and Human Rights Statement, to enshrine in law the ongoing threat to Clinically Vulnerable people from Covid-19 (and other pathogens), This would go some way towards embedding their protection in law, and in decision-making, and reduce the risk of them being relegated to the second tier of a two-tier strategy again.

88. CVF is grateful for the Chair's clear willingness to seek to understand CVF's issues of concern. For many Clinically Vulnerable people, this is the first time that they have felt genuinely listened to and heard. CVF looks forward to receiving the Inquiry's report and reading the Chair's recommendations, which it knows will be formulated with the care and attention that have defined the approach to this important module so far.

KIM HARRISON
SHANE SMITH
Solicitors for CVF

ADAM WAGNER
HAYLEY DOUGLAS
Counsel for CVF
Doughty Street Chambers
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[112] Helen Knight, §144, [INQ000474611_0058].
[113] [11/58/23-25].