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COVID INQUIRY

WRITTEN STATEMENT OF BORIS JOHNSON FOR MODULE 4

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Introduction

1. I provide this statement to the Covid Inquiry in response to a 'Rule 9' Request (issued pursuant to the Inquiry Rules 2006) dated 31 January 2024 and updated on 18 November 2024.

Opening Comments

2. At the risk of belabouring points already made to the Inquiry, I believe that the discovery and roll-out of Covid vaccines showed the UK state at its best. It is in my view extremely difficult in a modern freedom-loving democracy to stop the transmission of a new and highly contagious disease. We are not an authoritarian country. As I have explained to the Inquiry, I believe that our decisions on non-pharmaceutical interventions ('NPIs') were all reasonable and proportionate, given our state of knowledge at the time. But there are plainly limits on what government can enforce.

3. It is on the other hand a very long-standing function of government to provide medicine, and to take charge of immunising the public. Here the UK state, in all its aspects, unquestionably succeeded. Thanks to early investments in

vaccine technology, the UK was the first country in the world to produce a vaccine that could be distributed at room temperature. Thanks to agreements struck by the UK with AstraZeneca, that vaccine was then used – at cost price – to give protection to hundreds of millions of people around the world. Thanks in part to the regulatory freedoms flowing from Brexit, the UK was the first country to approve the (effective) Covid vaccines, and the first country to put a licensed and effective vaccine into the arms of the population.

4. We therefore had the fastest vaccine roll-out in Europe, and among the fastest in the world. By March 2021, the UK had vaccinated about 45 per cent of its adult population, and getting on for 100 per cent of those who were either vulnerable or over 80. The comparable figure for the EU 27 was then about 10 per cent. It was this discrepancy, which became obvious to the media and public in other European countries, that infuriated some continental politicians, and which led, I am afraid, to some of their regrettable but ultimately abortive attempts to frustrate UK supply chains. What they could not stomach – but what was demonstrably true – was that Brexit was helping to save the lives of many elderly, vulnerable and frightened people. It is still astonishing, and disgraceful, that these continental politicians should have responded to this embarrassment by taking steps to deprive the UK of vaccines to which we were legally entitled. Bear in mind that this was mainly dog-in-the-mangerishness. The EU was blocking doses of AstraZeneca from coming to the UK – while EU leaders were simultaneously denigrating the efficacy of the very same UK drug.

5. In the end, the actions of the EU did indeed put pressure on our roll-out, and forced us to recalibrate, but they were far from fatal. We were able to complete the vaccine roll-out at great speed, and as a result we came out of Covid restrictions many months faster than other European countries, and had the fastest economic recovery in the G7. As I have said before, the credit for this achievement belongs to the scientists, the doctors and nurses of the NHS, the vaccinators and volunteers, the army, local government and just about every manifestation of the UK state, but above all to the British public who, disdaining any fear of needles, came forward in huge numbers to protect themselves and everyone else from the disease.

6. I have prepared this statement with assistance from my legal advisers and having refreshed my memory from the documents I have exhibited. That said, it is now several years since the events and it is hard to recall the exact sequence of events. I have done my best to answer the questions put to me

and to verify my recollections where possible from contemporaneous documents.

Development, Procurement, Manufacture and Approval

Overview of my input into the key policy decisions

7. In early 2020, during the first few months of the pandemic, I sought to invest all possible effort and resources into finding an effective treatment or vaccine to combat Covid. This was central to the UK Government's overarching strategy for responding to the pandemic. I initially felt sceptical that we would find a vaccine, after all, we still do not have a vaccine for AIDS or SARS. But as long as there was the hope of scientific salvation, I wanted to throw everything at it and then be ready to ensure we were able to roll the vaccines out across the country as fast as possible. As the news got better and better, my initial scepticism turned into intense enthusiasm. As the end of 2020 approached, it became clear that we were going to have several vaccines.

8. I consider that the key policy decisions relevant to the strategy for the development, manufacture, procurement and approval of the Covid vaccines and in which I played a crucial role as Prime Minister were:

    a. To invest heavily in research and development to find a vaccine;

    b. To appoint Kate Bingham as Chair of the UK Vaccine Taskforce ('VTF');

    c. Protecting our Oxford vaccine to ensure supply for the British people;

    d. To opt out of the EU procurement scheme;

    e. Setting up and steering the vaccine delivery roll out team.

9. I describe each of these decisions in the narrative below.

Investment

10. The first key policy decision was to start investing in research and development of a vaccine and for the Government to provide whatever funding was necessary to combat the virus. I felt that we had to invest every effort into sourcing an effective vaccine or treatment to beat the virus and even though I knew that was going to be vastly expensive, compared to the costs of not doing so, it was cheap at the price.

11. While I cannot say the exact moment I decided this, it was well before the lockdown. This key decision led to early investment in vaccines and treatment research from the beginning of February 2020 onwards, for example:

12. We issued two funding announcements in early February 2020 for £20 million of new funding for the Coalition for Epidemic Preparedness Innovations ('CEPI') **[BJO2/001 - INQ000051881]** and £10.5 million investment in rapid research initiative funding Covid research projects on vaccine, therapeutics and diagnostics **[BJO2/002 - INQ000203986]**. This program invested in the Oxford University project which led to the AstraZeneca vaccine. We later invested much more into this initiative.

13. On 6 March 2020, I announced that a £46 million funding package for Covid, of which £25 million was earmarked for research and development to find an effective vaccine and/or treatment **[BJO2/003 - INQ000086750]**.

14. On 11 March 2020, the Chancellor presented the 2020 Budget to Parliament and outlined our three-point plan in his speech **[BJO2/004 - INQ000236874]**. The first point of that plan was that we would provide any extra resources that the NHS needed, including for research for a vaccine.

The UK Vaccine Taskforce ('VTF')

Establishment of the VTF

15. The VTF started life as a unit in the Department for Business, Energy and Industrial Strategy ('BEIS'), established to lead the Government's efforts to procure an effective vaccine against Covid. At its inception in March 2020, it was a small Director-led team in BEIS under Patrick Vallance's leadership. Patrick Vallance put together an external advisory board comprising representatives from across government, but also industry and academia, to provide advice to the VTF about how the UK could access safe and effective vaccines as quickly as possible **[BJO2/005 - INQ000088455_027]**.

16. In mid-April 2020, the Secretary of State for BEIS, Alok Sharma announced publicly that the VTF would lead and coordinate UK efforts to develop and supply a vaccine.

17. This was all to the good but my concern was that the VTF was more of an advisory group for the NHS, rather than a no-holds barred delivery team. We needed more than this. In the very first days of the pandemic, I'd been spooked by the difficulties of obtaining and distributing enough PPE. This time I was

determined that the British people would be properly provided for. At a certain moment it became clear to me that we were going to be in a position where the UK would be scrabbling for supplies of vital defences against Covid. I thought about the problem which was clearly going to be that the whole world was after the same vaccines and treatments. I anticipated that the issue was going to be about security and speed of supply.

18. We could not leave this to the NHS procurement teams, admirable though they were. I saw that, as often in government, we needed someone who could be the Tsar or Tsarina of the whole operation and who could take charge of the VTF. They needed to drive through the development, procurement, manufacture and approval of the vaccines. It could not be Patrick: he had more than enough to do.

Appointing Kate Bingham

19. It was this that led to me identifying and appointing Kate Bingham to lead the VTF. That was one of the key decisions relating to the vaccines.

20. On 4 May 2020, Matt Hancock sent me a WhatsApp message saying that he still needed someone to lead on vaccines **[BJO2/006 - INQ000129305]**. I had already thought of Paul Deighton but he was reluctant and it was not his area of expertise. Kate Bingham was one of the members of Patrick's VTF advisory board **[BJO2/007 - INQ000088455_027]**. I remember looking down the list and seeing her name. I knew immediately that she would be the best suited person. I had known her – though we were not close friends – for a very long time. As I have written elsewhere, I knew from personal experience that she had mastery in driving things forward and, that she was superabundantly qualified for the task. Indeed, her paper qualifications were perfect. She had built a career and reputation by investing in new medicines and she had the right leadership qualities to do the job. I maintain that I was right. I suggested her to Matt.

21. Two days later, on 6 May 2020, I have seen that Sir Mark Sedwill wrote a note which recommended immediately establishing three new Covid Taskforces, one of which was on Vaccines and Treatments and was to be led by Kate Bingham **[BJO2/008 - INQ000087170]**. Although I do not now recall the exact order of things, I think that I immediately approved the recommendation and appointed her. I spoke to her by telephone that evening (see for example

[BJO2/009 - INQ000229157]) and briefed her for the task. I gave her three objectives:

a. To get the vaccines we needed to protect the British public and to save life;

b. To spread vaccines around the world and help global supply;

c. To make the UK better prepared for the future.

22. On 13 May 2020, I had a Zoom meeting with Kate to discuss her role on the VTF. Alok Sharma, Sir Mark Sedwill, Patrick Vallance, Dominic Cummings and Emily Beynon were also on the call **[BJO2/010 - INQ000226185_0103]**. During her recruitment, Kate was clear that there was already progress on treatments such as therapeutics and that did not require her oversight. She would focus on the vaccine and antibody therapy (the latter was a natural adjunct as it overlapped with vaccine development). That sounded wise to me.

23. I have seen that Sir Mark Sedwill wrote to Kate in May 2020 and recorded her agreement to chair the VTF **[BJO2/11 - INQ000182372].**

24. I gave Kate full authority to negotiate with the big pharmaceutical companies and to do whatever was needed. Looking back now, I feel that this decision led to us being in pole position: Kate did a terrific job.

Ensuring good relations with global pharmaceutical companies.

25. I was also keen to keep strong personal relationships with pharma executives to ensure the UK got preferential access to vaccines, and also work with them to ensure better future global pandemic preparedness. To do this I would speak to them regularly. For example on 11 November 2020, I convened ten major pharma CEOs and Bill Gates to discuss their approach to Covid and future pandemics. After this meeting I said, "*I heard today about the herculean joint effort that life science companies and research institutions are undertaking to tackle this disease at record speed. The UK will use our G7 presidency next year to support this global endeavour and protect our citizens at home, now and in the future.*" **[BJO2/12 - INQ000474747].** I also did a number of 1-to-1 phone calls with the CEOs of various companies throughout the pandemic, including with Pascal Soriot of AstraZeneca, Dr Albert Bourla of Pfizer, and Stéphane Bancel of Moderna.

Saving the Oxford Vaccine

26. Towards the end of April, after Oxford had made the breakthrough that would eventually lead to the AstraZeneca vaccine, the scientists led by Sarah Gilbert needed a commercial partner to bring it market. Although we had invested some I&S in this vaccine by around this point, the intellectual property belonged to Oxford. There was a moment when I heard that Oxford were in advanced discussions with Merck, the American pharmaceutical giant. They were already talking about non-binding heads of terms and I asked to be kept sighted on the negotiations. Clearly this was not good news for us. Under all sorts of US statutes such as the Defense Supply Act, it would be possible for the US government to sequester the supplies, even though it was *our* vaccine. We had invented it, pioneered it, developed it. The British state paid a lot for vaccine capacity. We needed a UK company to supply the vaccine. I had to take action.

27. On 24 April 2020, I wrote a pretty stiff letter to Lord Patten and Professor Louise Richardson, the Chancellor and Vice Chancellor of the Oxford University respectively **[BJO2/013 - INQ000234349]**. I said that the Government's objectives were:

> *to ensure that the vaccine is available to the world at a scale of billions of doses and to ensure the UK gets sufficient immunisation courses to vaccinate the UK population, supported by UK manufacture and access to overseas manufacture.*

28. I continued, saying:

> *Whichever company partners with Oxford following negotiations over the weeks ahead, we would want to ensure that the deal did not risk giving walk-in rights to other countries, which could put UK and global supply at risk.*

29. They took the hint. Soon after, AstraZeneca – descendant of the pharmaceutical arm of Imperial Chemical Industries ('ICI') and headquartered in Cambridge – stepped forward.

30. I think that intervening like this, in retrospect, was an important decision, not just for the UK but for the global fight against Covid. The Oxford-AstraZeneca vaccine had a huge global public health benefit, preventing an estimated 6 million deaths, I believe. The experience of the pandemic taught me that, when

national politicians panic, and become fearful that they will not be able to meet the needs of their immediate electorate, international cooperation goes out of the window. We could not lose our carefully nurtured vaccines to another country, even our greatest ally.

Reflections on Innovations

28. I have been asked to reflect on innovations that were introduced to expedite the development, manufacture, procurement and approval of the vaccines. Even before the pandemic struck, I was determined to make the UK the best place in the world to do biomedical research and ensure the right people were in the key positions. In the 2019 manifesto I committed to "*make the UK the leading global hub for life sciences after Brexit.*" I approved Dr June Raine's initial appointment as interim CEO of the Medicines and Healthcare products Regulatory Agency ('MHRA') shortly after coming into Government in August 2019.

31. Of course, the major innovations were scientific: the geniuses in Oxford who had used chimpanzee flu to mimic the Covid virus and those brilliant Nobel-prize-winning minds who worked tirelessly to develop effective mRNA vaccines. I cannot speak to the detail of those innovations, other than to express my awe and gratitude.

32. I think that the way that we were able to validate, approve and license the vaccines so fast was itself an innovation, and this innovation was possible because the MHRA, led by Dame June, was not part of the European Medicines Agency ('EMA'). This was a result of the particular model of Brexit that the government had chosen to follow – the so-called 'hard Brexit' which meant that the UK had complete regulatory freedom. To be clear: other models of 'leaving' the EU, such as the one abortively chosen by the government of Theresa May, would have kept us in the EMA. This decision to go for a hard Brexit was of course controversial, but it meant we could go at our own speed and gave us the option, where required, to be quick and nimble. Dame June and Kate Bingham worked exceptionally well together, helping to process approvals. They engaged actively with the pharmaceutical companies, working hard to assess the trials as they were happening. I thought of them acting not like police officers who issue orders and say no, but as air traffic controllers: scanning the horizon for problems to solve and bringing the vaccines safely in

to land. I describe below getting more doses out of vials, extending the gaps between doses which were, in my view, also key innovations.

Successes of the VTF

33. Of course, the major success of the VTF and the whole UK Government was that we actually pulled it off: we were the first country in the world to launch a Covid vaccination programme. I had been told that normally it takes years – as many as ten to fifteen – to bring a vaccine to market and that we might never even find one to combat Covid. But, within months of this hideous disease emerging, we had done it. On 8 December 2020, the first Covid vaccines were given. The very first one was given to Margaret Keenan, a grandmother in Coventry. Later that day, at a safe distance, I witnessed 81-year-old Lyn Wheeler receive her vaccine at Guy's Hospital in Southwark. She told us, "*I am doing it for Britain.*" But it was not just for Britain. It was for the whole world.

34. The VTF's key successes were identifying and investing in the successful vaccines, ensuring they were safe for use on the public, assisting in getting them licensed so they could be prescribed with confidence and then securing supply at scale and rolling it out and into the arms of the population. Of course, this success was not only down to the VTF: the speed and success of the roll-out relied too on the unstinting hard work of countless other government officials, academics, doctors, nurses and NHS workers, pharmacies, regulators, local government and public authority employees, the private sector, and many, many amazing volunteers. But, working collaboratively, the VTF procured enough vaccines for the entire population with incredible speed. They did an outstanding job and I have no complaints or suggested improvements.

Opting out of the EU Procurement Scheme

35. As I touched on above, the speed of our vaccine programme was unquestionably assisted by Brexit. It is sometimes said that – as so often with EU legislation – the UK could in fact have technically derogated from the EU process. In reality, that would simply never have happened as long as we were inside the EU. The pressure to conform, to stick with the pack, at a time of huge medical anxiety and uncertainty, would have been overwhelming. If we had stayed in the EU, and within the EMA, I don't believe the option of early vaccine approval would have been even presented to ministers. It is highly

telling that all the other 27 countries remaining in the EU stuck to the EU timetable for approvals, and waited for week after week. Only Brexit Britain jumped the gun – and that was because of Brexit. We also had a chance to join the EU's scheme but, again, we opted out, for the reasons I now explain.

36. In June 2020, the European Commission invited the UK to join the EU's vaccine procurement initiative under the terms of the Withdrawal Agreement and on the basis that it was funded by the current EU budget to which we were still contributing. The scheme would invest in European manufacturing capacity but it came as a price: agreeing to the EU's timetable, prices and volumes without having any say in those decisions. We could not participate in the governance of the programme or in the negotiating team. Not only that, if we were already negotiating with a manufacturer and the EU then chose to negotiate with them, we would be forced to stop all our negotiations and stand aside. By now we were in advanced negotiations with four vaccine manufacturers (GSK/Sanofi, Janssen, BioNTech/Pzifer and Moderna).[1] We would be bound to stop them at any moment if we signed up to this scheme.

37. On 8 July 2020, Alok Sharma, wrote to me setting out some of these concerns and recommending that we opt-out of the EU procurement scheme. On the issue of our being required to abandon any commercial negotiations should the EU start negotiations with the manufacturer in question, he said that the Commission were "*clear that there is no flexibility on this point*". He also mentioned that "*my officials also do not have confidence that the EU programme could be delivered effectively or in a way that would meet the needs of the UK population*" **[BJO2/14 - INQ000420943].**

38. Alok's letter came to me in my Box alongside a box note that recorded that the Foreign Secretary, Health Secretary and Cabinet Secretary agreed with his recommendation. I commented on Alok's letter underlining the point that "*the UK would be unable to participate in the governance of the programme or in the negotiating team. We would therefore have no say in decisions concerning*

[1]To the best of my recollection, I did not have any involvement in contractual arrangements entered into by the UK Government with the vaccine developers, manufacturers or suppliers. I do not have any recollection of having discussions about liability and indemnity arrangements. I was in fairly regular contact with Albert and Pascal, but I left it to others to conduct the actual contractual negotiations.

which manufacturers to negotiate with, or the price, volume and delivery schedule negotiated."

39. Although I thought it was clear we should reject this offer, before doing so, I wanted to hear Patrick's view. I therefore wrote on the letter, "*what does Patrick Vallance think? We should be pretty aggressive in arguing that the UK is better off having flexibility*".

40. There were some further negotiations and communications but pretty quickly it was clear to me that the EU was struggling as compared to the VTF. It seemed that this was an opportunity to do things differently from the EU with more speed and flexibility. Furthermore, despite our best efforts, the terms of the offer were not appealing.

41. On 10 July 2020, Sir Tim Barrow, the UK's Ambassador to the EU, sent a letter informing the EU of our decision whilst also emphasising our continued commitment to collaboration. He specified the areas in which we should strengthen our partnership: "*sharing of information on promising vaccine candidates; negotiations with vaccine manufacturers; vaccine trials; manufacturing investment and capacity building; mitigations to supply chain bottlenecks and other delivery risks such as global trade disruptions*" **[BJO2/15 - INQ000421123].**

42. The insights of the BEIS officials proved to be correct; the flexibility we had allowed the VTF to 'place bets' on a number of potential vaccine manufacturers, securing an initial 367 million doses under 7 contracts by November 2020 (see for example 'A review of the Vaccine Taskforce', 31 August 2023, for the data **[BJO2/16 - INQ000474752],** , all on the UK's own terms. This was critical in securing the necessary supply to the UK, which ultimately allowed us to ease restrictions much sooner than our EU counterparts. I believe it was critical to the UK's success that we were not only able to approve the vaccines faster, but also that we were outside the EU's vaccine procurement scheme. These were clearly crucial policy decisions.

Vaccine Delivery

43. Because of the considerable work that went into vaccine delivery and my heavy involvement throughout, I have provided a narrative chronology before turning to some reflections on the policy decisions.

Narrative of Vaccine Rollout

44. Planning for the roll out began at an early stage. At a Covid-O on 23 June 2020, an action was decided for the VTF to share detailed operational plans (including timelines and capacity trajectories) to manufacture and deploy 30 million doses of a vaccine by the end of September 2020 **[BJO2/017 - INQ000088852]**. This timeline proved overly optimistic and, on 22 July 2020 at a Covid-S meeting, Kate Bingham stated that the earliest possible timetable for making two different vaccines available was in the fourth quarter of 2020, but the majority could be expected across 2021 **[BJO2/018 - INQ000088251]**. At that meeting, I emphasised that the process to secure HMT funding needed to be accelerated. The major step to expedite funding for vaccine development was that on 30 July 2020, a delegated budget was approved by HMT for the VTF and its budget request of £5.23 billion was approved.

45. As 2020 progressed, it became more and more clear that we would be rolling out a workable vaccine in accordance with Kate's timeline. Ongoing work was being done by the DHSC, the Joint Committee on Vaccination and Immunisation ('JCVI'), the VTF and the Covid Taskforce to consider the prioritisation of eligibility for the vaccine.

46. On 9 November 2020, Pfizer and BioNTech issued a joint press release announcing that their phase 3 clinical trial indicated that their vaccine was over 90% effective at preventing participants contracting Covid **[BJO2/019 - INQ000100258]**.

47. From 10 November 2020, I chaired Vaccine Deployment meetings on around a weekly basis. The basic job was to gather the appropriate personnel, consider any issues that needed to be ironed out and then encourage them to deliver, including by the setting of targets. The key personnel included Dr Emily Lawson, NHSE's Head of the Vaccination Programme, who was brilliant. I appointed Nadhim Zahawi as the Minister for Vaccine Deployment in November 2020. Nadhim was very competent and did an excellent job.

48. On the same date, I chaired a Cabinet meeting **[BJO2/020 - INQ000088986]**. I noted that we had secured 40 million doses of the new Pfizer vaccine and more than 300 million doses of other vaccines. I said there was "*a prospect of effective vaccines in the coming months if the current trend continued*" although caution was advisable. This was also the same date that I convened the top ten pharma CEOs to hail their herculean effort in tackling Covid, continue to

ensure good relations with these vital companies and help work with them on future pandemic preparedness, as I note in my opening remarks.

49. By 13 November 2020, a Covid-O meeting agreed that I would take the final decision on Phase 1 prioritisation in an appropriate forum **[BJO2/021 - INQ000090919]**. Phase 1 referred to vaccination of those over 50 years old. Recommendations on prioritisation were to be shared with me, in line with the Health Secretary's paper 'COVID-19 Vaccination: prioritisation, communications' **[BJO2/022 - INQ000090908]**. Decisions on other cohorts to prioritise were to be considered as more research became available, such as those most at risk of catching or transmitting the virus, or national key workers. A Phase 2 plan was required for under 50s and additional public sector workforces which, when completed, would return to a Covid-O or Covid-S meeting for my approval.

50. On 1 December 2020, I chaired a Cabinet meeting **[BJO2/023 - INQ000088885]**. I stated that we should adopt the approach in communications on the prospect of a vaccines coming down the track "*to under-promise and over-deliver*" **[BJO2/024 - INQ000088885]**. I think this was the right approach. In the early phases of the pandemic, it was not clear where we would end up with a vaccine. Even though we did over deliver – by a long way – in relation to vaccines, I always retained a concern that something could go wrong. I did not want people to think that the battle was won and get complacent or to stop following rules concerning NPIs (e.g. lockdown measures). I wanted people to get vaccinated but remain sensible in the meantime. I was not worried that there would be a public perception that the vaccine was developed too quickly at the cost of safety. I felt that the population understood that science can produce a solution that seems miraculous and would be familiar with this from their everyday lives.

51. On 2 December 2020, the MHRA approved for the use of Pfizer vaccinations. That afternoon, I held a Vaccines Deployment meeting with Rishi Sunak, Michael Gove, Matt Hancock, Nadhim Zahawi, Chris Whitty, Patrick Vallance, Jonathan Van-Tam (known as JVT), Ed Lister, Henry Cook, Imran Shafi and others **[BJO2/025 - INQ000062987]**. I concluded that the priority for deployment of the Pfizer vaccine should be those individuals who were most at risk of dying from Covid. At that stage, we did not know when other vaccines would be approved and had only limited supply for Pfizer vaccines in the New Year. As a result, it was right that the limited guaranteed supply that we had

was focussed on the most vulnerable and the approach was consistent with the JCVI prioritisation and guidance. In practice, this meant that the overwhelming majority of initial vaccinations (c. 80%-90%) were to be provided to over 80-year-olds. This careful, risk-based deployment ensured we used our initial limited supply of vaccine for maximal effect, to prevent as many deaths as possible. Some other nations chose to distribute vaccines to a wider population and not to prioritise the vulnerable. I believe our approach was clearly more sensible. I was desperate to avoid more lockdowns and knew that vaccinating the elderly quickly would help with that aim. The remainder were to be provided to those health and social care workers who were most likely to cause transmissions which lead to hospitalisations / deaths. A sufficient number of doses were to be held in reserve to ensure that we were able to vaccinate all care home residents with our initial guaranteed supply from Pfizer. DHSC was to work through the operational delivery of these decisions.

52. On the same date, we lifted the second lockdown as planned. In the press conference that day, I announced that the mass vaccination programme was to begin the following week. I noted that, thanks to the fantastic work of Kate and the VTF, the UK had purchased more than 350 million doses of seven different vaccine candidates and the UK was the first country in the world to pre-order supplies of this Pfizer vaccine, securing 40 million doses. I noted that, through the Winter Plan, the NHS had been preparing for the biggest programme of mass vaccination in the UK's history which was to begin in the next week. The first phase was to include care home residents, health and care staff, the elderly and those who were clinically extremely vulnerable.

53. On 8 December 2020, the first Pfizer vaccination was administered in the UK, as I explain in paragraph 33 above.

54. By December 2020, we were considering data about vaccines daily at the Dashboard meetings. On 10 December 2020, I noted in a meeting about tiers that I was very keen to understand the deployment trajectory of vaccines **[BJO2/026 - INQ000063008]**.

55. On 15 December 2020, I chaired a Vaccines Deployment meeting, attended by Michael, Matt, Nadhim, Chris, Patrick and others **[BJO2/027 - INQ000063029]**. I congratulated the NHS on recent deployment successes and emphasised the need to deploy as fast as supply allows and focus on the most vulnerable cohorts. I asked for greater clarity on key data and projections, noting that line

of sight on vaccine deployment plans in the new year was critical for broader decisions on NPIs.

56. The NHS described a three-phase process in which the aim was to have vaccinated all those in the initial JCVI prioritisation list by the end of April 2021. Assuming that AstraZeneca came on stream, we should aim to have vaccinated all the over 70s and the Clinically Extremely Vulnerable (and the cohorts above them) by the end of February 2021. I "*urged maximum ramp up*", acknowledging the importance of an operationally smooth roll-out on the wider success of the programme. I repeated the priority to reduce the death rate as fast as possible with focus on vaccinating as many over 80s as we could, noting my previous decision to provide the significant portion (c. 80-90%) of our initial vaccines to the over 80s and care home residents. Chris agreed that this was a clinically valid decision.

57. By 16 December 2020, 137,000 people had been vaccinated. A target had been set that the NHS would administer 2.4 million injections by the end of the week commencing 4 January 2021.

58. On 22 December 2020, I chaired another Vaccines Deployment meeting where I, again, urged maximum pace, noting the characteristics of the new variant **[BJO2/028 - INQ000063084]**. JVT had been asked to speak about prioritising a single injection into as wide a group of the vulnerable as possible, rather than getting both injections into a smaller group. This was as a result of growing interest on this issue in No.10 **[BJO2/029 - INQ000153518]**. JVT noted that the JCVI believed it would be preferable to prioritise the injection of the first doses of both vaccines to a wider group of the vulnerable. Under this approach, the second doses would be deferred by up to 12 weeks. The MHRA were considering this approach and were likely to make a decision (alongside giving their approval of the AstraZeneca vaccine). I was very attracted by this idea, since it would clearly allow us to give protection, faster, to a larger group.

59. Further work was to be done to develop an operational roll out plan. Next steps included that NHS England ('NHSE') and NHS Improvement ('NHSI'), DHSC and the VTF were to work up deployment scenarios, setting out forecast vaccine supply and the maximum pace of vaccine rollout, including a clear view on when the programme would move down the JCVI cohorts.

60. As the rollout progressed, we would look at the vaccine supply and the roll out figures provided by NHSE and the VTF. We would look at the JCVI hierarchy

and the number of people in each cohort before considering where we had got to and whether we had vaccinated enough of one cohort so that we could move onto the next. We would then set targets for vaccination of the next cohort (set out below).

61. On 29 December 2020, I chaired another Vaccines Deployment meeting **[BJO2/030 - INQ000234268]**. I congratulated everyone on the continued rollout but noted concerns with projected supply in January 2021 and the impact this would have on vaccination rate. Figures for delivery of AstraZeneca vaccines, discussed in the previous week, had been revised downwards. Nadhim stated that they were pushing AstraZeneca as hard as possible to bring forward delivery and I agreed to help with this, speaking to AstraZeneca if necessary.

62. JVT noted that the AstraZeneca data indicated that protection increased with a greater gap between the two doses. There was no data in relation to Pfizer but a deferral of the second dose was highly unlikely to reduce effectiveness, based on immunological principles. JVT and Chris had discussed second dose deferral and were very comfortable with extended the period between doses from a clinical perspective. Simon Stevens, Chief Executive of the NHS, noted that second dose deferral would mean that first doses could be offered to JCVI cohorts 1-2 by the end of January 2021 and first doses could be offered to cohorts 3-4 by the week of 15 February 2021. Emily confirmed that the NHS was prepared to inject all vaccines available to them.

63. I remember thinking that it was incredible that we had enough supplies by December 2020 and January 2021 to vaccinate all those over 80 and the clinically vulnerable. Shielding and segregating the vulnerable had not been effective up to that point in the pandemic. I knew that we could put a forcefield around the vulnerable so that they were effectively 'shielded' via the vaccine, rather than by staying at home.

64. On 30 December 2020, the MHRA gave their approval for the AstraZeneca vaccine. New advice from the JCVI was that the first dose could protect people against the worst effects of this virus and so, consistent with the discussion at the meeting on 15 December 2020, we decided to accelerate delivery of the first dose to as many vulnerable people as possible, with the second dose to follow 12 weeks later. The JCVI '*advice on priority groups for COVID-19 vaccination*' was released on this date **[BJO2/031 - INQ000256950]**.

65. I backed the decision to defer the second dose. It was an important one that enabled us to administer the first vaccine more quickly to the most vulnerable. It turned out that one dose gave a substantial amount of protection from serious illness in any event.

66. At this stage, as the practicalities of the rollout became clearer, I decided to set targets for the vaccine rollout. The aim was to set targets that were achievable but stretching (words used by Matt at the Vaccine Deployment meeting on 5 January 2021 – see below **[BJO2/32 - INQ000234275]).** The hope was that the targets would galvanise those responsible for the delivering the rollout and also those in each cohort to get vaccinated. We had taken a similar approach to testing earlier in the pandemic.

67. On 4 January 2021, I chaired a Covid-O meeting on National Intervention for which the Covid Taskforce had circulated a paper, 'Proposition for National Intervention' **[BJO2/033 - INQ000146740]**. The paper proposed a new 'stay at home' message until the end of February 2021, two weeks after the top four vulnerable cohorts had received their first dose of vaccine. This would be the final push before the rollout of the vaccine provided for a gradual easing of restrictions.

68. On the same date, following the Covid-O meeting, I announced the third national lockdown **[BJO2/034 - INQ000075743]**. I also announced everyone in JCVI groups 1-4 would be offered a first dose by mid-February 2021 (all older care home residents and their carers, over 70s, frontline health and social care workers and the clinically extremely vulnerable). At this stage, the UK had vaccinated more people than the rest of Europe *combined* and this pace was increasing with the arrival of the Oxford-AstraZeneca vaccine. This was a piece of good news and hope, to go alongside the dreadful reality of a further lockdown.

69. On 5 January 2021, I chaired a Vaccines Deployment meeting **[BJO2/035 - INQ000234275].** I emphasised that the overarching aim must always be to reduce mortality and morbidity as fast as possible, and that targets should not detract from this. DHSC was asked to provide a table setting out population by each JCVI cohort, a proposal on how and when the NHS would move down the cohorts and how the NHS would deal with any regional unfairness, while ensuring maximum pace.

70. On 6 January 2021, I chaired a meeting on the details of the NHS's plan to ramp up vaccine deployment over the coming weeks **[BJO2/036 - INQ000234278].** There was, at that time, some scepticism and the government needed to demonstrate that it could deliver. I noted concern about uptake rates amongst disproportionately impacted groups and we should be doing everything possible to maximise uptake amongst such groups. I sent WhatsApp messages expressing my alarm about the speed of vaccination, based on discussions the day before, and the need for figures so that progress could be ascertained **[BJO2/037 - INQ000095284]**.

71. On 12 January 2021, I chaired a Vaccine Deployment meeting **[BJO2/038 - INQ000063195]**. I noted the disparity between regions and questioned whether the NHS were assured that all regions were doing their utmost. I asked what was being done to access the harder to reach communities and people. I asked the NHS to work closely with the Ministry of Housing, Communities & Local Government and local authorities to provide them with everything they needed to maximise rollout. Simon Stevens committed to providing data to local authorities by the end of the week and I pressed for this to happen as soon as possible. Matt noted that hesitant groups were disproportionately young and BAME. I noted that local authorities were crucial to accessing these groups and that we needed to foster very strong relationships between the NHS and local authorities.

72. I sought assurance that the military were supporting the rollout. MOD attendees offered to carry out a 'red team' exercise in relation to the vaccine rollout and I asked them to explore every possible marginal gain to ensure the programme was running at maximum capacity. The idea of a red team exercise was to review the programme and identify any opportunities to accelerate the vaccine programme further.

73. The meeting also discussed that we were able to get more doses out of the vials. Using the most efficient syringe, six doses could be obtained from almost every Pfizer vial and there were 11-14 doses in most ten dose vials of the AstraZeneca vaccine. This was an important innovation that allowed us to speed up the roll out – something I was constantly encouraging – all thanks to the technical skills of those on the ground.

74. On 19 January 2021, I chaired a Vaccine Deployment meeting **[BJO2/039 - INQ000063253]**. Emily updated that the target set remained achievable,

although I noted it was highly challenging and contingent on supply. I asked, again, what was being done to access the hard to reach and how local authorities could best be used to support the programme. I emphasised that we needed to provide local authorities with whatever they needed to drive uptake, including relevant data. We were to return to the targets for Phase 2 (cohorts 5-9) the next week.

75. On 2 February 2021, I chaired a Vaccine Deployment meeting **[BJO2/040 - INQ000421505].** We discussed an appropriate target date for offering a first dose to cohorts 1-9. At that stage, there remained uncertainties around the data, such as the size of the cohorts. There was debate on whether mid-April or the end of April would be the appropriate target. I pressed on whether anything could be done to increase vaccine supply but was told that there were no near-term options. Matt said that the NHS were delivering everything they were being provided with and therefore it was not obvious that a stretching target would have a galvanising effect. There were other views that a stretching target would help and I decided to take a decision the following week.

76. By 3 February 2021, we had procured 400 million doses of the vaccine and administered 10 million doses. My team also pushed the NHS to create a higher incentive payment for GPs to vaccinate care-home residents, which led to substantial increases.

77. By 9 February 2021, we were approaching the date for our first target. In addition, there was ongoing consideration of the next target of offering first doses to cohorts 5-9 (all those over 50 and those at risk). We were to debate whether the target should be May 2021 or more ambitious **[BJO2/42 - INQ000087230].** At the Vaccine Deployment meeting, I probed the action taken to increase vaccine uptake in care homes given the lower uptake rates among staff (66%) and the importance of protecting care homes.

78. On 13 February 2021, the Government's Vaccine Uptake Plan was published which set out the plan to boost vaccine uptake **[BJO2/042 - INQ000185184]**. By that stage, 13 million people had received a vaccine and uptake across cohorts was strong. The assumed uptake was around 75%, based on previous vaccination programmes, however over 90% of care home residents and the over 75s had received a first dose.

79. We incentivised doctors to administer vaccines which was effective. The Government's Vaccine Uptake Plan noted that there were over 2,700 locations offering vaccinations, including GP surgeries and high street pharmacies.

80. On 14 February 2021, more than 15 million people had received their first vaccine which I described as a "*significant milestone*" and thanked everyone who had played a part in the effort. In England, I announced that we had offered vaccinations to everyone in the first four priority groups, therefore meeting the target that had been set on 4 January 2021.

81. The next day, 15 February 2021, I announced the next target. I believed we could offer a vaccination to everyone in the first nine priority groups – including everyone over 50 – by the end of April **[BJO2/043 - INQ000086649]**. This was to be done while giving second doses to millions of the most vulnerable.

82. On 17 February 2021, I chaired another Vaccine Deployment meeting **[BJO2/44 - INQ000479209].** I re-iterated my thanks to everyone involved in the programme, especially in light of achievements over the past week. I agreed that the NHS should take decisions on how to move down the rest of cohorts 1-9 but should ensure that they did not disadvantage prior cohorts or give rise to major geographical disparities. There was further discussion of approaches to increase uptake in certain communities. Hyper-local activities led by trusted community figures was said to be key. Gentle persuasion was seen to be yielding results and it was noted that too strong an approach from central government could have a negative impact. I agreed but re-iterated that I wanted to see the whole country moving together and that we must be careful that no groups fall behind. I also asked for full advice grounded in behavioural science be worked up to increase care home uptake. I asked for a clinical view from Chris on vaccine passports/certification. Chris noted that it was predominantly a political question and might be better suited for some activities than others. I stated that I did not want society to exclude certain groups who had a principled / religious opposition to vaccines, and that moral and ethical implications should be considered. However, it was right initially that we provided space for market/sectoral responses by providing technical proof of certification, that private companies could rely upon.

83. On 20 February 2021, I announced that, by 15 April 2021, all adults aged 50 and over, as well as younger people with underlying health conditions that put them at higher risk, should have been offered a jab **[BJO2/045 -**

INQ000250262]. This was, therefore, an acceleration of the plan announced on 14 February 2021, as further data had shown the earlier date was achievable. In addition, Phase 2 (for under 50s) was to start by mid-April 2021 and, as a result, all adults in the UK would be offered their first dose of a coronavirus vaccine by the end of July 2021. By that stage, more than 17 million people had received vaccinations.

84. The announcement was consistent with a paper titled 'COVID-19 Response - Spring 2021' **[BJO2/46 - INQ000185087]** that I presented to Parliament, which noted that the target for cohorts 1-4 had been met two days early and that the UK had vaccinated a higher proportion of its population than any other country in the G20. This was, in part, facilitated by the decision to extend the interval between doses, enabling first doses to be distributed more widely. The paper contained the 'Roadmap' which relied on four steps for unlocking, including: the vaccine deployment programme continued successfully and evidence shows vaccines are sufficiently reducing hospitalisations and deaths in those vaccinated (as well as considering any surge in hospitalisations and variants of concern).

85. On 22 February 2021, I chaired a Cabinet meeting about the Roadmap **[BJO2/047 - INQ000088893]**. The meeting considered reopening schools and whether to vaccinate children. At that time, Chris stated that there was no licence from regulators to do so and, in any event, children were low down the priority list so it was not a current issue. There were, however, vaccine trials ongoing with children.

86. On 10 March 2021 at a Vaccine Deployment meeting **[BJO2/048 - INQ000063519]**, I emphasised the need to maintain 100% effort on the vaccine programme. The NHS confirmed that the end of March 2021 remained an achievable target for offering a first jab for cohorts 1-9 and 21 June 2021 for a first jab to all adults. However, the group agreed not to change any public targets. I was keen not to allow the success of the vaccine roll-out to encourage any premature complacency about the disease. It was noted that uptake was increasing across all groups and was far better than any comparable programme. I enquired whether incentives might be deployed later in the programme when trying to reach final groups.

87. It was noted that vaccination rates among social care workers were 75%, whereas SAGE advised that 85% was required to mitigate against future

outbreaks. I asked Matt, Michael and Chris for their views on mandating vaccinations among social care workers. I decided that we should move ahead with mandating of vaccination for social care workers initially and consider mandating vaccination for all healthcare workers, subject to further conversations with the NHS and ongoing efforts to increase uptake. This was progressed and became operational on 11 November 2021. However, I understand that, by January 2022, circumstances had changed and the policy was no longer in line with the science. As a result, a decision was made to revoke those provisions and stop further work which would have mandated vaccinations for health and wider social care workers (see Covid-O minutes 31 January 2022 **[BJO2/049 - INQ000091577]**).

88. In early March 2021, there were reports of blood clots in patients who had received the AstraZeneca vaccine and, as a result, some countries suspended the use of AstraZeneca pending further investigation.

89. On 11 March 2021, the MHRA advised that people should still get the vaccine when asked to do so.

90. At a Cabinet meeting on 16 March 2021, Chris noted that pharmaceutical regulators were investigating blood clots but any such 'signals' were likely to be very small **[BJO2/050 - INQ000089017]**. He was confident that the regulators findings would not change the UK's approach but urged caution in public communications in the meantime, while noting that it was unfortunate that the news stories meant an increase in people who were resistant to the idea of having a vaccine. I noted that: "*it was possible that by pausing the use of the Oxford/AstraZeneca vaccine, some European countries were trying to provoke the UK to react. The message from regulators was clear that the vaccine was safe; the UK should maintain the moral high ground. Now was the time to redouble the effort to persuade everyone to understand the benefits of having a vaccine*". It was clear to me that in counselling caution, Chris was not suggesting that we should now generally discourage people from taking AstraZeneca - far from it. I continued to receive updates on the progress of the MHRA investigation and had personal briefings with Chris. I address this issue further at paragraph 125 below.

91. By 23 March 2021, we had administered 30 million doses of vaccine.

92. On 6 April 2021, I chaired a Vaccine Deployment meeting **[BJO2/051 - INQ000217334]**. The meeting discussed ongoing work with respect to

AstraZeneca blood clotting issues. The independent regulatory process was continuing and, depending on its outcome, there was strong support for asking Prof Sir David John Spiegelhalter, a statistician, to explain the risks to the public as part of wider clinician led communications. GPs had now offered an appointment to all in cohorts 1-9 which meant that we could announce that target had been met.

93. On 7 April 2021, the MHRA said, in a statement, that the AstraZeneca vaccine brought a slightly higher risk of a specific type of blood clot in the brain for those who had low platelets, though the risk was extremely rare. The data suggested a slightly higher incidence of this issue in younger adults, who also had the lowest risk of severe disease associated with Covid. There were no issues with other vaccines approved in the UK (at that time, Pfizer and Moderna). As a result, the JCVI recommended that adults under 30 should be offered an alternative vaccine, if available **[BJO2/052 - INQ000234852]**.

94. On 12 April 2021, I announced that all adults over 50, the clinically vulnerable and health and social care workers had been offered a vaccination **[BJO2/053 - INQ000257443]**. This meant that, again, the target set on 20 February 2021 had been met ahead of schedule. We remained on track to offer a first vaccine to all adults by 31 July 2021.

95. On 16 April 2021, the JCVI advised that pregnant women should be offered a vaccine at the same time as the rest of the population, based on their age and clinical risk group. More safety data was available on Pfizer and Moderna vaccines so those were preferable. Previous advice had been to offer the vaccine only in cases of high exposure or high risk **[BJO2/054 - INQ000111011]**.

96. By 20 April 2021, we had administered 33 million doses of vaccine.

97. On 27 April 2021, I chaired another Vaccine Deployment meeting **[BJO2/055 - INQ000063687]**. I noted that we had recently crossed the threshold of 50% of the population vaccinated. The NHS confirmed that we remained on track to meet the July target. I pressed again on the need to maximise BAME uptake, noting the gap was not reducing. I asked for all work to maximise uptake.

98. On 4 May 2021, a Covid-O meeting noted that DHSC was working with the NHS on communications to "*emphasise that pregnant women should receive the vaccine in the same way as others*" **[BJO2/56 - INQ000091895].**

99. On 6 May 2021, Matt agreed to the JCVI recommendation to raise the age under which individuals are offered an alternative vaccine to AstraZeneca, where possible, from 30-40 **[BJO2/057 - INQ000060859]**. This advice was based on the favourable UK epidemiology at that time, the success and pace of the vaccine rollout, and the supply trajectory of alternative vaccines. I had emphasised, the day before, that this change was to be carried out in a way that did not delay the rollout. NHSEI estimated that, with the additional supplies of alternative vaccine expected, it would still be possible to offer a first dose of the vaccine for all adults aged 18 and over by 31 July 2021. The JCVI advice was published the next day.

100. On 7 May 2021, a Covid-O meeting agreed to explore a domestic certification policy which provided certification through vaccination, testing, or natural immunity **[BJO2/058 - INQ000091914]**.

101. On 4 June 2021, the MHRA authorised the Pfizer vaccine for children aged 12 and over.

102. On 19 July 2021, I was able to announce that the target to offer every adult in the UK a first dose of vaccine had been met ahead of schedule **[BJO2/059 - INQ000086704]**. By that stage, 46 million people had received their first dose and 35 million had both doses. I noted that this was an extraordinary achievement, coming barely eight months since the first vaccine was given. Data from PHE and the University of Cambridge showed that the vaccines had prevented 11.8 million infections and almost 37,000 deaths in England alone. YouGov polling showed the UK continued to top the list of nations where people were willing to have a vaccine or had already been vaccinated and ONS data showed 96% of adults reported positive sentiment towards the vaccine. The positive knock-on effect was that we were able to announce step 4 of the roadmap at the same time.

103. By 19 July 2021, there was JCVI advice on the vaccination of children **[BJO2/60 - INQ000387481].** There were, at that stage, emerging reports from the UK and other countries of rare but serious adverse events, including myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the membrane around the heart) following the use of Pfizer and Moderna vaccines. At that stage, the JCVI did not advise the routine vaccination of children until more data became available. However, it did recommend

vaccination of those aged 12 and over at risk due to certain underlying health conditions and household contacts of the immunosuppressed.

104. On 20 July 2021, I chaired a Cabinet meeting **[BJO2/061 - INQ000089048].** I noted that I did not think that vaccine passports would be needed for pubs but nightclubs were a different matter, as was clear from experiences in other countries. Chris said that he had written to the Chair of the JCVI asking for them to press ahead faster on the question of vaccinating children. I noted that the vaccination of children was a huge issue because of the return to school in September. Other countries had decided to press ahead with vaccination of children and the issue needed to be considered by Minsters soon.

105. On 21 July 2021, I met with Chris and Patrick to consider the vaccination of children and reports of myocarditis and pericarditis in younger age groups following vaccination, along with four deaths around the world. It remained unclear, at that stage, whether the deaths were completely attributable to the vaccines. The JCVI was asked to conduct their review into these adverse effects as quickly as possible. Chris wrote to the JCVI noting that "*the question about whether to vaccinate children and young people more widely is now becoming a very pressing one for the government, in common with governments around the world*" **[BJO2/062 - INQ000073639]**.

106. On 22 July 2021, I was clear that we needed to redouble our efforts to incentivise people to come forward who had not yet been vaccinated **[BJO2/063 - INQ000111708]**. As a result, communications campaigns were presented to me. On the same date, health chiefs gave a press statement to encourage more pregnant women to get their vaccine **[BJO2/64 - INQ000223992]**.

107. On 26 July 2021, I chaired a Vaccine Deployment meeting **[BJO2/065 - INQ000064049]**. The focus of the meeting was increasing uptake amongst the young and the approach to children's vaccination. There was ongoing work to appeal to the remaining 30-35% of unvaccinated 18-29 year olds. It was noted that, at that stage, they would be able to join in activities such as nightclubs if vaccinated (due to the vaccine passport system). I was keen for more to be done to firm up our certification policy. I noted that we should not pre-judge the JCVI's decision on the vaccination of children.

108. On 30 July 2021, I met with the CDL, Chris, Patrick and Simon Ridley to discuss key Covid policy decisions over the summer **[BJO2/066 - INQ000064057]**. I emphasised the need to take a more definitive position on certification. Chris noted that this could mitigate the risk of mass spreading events and enable certain venues to stay open if there was a significant further wave but people would not necessarily respond positively to its use as a tool to drive uptake. I concluded that we should announce detail of the policy shortly, including that its purpose was to ensure parts of the economy that could not stay open in previous waves could reopen, that we expected it to apply in all nightclubs and venues based on capacity thresholds and that a final decision would be taken in September.

109. I asked Chris to carry out a rapid review of vaccination in children and young people from JCVI **[BJO2/067 - INQ000073681]**. Chris concluded that the JCVI's conclusions, at a stage of incomplete information, looked like a careful balancing of risks and that they would look at further decisions in due course as more information became available.

110. On 4 August 2021, the JCVI announced their updated guidance on vaccination of children and young people **[BJO2/068 - INQ000256992]**. The advice was that, for adults aged 18 and over, the potential benefits of a Pfizer vaccination outweighed potential harms. For persons under 18 who did not have underlying health conditions, there was more uncertainty but older children were more likely to benefit from vaccination. The JCVI advised that 16-17 year olds should be offered a first dose of Pfizer, in addition to the two doses to be offered to 'at risk' groups. It was anticipated that a second dose would be offered but further data would inform exact details. Further advice was to be released in relation to healthy 12-15 year olds.

111. On 11 August 2021, I chaired a Vaccine Deployment meeting **[BJO2/069 - INQ000064079]**. The focus was on ramping up the vaccination of healthy 16-17 year olds. Injections had started the day after the JCVI announcement. Chris noted that it had been a finely balanced judgement for the JCVI referring to the incidence rate for myocarditis and pericarditis. I noted that we must handle recommendations on the use of AstraZeneca with care. It was the primary vaccine for much of the world and we needed to maintain and bolster global confidence in it.

112. On 13 September 2021, the CDL agreed to follow advice provided by the UK Chief Medical Officers ('CMOs') of (and further to JCVI guidance) on vaccinating children aged 12-15 at a Covid-O meeting **[BJO2/070 - INQ000092120]**.

113. On 5 November 2021, I chaired a Vaccines Deployment meeting **[BJO2/071 - INQ000064192]**. Amongst other things, I stated that we should ask the JCVI to start considering whether we should vaccinate 5-11 year olds, noting that other respected regulators and advisory bodies had recommended it.

Policy Decisions on the Vaccine Rollout

Encouraging Vaccine Uptake

114. It became clear quite early on that there was a problem of differential take up of the vaccine with some ethnic groups. This was a major concern and, as soon as we became aware of it, we took steps to remedy the issue. I was concerned about disparities in vaccine access and felt that it was my job to encourage the population to get vaccinated, provided I was certain that it was safe to do so. The topic was discussed regularly at the Vaccine Deployment meetings, that I have referred to above, and I raised it as an issue for discussion on a number of occasions (for example, on 12 January 2021 **[BJO2/072 - INQ000063195]**, 19 January 2021 **[BJO2/073 - INQ000063253]**, 17 February 2021 **[BJO2/74 - INQ000479209]** and 22 July 2021 **[BJO2/075 - INQ000111708]**).

115. In my Module 2 statement, I said that the colossal importance of ensuring that no one was left behind was the primary reason why Matt and I asked Kemi to lead a cross-government health disparities review in June 2020. The Government made a huge effort to address these disparities throughout the course of the pandemic. For example, as Kemi reported in her third quarterly report **[BJO2/76 - INQ000089776]**, the NHS allocated over £7 million of additional funding to local sustainability and transformation partnerships to enable targeted engagement in areas with health inequalities and with communities that were not vaccine confident.

116. I have also described above the Government's Vaccine Uptake Plan which noted that the intention to be vaccinated was lower for some groups of the population than others **[BJO2/77 - INQ000087230].** The plan emphasised the need to work together at a local level, with work from NHS, local authorities,

voluntary, community and faith sectors, as well as local directors of public health. It referred to a Vaccination Equalities Committee led by NHSEI to advise and guide the vaccine deployment programme on addressing inequalities. It noted £23 million of funding allocated through the Community Champions Scheme to expand work to support those most at risk and boost vaccine take up. In addition, a Vaccine Uptake Taskforce was established in July 2021 **[BJO2/078 - INQ000064049].**

117. We spent a lot of time with Emily discussing how to get these groups to increase their uptake. We launched a series of campaigns that sought to reach out communities, including through local leaders and community groups. For example, there was a wonderfully dynamic doctor in South London who led a lot of this messaging: Dr Nikki Kakani. I also remember speaking to churches in South London to reach out to different communities.

118. The uptake in some ethnic groups was initially slow but eventually started to catch up and the numbers levelled out. I am particularly proud of how, through targeted interventions, we were able to increase both positive vaccine sentiment and vaccine uptake across all ethnic groups (as Kemi reported in her final quarterly report **[BJO2/079 - INQ000089747]**). The report found that the vaccination rollout plan and related communications activity were rated highest of all government measures. Overall, we managed to achieve a very high vaccine uptake as a result of the communications to the population as a whole, as well as this more targeted approach. It seems to me that the need for tailored messaging to different communities is an important lesson for a future pandemic.

Communications and Disinformation/Misinformation

119. We had very good communications on vaccinations. It was an obvious thing to do at the time and brought people together. For example, many people volunteered to vaccinate people.

120. At the time, my memory is that there was very little active vaccine scepticism and it is an issue that is much more live now. Even before Covid, in August 2019, I talked publicly about the need to get vaccinated to counter small levels of vaccine scepticism for the MMR jabs. This included measures to strengthen the role of local immunisation coordinators – healthcare professionals that promote vaccines particularly with hard-to-reach families, and calling a summit of social media companies to discuss how they can help

to promote accurate information about vaccination. However, I have seen in the documents that there was reference to subtle anti-vaccination campaigns influencing vaccine uptake rates in children (see minutes of Vaccine Deployment meeting 30 September 2021 **[BJO2/080 - INQ000064137]**). I noted that, as the MHRA had approved the vaccine for use amongst 12-15 year-olds and the CMOs had agreed on a universal offer, we should not be bashful in trying to convince parents of the safety of the vaccine, and should consider more actively taking on anti-vax campaigns.

121. There was lots of disinformation/misinformation about vaccines and that continues to this day. On various occasions, my advisers warned me of inaccurate media reporting. I was also, at times, concerned about negative pronouncements about the AstraZeneca vaccine and the impact this may have on its uptake. Our approach was to blow this aside by releasing the relevant facts as quickly as possible, and providing our own accurate messaging which emphasised that vaccination was the right thing to do and was safe.

122. One of the most important public messages around Covid surrounded the Omicron variant, towards the end of 2021. On 30 November 2021, I chaired a Cabinet meeting **[BJO2/081 - INQ000089099]**, telling my colleagues that Omicron was a set-back and the risk was unquantified. However, expanding the booster programme had been the right response. I further encouraged people to get vaccinated during a press conference later that day, noting the sense of exhaustion that we could be going through this all over again **[BJO2/082 - INQ000086803]**. On 11 December 2021, I held a meeting where I noted the need for an acceleration of boosters and the need for this to be the "*key focus of the government…a national mission unlike anything we have done before in the vaccination programme*" **[BJO2/083 - INQ000145771]**. I think it was my idea to launch the 'Get Boosted Now' campaign, which was announced on 12 December 2021. The aim was to boost as much of the population in order to avoid a lockdown caused by the fact that Omicron more infectious. We achieved that aim with the successful campaign. By 10 January 2022, data at the Vaccine Deployment meeting showed that the UK had the second most complete vaccination programme worldwide, with 79% of the eligible population boosted **[BJO2/084 - INQ000354776]**.

Prioritising the Rollout

123. Our approach to the rollout was guided by scientific advice, in that we followed the hierarchy set by the JCVI (an independent advisory body), which I felt that was good and sensible. There was a debate around whether to prioritise certain people, for example prioritising people by job, such as those in the care sector. The Labour party suggested that public sector workers should be prioritised, including the NHS. I was against that suggestion because I wanted general public immunity as quickly as possible, in order to avoid further lockdowns. I did not think this would be achieved by favouring certain groups. Furthermore, people in all sorts of professions were equally exposed to virus and so such an approach would have been difficult to manage in a fair and logical fashion.

Vaccine Passports and Certification

124. I have mentioned some discussions about vaccine passports or certification at a Vaccine Deployment meeting on 17 February 2021 and a Covid Policy meeting on 30 July 2021. It was not something that I was philosophically opposed to, however, from memory, it was not a great success. Ultimately, we abandoned plans to mandate a vaccine passport to attend a nightclub. We did use certification to encourage vaccination of care home workers, however this took time to implement and, as I have described above, was eventually overtaken by events.

Safety

125. I have described above the moments where the key risks associated with the vaccine were brought to my attention. I do remember when it first looked as though there might be a link between blood clots and the AstraZeneca vaccine. This was a nail-biting moment and I remember wondering whether we would have to stop giving the vaccine. I went to great lengths to satisfy myself that the vaccine was safe. I asked immediately for an account of complications to be given to me and for confirmation that the incidences of such issues were sufficiently rare to justify continuing the roll out. I received an oral briefing from Chris and others which was reassuring and I decided that the balance was in favour of carrying on. Overall, I do consider that the correct balance was struck between expediting the development of Covid vaccines and ensuring that appropriate safety standards were maintained.

Children

126. One issue we spent a lot of time thinking about was whether to discontinue the AstraZeneca vaccine in younger people. This raised difficult medical ethics issues because the risk of Covid to a person under 45 years old was small and the vaccine might be associated with a risk of blood clots. Doctors had to consider the benefits to each individual patient, rather than the population as a whole, when administering the vaccine. I was also concerned that there would be a general pejoration of the AstraZeneca vaccine and it would be regarded as the vaccine to avoid. It would have been a disaster if that meant that we could not vaccinate the population.

127. I remember being very uneasy about vaccinating children, particularly after the scare in relation to blood clotting. I was very worried about those risks and the effect that they might have on the vaccine rollout – which was obviously key to our route out of the pandemic. As a result, I sought advice from Chris and the JCVI. As the narrative above shows, we encouraged the JCVI to consider these risks, in particular their impact on children whose risk from Covid was lower, as quickly as possible. The JCVI took a careful approach, issuing their advice as more data became available, which seemed to be to be a sensible approach and we agreed to put their guidance into effect.

Vaccine Export Controls and Article 16 of the Northern Ireland Protocol

128. Article 16 is an emergency mechanism within the Northern Ireland Protocol which allows the UK or the EU to undertake unilateral safeguarding measures if the protocol leads to "*serious economic, societal or environmental difficulties that are liable to persist, or to diversion of trade*". On 29 January 2021, the European Commission invoked Article 16 of the Northern Ireland Protocol, by introducing export controls requiring authorisations for exports of vaccines outside the EU until the end of March 2021. This would potentially stop our vaccines being sent to Northern Ireland from the EU, and then onto Great Britain. It very quickly retracted these measures.

129. To understand these events, one needs to take a step back and look at the background. As I have described above, we refused to opt-in to the EU's procurement scheme in July 2020. In August 2020, the UK signed an agreement with AstraZeneca and the University of Oxford for 100 million doses of the vaccine. Also in August, the EU signed a separate agreement for 300 million doses. Crucially, our agreement contained an obligation on

AstraZeneca to fulfil our order before they could supply any other party from the UK supply chain, which included their contractors, the manufacturers Cobra Biologics, Oxford Biomedica and Halix (for large-scale commercial drug substance) and Wockhardt (for drug product).

130. As I have said, the UK's investment was critical to the development of the Oxford-AstraZeneca vaccine. This pre-dated the pandemic. In 2016, the Government had invested £1.87 million to support the University of Oxford to develop a vaccine for Middle East Respiratory Syndrome ('MERS'). On 23 March 2020, I&S was invested into University of Oxford from National Institute for Health Research ('NIHR') and UK Research and Innovation ('UKRI') to repurpose MERS vaccine into a Covid vaccine. On 21 April 2020, the UK government invested another £20 million in the University of Oxford for clinical trials. On 17 May 2020, we invested £65.5 million for the early manufacture of the University of Oxford - AstraZeneca vaccine. This was used to fund initial at-risk manufacturing by contract manufacturing organisations including Halix and Oxford Biomedica **[BJO2/085 - INQ000128583]**.

131. In late January 2021, the EU was struggling with its roll-out and they identified AstraZeneca – and specifically the UK's 'priority supply' under our agreement – as the issue. The European Commission believed that AstraZeneca had misled them as to their obligations to supply the UK with vaccines before fulfilling its EU commitments. At the same time, Germany was making noises that AstraZeneca was unsafe.

132. Nadhim Zahawi was our principal contact with the heads of AstraZeneca, Pascal Soriot, and Pfizer, Dr Albert Bourla. Following a tweet by the EU Commissioner Stella Kyriakides that "*[i]n the future all companies producing vaccines against COVID19 in the EU will have to provide early notification whenever they want to export vaccines to third countries*", Nadhim obtained Pascal's assurance that our contract was clear in that the UK had priority. I was also told that Madelaine McTernan, Director General of the VTF, had obtained the same assurance from Sir Mene Pangalos (AstraZeneca's Executive Vice President of R&D) **[BJO2/086 - INQ000095570]**.

133. The EU's announcement would potentially impact supplies of the Pfizer vaccine to the UK, as they were manufactured in Belgium and Germany. Nadhim also reported that Ben Osborn of Pfizer had messaged to say that that Dr Bourla had spoken with Ursula van der Leyen and they did not foresee any

issues with the delivery of their one million vaccines **[BJO2/087 - INQ000095570]**.

134. Still, without any advance warning, on 29 January 2021, the Commission invoked Article 16 of the Northern Ireland Protocol and introduced export controls requiring authorisations for exports of vaccines outside the EU until the end of March 2021. This applied to companies with whom the EU had concluded 'Advance Purchase Agreements', which included Pfizer and AstraZeneca. I was briefed the same day by the Transition Taskforce that 'exports' had been defined to include supplies from the EU – including the Republic of Ireland – to Northern Ireland, which cut right across the Northern Ireland Protocol and the Good Friday Agreement **[BJO2/88 INQ000528320]**.

135. Understandably, the move prompted anger throughout the Republic of Ireland and Northern Ireland (Arlene Foster called it "*an incredible act of hostility*" **[BJO2/89 - INQ000474748]**, but it was also swiftly criticised by the WHO for undermining international co-operation on vaccines **[BJO2/90 - INQ000474751]**.

136. I recall that this prompted a series of calls late that day as I sought to resolve the situation. First, Arlene Foster in the afternoon and then in the evening with the Taoiseach, Michael Martin, before two calls with Ursula von der Leyen **[BJO2/091 - INQ000226185_0340]**.

137. I recall that Ursula von der Leyen seemed embarrassed by the situation and it was clear to me that the Commission had been acting on orders from some of its Member States. She assured me that the purpose of the export control was for transparency, not actually to block exports. She further said that any attempt to block vaccine exports would need to be approved by the Commission and provided an explicit assurance that Pfizer deliveries would not be affected **[BJO2/92 - INQ000128584]**.

138. Shortly after (at 11:37pm), Ursula tweeted, "*Constructive talks with Prime Minister @BorisJohnson tonight. We agreed on the principle that there should not be restrictions on the export of vaccines by companies where they are fulfilling contractual responsibilities.*" **[BJO2/93 - INQ000474750]**. The Commission also issued a press release to say that it would "*ensure that the Ireland / Northern Ireland Protocol is unaffected. The Commission is not triggering the safeguard clause.*"

139. However, the threat of invoking Article 16 again remained as the Commission said, "*[s]hould transits of vaccines and active substances toward third countries be abused to circumvent the effects of the authorisation system, the EU will consider using all the instruments at its disposal* **[BJO2/094 - INQ000474749].**

140. In my 'box return' on 1 February 2021, I commented upon the 'Weekly Transition Update' from the CDL (dated 29 January 2021) that "*They [the EU] have shown their true colours on the article 16 affair. No more Mr Nice Guy!*" **[BJO2/95 - INQ000528321].**

141. Nadhim messaged me again on 1 February 2021 to say that he had spoken to Soriot that morning and thought he was much more relaxed and things were in a better place with von der Leyen **[BJO2/096 - INQ000095619].**

142. Having received advice over the weekend, on Tuesday 2 February 2021, I agreed to the CDL sending a letter to the Vice-President of the Commission, Maroš Šefčovič, formally registering our objection to the Commission failing to follow the agreed procedure for triggering Article 16 and our assessment that the revised regulation, Regulation (EU) 2021/11, '*did not place any restrictions or new processes of any kind on movements of vaccine from Northern Ireland to Great Britain, in accordance with Article 6 of the Protocol (as well as no restrictions from the European Union to Northern Ireland).*" **[BJO2/97 - INQ000474753].**

143. Before this incident, as part of the Brexit transition, there were still a large number of important issues to resolve with the Northern Ireland Protocol, relating to the supermarket authorised trader scheme, supply of chilled meats, parcels, tariff rate quotes and steel, and pets. However, in practice, there were no supplies of EU vaccines to the UK through Northern Ireland, and the invocation of Article 16 itself would not – at that point in time – have had any practical impact on vaccine supply **[BJO2/98 - INQ000528320].**

144. Nonetheless, it caused considerable shock and anger across both Northern Ireland and the Republic of Ireland – especially given the complete lack of notice and failure to follow due process. This left us with a big job to restore trust and confidence in the Northern Ireland Protocol, bringing a renewed urgency swiftly to resolve the outstanding issues at the Northern Ireland border through political engagement, rather than further technical negotiation with the Commission.

145. Despite the assurances Ursula von der Leyen provided, the EU and Commission again created tensions at the end of February and beginning of March, suggesting that the UK had effectively imposed an export ban – which was simply untrue. On 4 March 2021, Italy blocked a shipment of Oxford-AstraZeneca to Australia, to which the Commission did not object **[BJO2/099 - INQ000128584].**

146. On 11 March 2021, the EU extended its export control regulations to the end of June 2021. I spoke with Pascal Soriot on 15 March to reiterate the UK's support for the Oxford-AstraZeneca project. We agreed that the EU's stance was paradoxical in blocking exports and preventing its use in the EU. Pascal explained that they had informed the EU that their stance would prevent AstraZeneca fulfilling its UK supply, but thought that there was no chance the Commission would allow exports from Halix, as they believed they had a right to share the product. We agreed to explore all available options to ensure the UK supply **[BJO2/100 - INQ000528323].**

147. Then, on 17 March 2021, Ursula von der Leyen decided to make a number of public statements threatening to seize production and intellectual property of vaccines on the basis that Europeans had to be vaccinated and it was therefore proportionate to block exports to countries with higher vaccine rates **[BJO2/101 - INQ000128577]**.

148. At that point, the UK's death toll was the highest in Europe and 8 million Britons were waiting for a second dose of Pfizer. AstraZeneca had a contractual obligation to fulfil 100 million doses to the UK before it could supply the EU from Halix. Whilst we had administered 94.1% of the AstraZeneca vaccines we held, the EU had administered less than 50%. The view in the EU was that AstraZeneca had misled them in suggesting that their prior contractual commitments would not conflict with the EU, when ours in fact took precedence **[BJO2/102 - INQ000128584].**

149. We had been monitoring the situation closely and, despite the Dutch sentiment that they did not want to block vaccines, they were beholden to EU roles. I felt that I was under a duty to consider any potential steps that could be taken to secure the vaccines. This included exploring whether we could physically take possession, even considering military options although thankfully it never came to that.

150. On 17 March 2021, the same day she had made this announcement, I spoke to Ursula von der Leyen at 5.30pm **[BJO2/103 - INQ000217326].** I set out my concerns that AstraZeneca was struggling to export from Halix which ran counter to her previous assurances that there would be no restrictions on the supply of vaccines. She said that there was frustration with Pascal Soriot and AstraZeneca's under-delivery to the EU, and complained that, whilst the EU had delivered 10 million doses of Pfizer to the UK, the EU had not received a single dose from the EU. I pointed out the UK's investment in AstraZeneca was critical – the vaccine would not exist otherwise. The UK had priority supply which, once fulfilled, would result in UK exports to the EU. The supply chains were complicated and we were already exporting lipids to the EU, which were needed for the Pfizer vaccine. She maintained that AstraZeneca's contracts with the UK and EU were contradictory and she expected UK sites to fulfil the EU's orders, also.

151. We agreed that our respective teams needed to discuss this further but, before the call ended, I emphasised that the EU had 7.5 million doses going unused and its actions and comments were irresponsible. I asked her directly if, at least, her previous assurances still stood. She said she would not give one, as she had not received one. I did not know what sort of assurance she wanted. We had developed the vaccine, ensured its affordability, and provided the EU with vaccine components. She said that she expected the UK to be delivering AstraZeneca to the EU and simply did not accept the UK's priority supply.

152. Nadhim was in regular contact with Pascal throughout this period, as the EMA deliberated on its approval for the AstraZeneca vaccine **[BJO2/104 - INQ000095990]**, with European leaders making reckless and contradictory statements as to potential safety concerns.

153. Ultimately, this was a commercial issue between AstraZeneca and the EU. Still, I did not want the issue being politicised and I sought to work through the issue with European leaders. For example, I proposed to President Macron, on 21 March 2021, that we could potentially agree that the EU could release the Halix products and the UK would send a proportion back to the EU once we had met our own needs **[BJO2/105 - INQ000528324].** This did not come to anything.

154. Whilst the EMA approved the Halix site on 26 March 2021, I do not believe that we ever obtained any vaccines. I believe that we had expected to receive c.10-15 million Halix doses. Instead, AstraZeneca fulfilled their contract through other supply chains. As a practical matter, we had to assume that there would be no supply from Halix and we were working with AstraZeneca to supply from alternative sources, including from the Serum Institute of India **[BJO2/106 - INQ000145760]**, which I address below.

155. Whilst we were also concerned that the EU might block Pfizer exports, thankfully, we did not experience any issue as a result of the export control and Pfizer's supply remained consistent throughout 2021 (see for example **[BJO2/107 - INQ000528325].** I spoke fairly regularly with Dr Bourla in early 2021 and, during this period, he provided assurances directly about our supply. For instance, when we spoke on 18 March 2021, his impression was that Pfizer's supplies would be unaffected because it was delivering as planned to Europe **[BJO2/108 - INQ000217327].**

The Serum Institute of India

156. I have been informed that, in around October 2020, the Serum Institute of India (the 'SII') approached the UK to offer ten million doses of the AstraZeneca vaccine, which was rejected by the VTF. For context, India is the biggest global vaccine producer in the world and the one of its major manufacturers. SII manufactured the 'Covishield' vaccine under licence from the University of Oxford and AstraZeneca (similar, but different, to their vaccine).

157. I do not now recall being involved with that decision but, at the beginning of 2021, I saw stories reporting that India had an excess of vaccines. I asked Nadhim and Matt to investigate whether we had attempted to secure any. They informed me that the VTF was concerned that it would have taken the MHRA too long to approve the SII manufacturing sites and had decided we had sufficient supply elsewhere **[BJO2/109 - INQ000095239]**.

158. The issue resurfaced when we became aware that the EU was planning to introduce its export control, as the SII could potentially fulfil part of AstraZeneca's commitment **[BJO2/110 - INQ000095557]**.

159. On 3 February 2021, I received a briefing on 'Project Venture' (as this potential deal was called) from Madelaine McTernan, Director General of the VTF, which explained that SII was offering an additional 20 million doses to the

UK. However, as the briefing explained, this was a particularly complex deal. It would require AstraZeneca's approval, temporary MHRA approval, as well as the Government of India's agreement to export. Further, 7.5 million of the doses available had to be used by the end of March 2021. We also wanted to avoid giving the impression that we might be diverting vaccines away from deployment in India itself, or low- and middle- income countries which, as I explain below, was not in fact the case **[BJO2/111 - INQ000528322].**

160. Nadim led discussions with Pascal Soriot and terms were agreed for the delivery of ten million doses to the UK. However, Kate Bingham informed me that Sir Clive Dix had threatened to resign as Chair of the VTF if the deal was signed on the basis that the UK should not be "*taking away vaccine from India*". However, AstraZeneca was prepared to warrant against this – the contract said that the supply would not impact SII's obligations within India, or to low- or middle- income countries **[BJO2/112 - INQ000095800].**

161. On 19 February 2021, I discussed the issue with the Foreign Secretary, Health Secretary, Minister for Vaccine Deployment and Madelaine McTernan. The DHSC was recommending the procurement of ten million vaccine doses manufactured at the SII. Subject to MHRA approval, I approved the decision on the basis that the ten million formed part of the 100 million which we had already contracted for with AstraZeneca **[BJO2/113 – INQ000234302]**, and our AstraZeneca contract was amended on 22 February 2021. Further work was required to secure the Government of India's agreement to export the vaccine before we received the first delivery of five million doses on 6 March 2021 and the second in mid-April.

162. Securing this supply at such short notice was hugely impressive work by the VTF. In hindsight, one might argue that we should have accepted the SII's initial offer in 2020 but that decision must be considered in its context. The VTF were considering all potential vaccine supplies and had decisions to make as to which had the best chance of quick and successful deployment. As part of that, I understand that they ruled out any vaccine that had no realistic chance of starting clinical trials in 2020 **[BJO2/114 - INQ000474752].**

Investment and Taxation

163. I have been asked to provide further detail on the recommendation in my Module 2 statement (paragraph 157) that "*We need to invest in UK vaccine*

development and manufacturing and we need to the tax framework to encourage such investment".

164. On investment, whilst we had invested in projects such as the Oxford MERS vaccine before the pandemic, we had to take a lot of big decisions to invest a huge amount in vaccine research and development, manufacturing and supply in a very short space of time. Ideally, we would be continually investing in the UK's vaccine development and infrastructure, so it can be quickly redirected for the next pandemic.

165. On taxation, I do not recall any specific issue with the tax framework at the time, but this is one of the main levers which government has to encourage such investment. I have always been in favour of encouraging investment. This is demonstrated by a letter I received from Pascal Soriot, pre-pandemic, responding to my first statement as Prime Minister in which I said we should "*change the tax rules to provide extra incentives to invest in capital and research*". Pascal said, "*I appreciated your announcement that you will examine changing the tax rules to provide incentives to invest in capital and research and I attach a paper from the British Pharmaceutical Group that proposes changes to R&D Tax Credits that would encourage increased R&D activity in the UK*" **[BJO2/115 - INQ000528319].**

166. I also worked to encourage the onshoring of mRNA vaccine manufacturing to the UK to ensure we have resilience to future supply chain shocks. This led to Moderna doing a deal with us to build a vaccine plant capable of manufacturing tens of millions of doses. On landing this deal I said, "*We are bringing supercharged, homegrown vaccines right to our shores. I want the UK to be the brightest and best in research and technology, creating more jobs and securing our economic future*."

167. In June 2021, Dr Bourla also set out more general concerns about the UK's ecosystem and market being unattractive for Pfizer; the UK does not buy much innovative medicine due to NICE policies/procedures, but the relationships fostered by the CSA meant that their work with the VTF was the best of any country.

Prophylactics

168. I do not have any specific recollection of being involved in discussions regarding the decision not to source prophylactic antibody cocktails, such as

Evusheld. I know, however, that in February 2021 advice was provided by Chris which led to the VTF taking the decision to recommend that the Ministerial Investment Panel not make an advance purchase of Evusheld. I am confident that I would have been informed of this at the time.

169. I am aware that in her book Kate Bingham says that she was "*flabbergasted*" by DHSC's decision not to order any of the antibody cocktail that was being developed by AstraZeneca. At the time, I do not believe I was told of Kate's views. My recollection is that, by time this issue was presented to me, it had been decided that it was not an approach we were going to pursue as we were going to adhere to the strategy of dramatically suppressing the virus.

Therapeutics

170. One of the key breakthroughs of my Government in the therapeutic domain was supporting the RECOVERY Trial, which was a study to see whether we could repurpose existing therapies for other diseases to Covid. This was the largest such trial in the world (bigger than the next trial involving 40 different countries), and led to the discovery that dexamethasone dramatically reduces risk of death by up to 35% for Covid in patients. This trial was able to happen because of funding we provided (£2.1 million) and the way they were able to recruit from the entire connected NHS system, getting patients from almost every hospital in the country. It's estimated that the discovery of dexamethasone reducing Covid risk of death, saved 22,000 lives in the UK and one million lives globally.

171. In April 2020 the Therapeutics Taskforce was established in DHSC. The Therapeutics Taskforce reported to Matt and to me. In April 2021, it was merged with the Antivirals Taskforce following a suggestion that was made to me by Patrick. Matt wrote to me on 6 April 2021 to update me on the Antivirals Taskforce's strategy **[BJO2/116 - INQ000256956]**. A year later, the Antivirals and Therapeutics Taskforce was established.

172. Following their inception, I was constantly updated on the work being done by these taskforces. This was often done by Matt. For example, following the establishment of the Antiviral Taskforce, Matt wrote to me in April 2021 to update me on the work that was being done to manufacture and develop the

updated Life Science Strategy which I had previously requested **[BJO2/117 - INQ000420971]**.

173. I was updated on the work being done to develop therapeutics throughout the course of the pandemic. This often occurred in the 09.15 meetings. On 24 March 2020, for example, I was updated on both vaccines and countermeasures **[BJO2/118 - INQ000056112].** Following this meeting, steps were taken to accelerate trials of prophylactic drugs. On 27 March 2020, Jonathan Van Tam provided an update on three treatments which were thought to be promising. I recall Chris providing a briefing the following week on the treatment options which were available should ventilator capacity be exceeded **[BJO2/119 - INQ000088310].** Thankfully, this never happened. On 2 April 2020, I was updated on the treatments that were being used by other countries **[BJO2/120 - INQ000088332] [BJO2/121 - INQ000088333].**

174. I was also updated on the progress that was being made on therapeutics in the Dashboard meetings.

175. Decisions about which therapeutics to prioritise were guided by the medical advice we received. However, decisions about expenditure must be made by politicians and, ultimately, fell to me. I believe it was right for the Government to be willing to allocate significant amounts of public money to fund the development and procurement of both existing and new treatments for the virus.

176. By way of an example of the decisions which I was required to make, on 17 September 2021 I received a submission in which concerns were expressed by the Treasury about the large sums that were being spent on antivirals before their effectiveness was fully understood **[BJO2/122 - INQ000477899]**. These concerns were shared by the Covid Taskforce. It was recommended that I support the Treasury's position that certain antivirals should be funded by the Antivirals Taskforce's existing budget. In the meeting in which this issue was discussed, I was sceptical about spending significant amounts of public money in unproven treatment, but I recognised the need to protect the most vulnerable in case a vaccine resistant variant emerged. I therefore approved the recommendation which was made **[BJO2/123 - INQ000420975]**.

177. The development of Omicron in late 2021 posed particular challenges. In late November 2021 a funding proposal was made by DHSC to the Treasury

to spend [I&S] to purchase an additional 1.2 million doses of Merck and 3 million doses of Pfizer antivirals. The Treasury disagreed with this proposal on the basis that the extent to which antivirals would reduce the need for NPIs was still to be determined. On 13 December 2021, advice was provided to me by Simon Ridley **[BJO2/124 - INQ000421051].** That same day, I decided that the doses should be purchased as a matter of urgency. I also asked whether work could be done by DHSC to bolster the antiviral negotiating team. I also asked for clear delivery plans to ensure that antivirals could be made more readily available that winter.

178. I believe that the right balance was struck between investment and development of vaccines and investment and development of therapeutics. We were willing to try everything to suppress the virus and protect the vulnerable.

Lessons for the Future

179. We need to be better prepared for future pandemics. When I was Prime Minister I used my 2020 UN address to call for a five point plan to create a new approach to global health security. I think I was the first world leader to call for such an approach. I was proud to follow this up by bringing together the G7 leaders to agree the Carbis Bay Health Declaration, to improve the global health security infrastructure.

180. When I left government, we were still proceeding with the Vaccine Manufacturing and Innovation Centre in Oxford. The decision to mothball this site in November 2022, shortly after I left office, was a mistake and I fear the lessons learnt from the vaccine roll-out are being too quickly forgotten. What I wanted was for the UK to be properly fortified against the next pandemic – there will be one – through investments like this and the Moderna's mRNA Innovation and Technology Centre in Harwell, which I believe is due to become operational in 2025.

181. I also believe there are lessons in how the VTF forced collaboration between public and private sectors to accelerate development, that we can use to tackle the other great public health challenges, like cancer and dementia. That is why I then commissioned and launched the Life Sciences Vision, in which I pledged:

> "*Modelled on the approach of the Vaccine Taskforce, we will direct our record investment in scientific research towards new missions – uniting*

our world leading academic base, the power of our capital markets and the amazing data resource of our NHS to forge ground-breaking advances against diseases such as cancer, dementia, and obesity."
[BJO2/125 - INQ000474754].

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed **Personal Data**

Dated 18 December 2024