

January 2021

To Members of the Joint Committee on Vaccines and Immunisation,

Re: Review of Child Vaccination Programme

On 3 September 2021 the JCVI advised against recommending the mass vaccination of healthy 12–15-year-olds against Covid-19. The principal reason given for this was that, while the known benefits and harms from vaccination to this age group were both very small, the Committee was concerned about the *unknown* potential harms of the new vaccine, particularly the long-term and possibly serious risks of myocarditis. The [JCVI estimated](#)¹ that for every one million 12-15-year-olds vaccinated with two doses, 2.54 ICU admissions would be avoided and up to 51 cases of myocarditis caused. Subsequently, the risk of myocarditis and other adverse events has been shown to be greater than believed by the JCVI at the time.

The Government referred the matter to the CMO, asking him to consider the ‘wider benefits’ to children of vaccination. On 13 September 2021 [Professor Chris Whitty recommended](#)² that one dose of the vaccine be given to healthy 12–15-year-olds on the basis that it would possibly provide ‘marginal benefits’, specifically in reducing the time spent out of school as a result of Covid infection. This was calculated as a saving of, on average, [15 mins of education per child](#)³. (This estimate did not take into account disruption even from short term vaccine side effects and is also based on assumptions about the level of protection one dose of the vaccine gives against infection which have proved to be over-optimistic.)

The risk and benefit calculations made by the JCVI and the CMO were based on less complete data on both the harms and benefits of vaccinating children compared to the evidence now available. Four months later, we are in a very different position, with the virulent Delta variant almost completely replaced by the milder Omicron variant. Additionally, society now has a higher level of robust immunity from natural infection than it had when teenage vaccination was approved.

We have seen in recent weeks that Omicron is significantly more infectious than Delta (based on secondary attack rates, it was originally [twice as transmissible as Delta](#)⁴, but this has declined to [1.3 times as transmissible](#)⁵ as naturally acquired variant-specific immunity to it has risen). Vaccines are also far less effective at stemming the transmission of Omicron, compared to Delta (protection appears to fall to zero, [3 months after vaccination](#)⁶).

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<https://www.gov.uk/government/publications/jcvi-statement-september-2021-covid-19-vaccination-of-children-aged-12-to-15-years/jcvi-statement-on-covid-19-vaccination-of-children-aged-12-to-15-years-3-september-2021>

² <https://www.bbc.co.uk/news/health-58547659>

³ <https://www.spectator.co.uk/article/will-vaccinating-teenagers-really-prevent-disruption-to-schools->

⁴

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1042367/technical_briefing-31-10-december-2021.pdf

⁵

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1043807/technical-briefing-33.pdf

⁶ <https://www.medrxiv.org/content/10.1101/2021.12.20.21267966v3.full>

More data have emerged about the frequency of harmful side effects of Covid vaccination. One [study](#)⁷ found that for males under 40, risk of myocarditis was up to 14 times higher after vaccination than after infection (101 cases after the Moderna second dose, compared to 7 cases after infection).

It is particularly important to note that the risks of myocarditis in young men and boys seems to increase significantly after a second dose of the vaccine – which is why Chief Medical Officer Professor Chris Whitty initially recommended just one dose be given to 12-15 year olds – and yet we are now offering second doses to children, despite the evidence of risk growing.

It therefore seems clear that the risk to benefit ratio for child Covid vaccination has worsened since September. The risks of adverse events (including but not limited to myocarditis) increase as more doses are given, and any advantages are reduced as vaccine effectiveness in suppressing Omicron transmission decreases (especially given widespread natural immunity). Given that any potential benefits of vaccinating children were calculated to be marginal at best in the first place, we suspect that this margin has not only evaporated but actually reversed in light of the characteristics of the new and dominant Omicron variant and the increase in robust and durable naturally-acquired immunity.

Furthermore, the negligible risks of Covid infection to children have become even more nugatory if, as it appears, Omicron is associated with less severe disease, whereas the benefits of natural infection (rather than vaccination) in terms of longer lasting immunity are becoming more clear.

Unlike the elderly and clinically vulnerable population – for whom the potentially life-saving benefits of vaccination substantially outweigh any risks from vaccination – our children face no such threat from Covid-19 yet have 50 or more years of healthy life expectancy ahead of them that *could* be compromised by long-term vaccine harms. It is crucial that, if we are to proceed with the mass double vaccination of healthy children, we are absolutely certain that this policy will do more good than harm. Furthermore, we need to give consideration to what precedent is being set for triple or even continuous and regular vaccination for this age group.

We believe that the benefit to risk ratio of child vaccination should be reassessed in light of the Omicron variant and new evidence on both vaccine harms and superior natural immunity. We urge the JCVI to review this new evidence and provide updated advice to the Government with regards to the mass vaccination of healthy 12-15 year olds.

Yours sincerely,

Miriam Cates MP

Steve Brine MP

Thomas Coke, the Earl of Leicester

Philip Davies MP

Richard Drax MP

Baroness Foster of Oxton

⁷ <https://www.medrxiv.org/content/10.1101/2021.12.23.21268276v1.full>

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