

Professor Lim Wei Shen,  
JCVI and all members

Professor Sir Christopher Whitty  
Chief Medical Officer

Rt Hon Sajid Javid  
Secretary of State for Health and Social Care

Cc Rt Hon Boris Johnson  
Prime Minister

10th February 2022  
Updated 13th February

Dear Professor Shen, Professor Whitty and Sajid Javid,

We wrote to you and also the MHRA [last month](#) regarding urgent investigation of the acknowledged increase in all cause mortality in males aged 15-19 since the Pfizer covid vaccine rollout commenced in this age group in May 2021. [ONS](#) have acknowledged in the High Court in London, that the figure of 402 excess deaths is significantly higher than the previous 5 year average of 337 deaths. It has proved impossible to get the actual data. Indeed they stated it is probably an underestimate because of delays for coroners' cases. This equates to at least two additional teenage boys dying each week of the roll-out, possibly more. It is thus very disappointing not to have received any response.

We are writing further to ask you to pause the vaccines for children while you undertake and publish an urgent review of the risk/benefit analysis. In August 2021 you concluded that there was no medical justification for vaccinating healthy 12-15-year-olds, with the authorisation based on an aim to reduce school closures. But this new safety signal and the impact of this uncertainty, must affect your assessment of the risk to benefits.

Since that date, much has changed. The latest omicron variant has been shown to have a much lower risk of serious illness, [hospitalisations and deaths](#) than the previous alpha and delta variants circulating at the time of the decision. This is true



for [children](#) as well as adults, so given the [extremely low risk](#) for children in previous waves, any potential for benefit must surely have dwindled to virtually zero. Also, in your analysis you failed to take due regard to [naturally-acquired immunity](#), now [demonstrated](#) and widely accepted to be superior to vaccine acquired immunity. Children have had [high rates of infection](#) throughout recent weeks with at least 80% now estimated to be immune. In addition, the efficacy of Pfizer against omicron compared to previous variants is reduced to the point where infection rates are now [higher in the vaccinated](#) than the unvaccinated removing any potential indirect benefit to immune-compromised family members and perversely creating an increased risk to contacts of the vaccinated.

On the risks side of the balance sheet, we have further information regarding myocarditis, with an occurrence rate of 1/2680 young men in [Hong Kong](#), where unlike the UK, this was sought systematically from the start of their rollout. Indeed they paused their second dose, just as the UK moved from one to two doses. Data from the [US](#) also confirm high rates of 1/9443 in males aged 16-17 after their second dose. We still have no follow-up data on the increasing number of children reported from the US with significant abnormalities on their cardiac MRI scans. We also have worrying information on [all-cause mortality](#) by vaccination status, which even from the original adult Pfizer trial showed a higher mortality rate for the vaccinated group. Side effects are [higher](#) when vaccinating those already immune. Other side effects such as increased blood clots will all be playing a part in this balance of risk. Non-fatal adverse events, particularly neurological, have the potential to blight the lives of affected children. The latest information from the [CDC](#) is very worrying, that of 4149 injured children, 100 (2.41%) had a serious adverse event, 15/4149 (0.36%) had increased troponin (12 confirmed to be myocarditis), 12/4149 (0.29%) had seizures, 2/4149 (0.048%) died (being evaluated). This in itself is a reason to review. To clarify, this is 4149 non-serious adverse events and 100 serious adverse events reported in a total of ~8 million doses to this age group which is 1 in 80,000 but we know that VAERS is a gross underestimate.

Furthermore, there is increasing evidence of [impairment](#) of [immune function](#) particularly following multiple doses of vaccine. [Israel](#) is now seeing serious illness and death after the fourth vaccine dose. There is also new [bio-distribution](#) data showing that mRNA and spike protein, far from being eliminated within a few days, are still persisting for 60 days or more. We have **no** knowledge of the [long-term](#)



[implications](#) of vaccinating children against what is now acknowledged to be a very mild illness for them, indeed with 50% having no symptoms whatsoever..

With the arrival of omicron, SARS-CoV-2 has moved from pandemic to endemic. If the current situation had existed six months ago, there would have been no case made for commencing routine rollout for healthy children. Now, at a time when it is proposed that even those testing positive for omicron do not need to isolate. If omicron is no risk to others, why vaccinate? The prospect now of widening the coverage to 5-11s would be all the more ludicrous. We should, like Norway & Sweden, make clear that vaccination for this age group is simply not necessary.

The time has now come to pause and acknowledge that there is no emergency for children and that for them the balance of benefit and risk now clearly favours natural immunity. On that basis the routine programme could and should be halted. Failure to act will lay you open to liability for ongoing harms.

We would like to meet with you and members of the JCVI urgently, in order to support you in taking stock of all of the pertinent new and emerging data.

Yours sincerely,

Dr Rosamond Jones, MBBS, MD, FRCPCH, retired consultant paediatrician,  
On behalf of members of CCVAG (Children's Covid Vaccines Advisory Group) and many others...

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Dr Christian Buckland	Psychotherapist. Psych(D)
Dr Megan Fraser	MB ChB, General Practitioner
Tiziana Bertinotti	Acupuncture Clinician, BHSc (Acu), BA (Hons), PGCE, MAAC

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