10 February 2022

Notice of Legal Obligations and Potential Liabilities from the UK Medical Freedom Alliance to anyone advocating or administering COVID-19 vaccines to children

This letter is addressed to you in both your personal and professional capacities. It is to notify you of your legal duties to any children in your care in your capacity as a teacher, health care professional, public office holder, carer or parent, and the potential legal position should you breach those duties.

It refers to any and all harms caused by decisions that you have made or complied with pertaining to COVID-19 vaccinations for children.

The UK Medical Freedom Alliance is an alliance of medical professionals, scientists and lawyers who are campaigning for Informed Consent, Medical Freedom and Bodily Autonomy to be protected and preserved.

This letter aims to provide up-to-date information and referenced evidence regarding the indications for and the safety of COVID-19 vaccinations in children as well as the legal requirements for obtaining fully informed consent.

Before you consider advocating or administering COVID-19 vaccinations for children, it is imperative that you thoroughly consider at least four points, which we further expand on with supporting evidence below:

1. **COVID-19 vaccines do not benefit children**
2. **COVID-19 vaccines do not prevent infection or viral transmission**
3. **The safety of the COVID-19 vaccines has not been established**
4. **Informed consent and Application of Gillick Competence**

We argue and bring evidence that administering COVID-19 vaccines to children is not justifiable.

We also take this opportunity to remind you of your duties of care towards children and the legal position should you breach those duties contributing to any and all harms that may be caused by decisions you make or comply with pertaining to COVID-19 vaccinations for children.

Introduction

Any decisions made on behalf of children must be proportionate and ethical. There is no scientific justification to support any further rollout of COVID-19 vaccines to children as a reasonable response to the rapidly reducing public health threat of COVID-19.

1. COVID-19 vaccines do not benefit children

a. Risk of COVID-19 to children

The latest COVID-19 infection fatality rate (IFR) figures from December 2021 are shown in the table below, calculated by world-renowned epidemiologist Prof Ioannidis and his team, from analysis of 25 seroprevalence surveys across 14 countries. These results clearly demonstrate that **COVID-19 is not a life-threatening illness for children, and therefore significant interventional measures are not required or justified for this age group**[i ii iii iv v].

Age	Infection Fatality Rate (IFR)
0-19	0.0013%
20-29	0.0088%
30-39	0.021%
40-49	0.042%
50-59	0.14%
60-69	0.65%
70+ (non-care home)	2.9%
70+ (all)	4.9%
Source: https://www.medrxiv.org/content/10.1101/2021.07.08.21260210v2.full	

In addition, recent evidence indicates that the risk to immunocompromised children from COVID-19 is not as significant as previously feared. A study from Imperial College found that in a cohort of 1,527 immunocompromised children, followed from March 2020 to March 2021, 38 SARS-CoV-2 infections were recorded with 4 hospital admissions, but there were no cases of severe COVID-19 disease and no deaths[vi]. This suggests that immunocompromised children and young people are at no increased risk of severe COVID-19 disease compared to their healthy peers, and therefore also derive no significant benefit from vaccination.

b. Vaccine effectiveness

It is becoming increasingly clear that vaccine immunity is short-lived[vii], even according to the Pfizer CEO Albert Bourla[viii], with protection lasting only 4-6 months. Recently published data from Denmark (Fig 1)[ix] even suggests a potentially negative effect of the vaccines, i.e., a paradoxical increased risk of COVID-19 infection. There is also evidence from San Francisco / California suggesting that *"vaccine breakthrough cases are preferentially caused by circulating antibody-resistant SARS-CoV-2 variants, and that symptomatic breakthrough infections may potentially transmit COVID-19 as efficiently as unvaccinated infections"* [x]. A high proportion of cases infected with the current Omicron variant also appear to occur in vaccinated individuals[xi] [xii]. This undermines any case for further vaccine rollout to reduce spread of COVID-19 in the community.

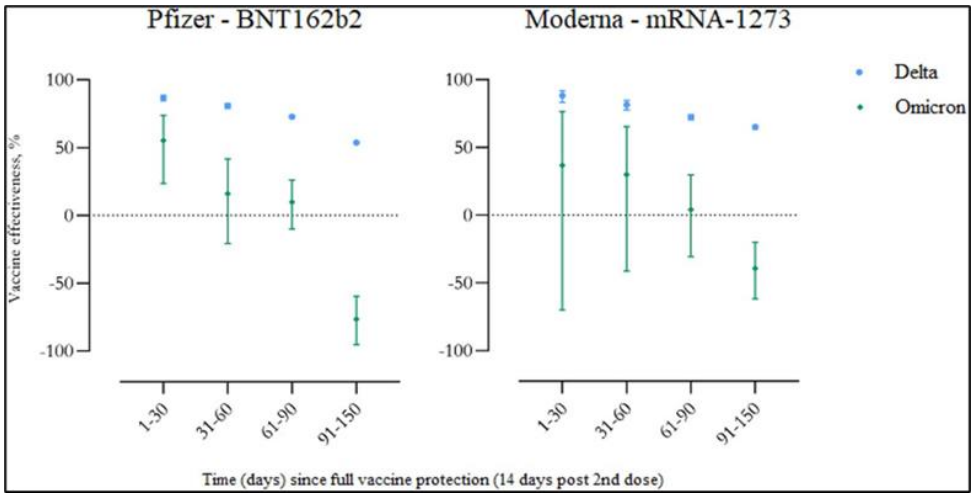

Fig. 1 Vaccine effectiveness wanes over time and is negative for Omicron after 3 months[ix]

c. Natural Immunity

After two years of the COVID-19 pandemic, the majority of children will have been exposed to SARS-CoV-2 and are likely to have developed robust, comprehensive, and long-lasting natural

immunity, which has been shown in over 140 published studies to be far superior to the highly specific, limited, and short-term vaccine immunity[xiii]. On 26 January 2022, the Office for National Statistics (ONS) published their estimate that 88.0-91.7% of 12–15-year-olds and 37.9-60.1% of 8–11-year-olds have SARS-CoV-2 antibodies (Fig 2)[xiv]. For these children, there is absolutely no benefit in taking a COVID-19 vaccine, but instead they will be exposed to known short-term and unknown long-term risks[xv]. For children, acquiring natural immunity is preferable, as this will last longer and cover a broad range of virus variants, contributing to herd immunity[xvi xvii xviii xix xx].

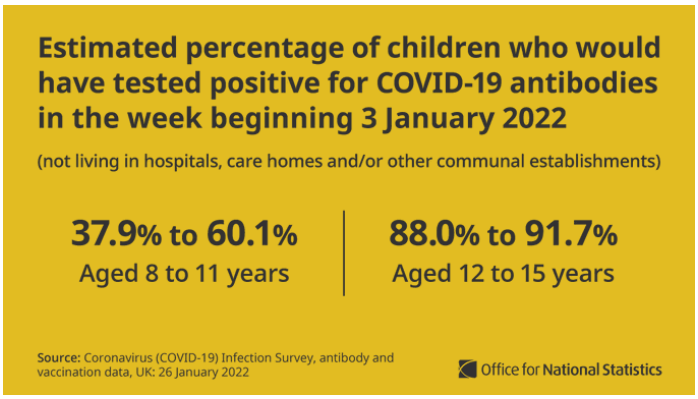

Fig. 2 ONS Estimate of Children with COVID-19 Antibodies

2. COVID- 19 vaccines do not prevent infection or viral transmission

a. Vaccinating children does not benefit their families or anyone else

Children play an **insignificant role in transmission** of COVID-19[iii xxi xxii xxiii xxiv xxv], supported by data showing that teaching is a low-risk occupation[xxvi]. In fact, a study from Scotland showed that **living with young children may even be protective against COVID-19 and COVID-19 requiring hospitalisation among adults**[xxvii].

It is now widely accepted that COVID-19 vaccines do not prevent infection and therefore cannot prevent transmission[xxviii xxix xxx xxxi]. Vaccinated individuals are just as likely to harbour and spread the virus, with comparable viral loads being reported in vaccinated and unvaccinated people [xxxii xxxiii xxxiv]. It may even be argued that the vaccinated are potentially more likely to transmit the virus to others if they are unaware of their infection due to reduced symptoms. **Vaccination therefore certainly does not confer any benefit to any person coming into contact with the vaccinee.**

b. COVID-19 vaccines do not help to keep schools open

Children and younger age groups are at minimal risk of being seriously affected by COVID-19 infection and hence gain little benefit, individually, from the COVID-19 vaccines[xxxv xxxvi]. Furthermore, there is still no robust evidence from any clinical trial data, and certainly not from a "gold standard" randomised control trial (RCT), that COVID-19 vaccination reduces either hospitalization or death[xxxvii]. **As COVID-19 vaccines do not prevent infection, they will not prevent school absences related to positive tests or minor illness**.

There is no precedent of vaccines ever successfully halting or mitigating an ongoing pandemic, and they may even risk the promotion of more virulent variants[xxxviii]. With the current COVID-19 vaccines, which do not prevent infection, it is not possible to end the pandemic, even by vaccinating the entire population, therefore **there is no scientific rationale for vaccinating children.**

3. The safety of the COVID-19 vaccines has not been established

a. Reports of adverse events

As we have clearly laid out in our Open Letter to all members of the UK Parliaments dated 9 November 2021[xxxix], concerns regarding the safety of COVID-19 vaccines are mounting. Initial theoretical concerns regarding possible mechanisms have been followed by large numbers of officially reported adverse events in the US (VAERS[xl]), Europe (Eudravigilance[xli]) and the UK (MHRA[xlii]).

In the report published by the MHRA on 20 January 2022, there were **over 1.4 million adverse reactions in the UK** from 439,578 reports (1 in 119 people injected), some of them extremely serious, including seizures, paralysis, blindness, strokes, blood clots and acute cardiac events. This report includes **1,972 fatalities**. Whilst the publicly accessible MHRA data does not differentiate age groups, it is most alarming that the database in the **US (VAERS) has reported several deaths and severe injuries in children**. It is widely recognised that only up to 10% of adverse events are officially reported, indicating that the actual number of adverse events is likely to be much higher.

Life-threatening adverse effects, such as blood clots, Guillain-Barré Syndrome, transverse myelitis and myocarditis[xliii], have been reported and listed as vaccine side-effects by regulators around the world, and the risks appear higher in young people. Although many cases of myocarditis are described as "mild", these carry a significant long-term risk of heart failure, and may require restricted exercise and medication for several months after recovery. The heart muscle does not regenerate, and therefore all damage, no matter how minimal, is permanent. It has now been acknowledged by health agencies and vaccine manufacturers that there is a clear association between myocarditis and COVID-19 vaccines[xliv xlv], and certainly for younger age groups the risks of COVID-19 vaccine adverse effects are likely to far outweigh their benefits[xlvi xlvii xlviii xlix].

b. Long-term effects

It is important to remember that **COVID-19 vaccines are still being used under temporary emergency authorisation, and do not yet have full approval**. The regulatory trials were not due to conclude until 2023, and these trials have also been compromised by allowing participants in the placebo group to cross over into the treatment arms[l]. No data from completed clinical trials is available. Certainly, no data is available regarding potential long-term effects of this completely novel gene-based (mRNA or DNA viral vector) technology, which has never before been used in humans on such a large scale. **We simply do not know what the health or fertility of the vaccinated will be in 2, 5 or 10 years as there is no-one in the world who has had any of these vaccines in their body for more than 18 months**. This is especially relevant for children who are largely healthy and have their whole life ahead of them.

c. Liability for injury

We would like to emphasize that there is no clarity as to who will be liable to pay compensation to the child or their family in the event of injury or death resulting from a COVID-19 vaccine. Vaccine manufacturers have been granted immunity from liability for any harms resulting from their products[li lii liii], and the vaccine injury compensation scheme run by the Government is inadequate to compensate for disability, with a maximum pay-out of £120,000 and a poor track record of accessibility. Aside from the manufacturer's liability, **anyone administering or facilitating**

administration of COVID-19 vaccines could potentially be liable for any damages caused to children who are injured as a result of vaccination.

4. Informed consent and Application of Gillick Competence

a. Fully informed consent

Informed consent is the cornerstone of good, ethical medical practice and is enshrined in UK and International Law and professional guidelines. The UKMFA have produced a summary document of the legislation and guidance relating to informed consent[liv]. Carrying out any medical procedure without informed consent is unlawful and constitutes medical negligence, which can lead to charges of misconduct. Without factually accurate information, with full disclosure of risks as well as benefits as outlined above, it is simply not possible for anyone, let alone children, to make a fully informed decision and give informed consent to COVID-19 vaccination. **In this instance, data regarding long-term safety and risks, which would be required for fully informed consent and is particularly relevant for children, does not yet exist.** At the very least this fact MUST be clearly disclosed, discussed and documented.

b. Application of Gillick Competence

Gillick competence is the principle deriving from the English and Welsh case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7[lv], which provides that children under the age of 16 may be able to consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. **In terms of the applicability of Gillick Competence, this cannot be assumed under current circumstances**. The judgement in Gillick makes it clear it is to apply only in exceptional cases:

> *"No reasonable person could read it as meaning that the doctor's discretion could ordinarily override parental right. Illustrations are given in the text of exceptional cases in which the doctor may take the "most unusual" course of not consulting the parent. Only in exceptional cases does the guidance contemplate him exercising his clinical judgment without the parent's knowledge and consent."*
> (per Lord Scarman at paragraph 181)

It has been stated that:

> *"The right to decide on competence must not be used as a license to disregard the wishes of parents whenever the health professional finds it convenient to do so. Health professionals who behave in this way would be failing to discharge their professional responsibilities and could expect to be disciplined by their professional body."* [lvi]

For a child to even be considered Gillick Competent, they MUST have "*a sufficient understanding and intelligence to enable them to comprehend fully what is proposed*" and:

1. understand the nature and implications of the decision and the process of implementing that decision;
2. understand the implications of not pursuing the decision;
3. retain the information long enough for the decision-making process to take place;
4. be of sufficient intelligence and maturity to weigh up the information and arrive at a decision;
5. be able to communicate that decision.

Deciding on competence must be decision-specific, child-specific, made with the specific factual context in mind, and based on the available evidence. **Competence may only be determined by a medical practitioner who knows the child, not by any other personnel administering the vaccines in schools**.

Furthermore, following the High Court case of *An NHS Trust v A, B, C and A Local Authority* [2014] EWHC 1445[lvii], Mr Justice Mosytn also stated the decision of the child must be given freely. He stated:

> *"Dr Ganguly was also clear that the decision that was reached by A was hers alone and was not the product of influence by adults in her family. Dr Ganguly did not detect in her any sign of distress when she set out her position to her."*

You will be aware that children are often subject to peer pressure from their fellow pupils. Children also look up to their teachers and can be influenced by the media and celebrities. In the current climate, relating to the prevailing dialogue around COVID-19 vaccines, it certainly cannot be the case that any child can provide fully informed consent, free from any undue influence.

c. Duty of Care

Everyone looking after children owes them a **Duty of Care**. This Duty of Care requires everyone to ensure that the legal requirements of Gillick Competence are properly adhered to when it comes to considering the administration of COVID-19 vaccines. In light of the above, and following the legal principles**, we do not accept that any child would be considered able to give fully informed consent to a COVID-19 vaccine**.

Conclusions & Requests

A) **We are calling for any further COVID-19 vaccination of children to be halted with immediate effect in order to fully investigate all injuries and deaths that have occurred to date in association with the administration of COVID-19 vaccines**. If due process of ethical clinical research was being followed, even a single death of a healthy person and certainly of a healthy child should have prompted a thorough and comprehensive investigation with disclosure of the findings to the public.

B) **Anyone involved in administering Covid-19 vaccines to children who chooses not to acknowledge the potential for serious harm to children from a Covid-19 vaccination, or who fails to share or use this information where necessary, could be held responsible in a criminal or civil court for the ensuing damage to any child suffering COVID-19 vaccine-induced injury or death from this day forward**.

C) **We therefore appeal to you not to contribute in any way to any further rollout of COVID-19 vaccines to children, but to share widely the vital information contained in this letter.**

UK Medical Freedom Alliance

www.ukmedfreedom.org

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