

What the JCVI Really Considered: Precaution, Risk-Benefit and What Was Hidden

Based on FOI Request FOI/212(1), 30 June 2025

Ethical Approach UK

Date: 9 September 2025

Introduction

On 30 June 2025, Ethical Approach UK submitted a Freedom of Information Act (FOIA) request to the Joint Committee on Vaccination and Immunisation (JCVI). The request sought evidence of how the precautionary principle and risk-benefit analysis were applied in relation to COVID-19 vaccination guidance, particularly for younger and low-risk groups.

The FOI response, received in September 2025, together with an unpublished internal presentation released under disclosure, provide important insights into how the JCVI

approached these questions and, crucially, what was not considered or communicated.

1. The Precautionary Principle

JCVI statements and minutes occasionally reference being “precautionary,” particularly in 2021 when considering vaccination for adolescents.

However, there is no evidence that the precautionary principle was applied as a systematic decision-making framework.

Its application was selective, ad hoc and absent in many deliberations, despite growing evidence of risks such as myocarditis and pericarditis.

Implication: The JCVI invoked precaution only where convenient, rather than embedding it as a core principle in its guidance.

2. Risk-Benefit Assessments

The JCVI did not conduct formal modelling themselves of risks such as myocarditis, neurological effects, or long-term outcomes.

Instead, it relied on data from the MHRA, external agencies and international literature.

The FOI disclosed one unpublished presentation (“Societal Risk-Benefit of Adverse Events Following Immunisation”) which modelled outcomes over a 10-year horizon.

Findings of the presentation:

Frequent non-fatal adverse events may produce a greater total health burden (measured in QALYs) than rare fatal events.

Vaccination was always projected as “net beneficial” at the societal level if lockdowns were avoided.

If lockdowns were anticipated, the benefits became marginal or negative for younger cohorts.

Implication: Internal materials show JCVI had access to nuanced risk-benefit analysis. Yet this nuance was not reflected in public statements, which portrayed the decision as straightforward.

3. International Comparisons

JCVI/UKHSA disclosed that they hold no documentation comparing UK decisions with those of countries such as Denmark, Sweden, Norway, Finland or Germany.

Those countries limited or withdrew mRNA vaccination for low-risk groups, citing safety concerns.

The absence of comparative assessment indicates a failure to properly contextualise UK policy against peer nations.

Implication: The JCVI operated in isolation, ignoring critical international evidence that contradicted its own direction.

4. Consideration of Vaccine Injury Data

JCVI did not carry out original analysis of MHRA Yellow Card or post-marketing safety surveillance.

They relied on MHRA summaries and presentations, without producing in-depth JCVI-led studies.

As such, the evaluation of vaccine injury was delegated, rather than integrated into JCVI's independent role.

Implication: A statutory advisory body ceded core responsibilities to regulators, raising questions about independence and rigour.

5. Policy Reassessment Processes

JCVI stated it reviews advice on a “consensus basis” as new evidence emerges.

No documentation was provided of formal procedures for:

- Frequency of reviews.
- Criteria triggering reassessment.
- Mechanisms for seeking or incorporating dissenting expert views.

Implication: JCVI lacks a transparent or codified process for reassessing policy, undermining accountability.

Conclusion

The FOI response and accompanying disclosure reveal major inconsistencies in JCVI’s approach to COVID-19 vaccine guidance:

- The precautionary principle was not systematically applied.
- Risk-benefit modelling was outsourced or unpublished, leaving the public narrative incomplete.
- International comparisons were absent, despite neighbouring countries adopting more cautious stances.
- Vaccine injury data was considered superficially, via MHRA summaries, rather than in JCVI-led evaluations.
- Policy reassessment lacked transparency, structure and independent challenge.

This raises critical questions about the integrity and independence of the UK's vaccine advisory process. The British public were entitled to expect decisions guided by consistent precaution, rigorous risk-benefit analysis and full transparency. Instead, key considerations were unpublished, unstructured, or absent.

Transparency is overdue. The JCVI must disclose in full how decisions were made and why internal evidence of risk was not shared with the public.

Addendum

Compliance with the JCVI Code of Practice (2013 Revision)

The JCVI is bound by its own Code of Practice (2013), which sets out principles of transparency, independence and accountability in its decision-making. The FOI disclosure (FOI/212(1)) highlights several areas where JCVI practice fell short of these requirements.

1. Precautionary Principle

Code Reference: 8 -11 require JCVI to make clear the principles underlying its advice, including precaution when evidence is uncertain.

FOI Finding: The precautionary principle was mentioned selectively (e.g. adolescent vaccination) but not embedded in decision-making.

Assessment: Breach - JCVI failed to apply precaution consistently or transparently.

2. Risk-Benefit Assessments

Code Reference: 13 - 16 require JCVI to provide independent, expert advice and ensure all relevant modelling and evidence are considered.

FOI Finding: JCVI outsourced risk-benefit analysis to MHRA and external studies, without JCVI-led modelling. Only one unpublished analysis was disclosed.

Assessment: Breach - lack of independent JCVI evaluation undermines the integrity of its advice.

3. International Comparisons

Code Reference: 20 - 22 emphasise the need to consider international evidence and comparator nations.

FOI Finding: JCVI/UKHSA hold no records of comparisons with countries (e.g. Denmark, Sweden, Germany) that restricted mRNA vaccines.

Assessment: Breach - omission of international benchmarking contradicts explicit Code duties.

4. Vaccine Injury Data

Code Reference: 14 and 18 require systematic assessment of adverse event data and a clear rationale for decisions.

FOI Finding: JCVI relied on MHRA summaries and did not conduct its own evaluation of Yellow Card data.

Assessment: Breach - inadequate scrutiny of vaccine injury signals.

5. Policy Reassessment Procedures

Code Reference: 27 - 30 require transparent procedures for review, including triggers, frequency and recording dissent.

FOI Finding: JCVI described reviews as “consensus-based,” but provided no evidence of formal processes or dissenting views.

Assessment: Breach - lack of codified review undermines accountability.

6. Transparency and Accessibility

Code Reference: 31 - 35 require proactive publication of relevant information unless restricted for compelling reasons.

FOI Finding: Unpublished risk-benefit modelling was withheld from public communication, leaving advice oversimplified.

Assessment: Breach - JCVI failed to proactively disclose material evidence underpinning its advice.

Addendum Summary

The FOI disclosure shows that JCVI did not comply with multiple provisions of its own Code of Practice. Failures in precautionary application, risk-benefit independence, international benchmarking, vaccine safety scrutiny, policy review processes and transparency collectively amount to systemic breaches of duty.

This undermines the credibility of JCVI's advice during the COVID-19 vaccination campaign and raises urgent questions of public accountability.



By email

request-1303065-8b3f6fd6@whatdotheyknow.com

Our ref: 30/06/25/JS/212

9 September 2025

Dear Ian Clayton,

Re: Freedom of Information request - Application of the Precautionary Principle in JCVI COVID 19 Vaccine Guidance considerations

Thank you for your request received on 30 June 2025 addressed to the UK Health Security Agency (UKHSA). Please accept our apologies for delay in issuing this response.

Request / Response

Dear The Joint Committee on Vaccination and Immunisation,

I am writing under the Freedom of Information Act 2000 to request information regarding the application of the precautionary principle in Joint Committee on Vaccination and Immunisation (JCVI) decision-making, specifically in relation to COVID-19 vaccination guidance.

In accordance with Section 1(1)(a) of the Freedom of Information Act 2000 (the Act), I can confirm that UKHSA does hold some of the information you have specified. Please see the below and the attached pdfs. Please note that in line with Section 40(2) of the Act and UKHSA's data disclosure policy, names and other identifying details of staff and third parties have been redacted.

1. Please provide the following information:

1a	All documentation, internal correspondence, meeting minutes, or policy evaluations that explicitly refer to the precautionary principle in relation to COVID-19 vaccination guidance, from 1 January 2021 to present.
1a	It may be helpful to explain that the JCVI is not a policy maker. All JCVI meeting minutes are publicly available on gov.uk: https://www.gov.uk/government/groups/joint-committee-on-vaccination-and-immunisation. JCVI statements contain the advice of the committee. The following statements include “precautionary” in them: • Statement on vaccination of young people aged 12-17 years (19 July 2021): JCVI statement on COVID-19 vaccination of children and young people aged 12 to 17 years: 15 July 2021 - GOV.UK (www.gov.uk) • Vaccination of 12-15 year olds (3 September 2021): JCVI statement on COVID-19 vaccination of children aged 12 to 15 years: 3 September 2021 - GOV.UK (www.gov.uk) • [Withdrawn] Priority groups for coronavirus (COVID-19) vaccination: advice from the JCVI, 2 December 2020 https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-2-december-2020

2. Any risk-benefit analyses, risk modelling, or formal reviews conducted or commissioned by the JCVI which assess:

2a	The risk of adverse events (e.g. myocarditis, pericarditis, neurological effects) by age and health status.
2a	This information is partially held. The JCVI did not conduct or commission any risk-benefit analyses, risk modelling, or formal reviews to assess the above as described in 2a. While not explicitly stated, we have taken the risk of adverse events by age and health status to mean, <i>following COVID-19 vaccination</i>. The Medicines and Healthcare products Regulatory Agency (MHRA) is the UK regulatory authority which monitors medicine/vaccine safety. MHRA regularly presented to the JCVI, details of which can be found in published JCVI meeting minutes.

	The FOI Act does not require a public authority to provide information in response to a request that falls outside of the scope of the request. However, we have included the following publicly available analyses in our response as, whilst the JCVI may not have specifically commissioned these analyses, they were seen and discussed by the Committee. We have also included one unpublished analysis that was presented to the Committee.
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Meeting	Availability
Sub - committee 2021.04.01	https://assets.publishing.service.gov.uk/media/65f0e1b3981227001af613fe/FOI_23-782_PDF_attachment_5_.pdf
Sub - committee 2021.04.29	Risk/Benefit assessment of thrombotic thrombocytopenic events after Janssen COVID-19 vaccines : Applying evidence to recommendation framework
Sub - committee 2021.04.29	https://pubmed.ncbi.nlm.nih.gov/34927118/
Main committee 2021.05.04	UNPUBLISHED, PDF ATTACHED - 3 Presentation - societal risk-benefit of AEFIs
Main committee 2021.06.15	https://www.fda.gov/media/150054/download
Main committee 2021.06.29	https://pmc.ncbi.nlm.nih.gov/articles/PMC10286992/
Main committee 2021.07.29	https://stacks.cdc.gov/view/cdc/108883

2b	<i>Any risk-benefit analyses, risk modelling, or formal reviews conducted or commissioned by the JCVI which assess: The expected benefits of COVID-19 vaccination in individuals under 40 years old who are not clinically vulnerable.</i>
2b	This information is partially held. The FOI Act does not require a public authority to provide information in response to a request that falls outside of the scope of the request. However, we have included the following analyses in our response as, whilst the JCVI may not have officially commissioned these analyses, they were seen and discussed by the Committee. We have also indicated specific meeting minutes which may be of interest.

Meeting	Analyses
Sub – committee 2021.04.01 Part 1	Please see published meeting minute
Sub – committee 2021.05.20	PDF attached: 210520 Vaccination impact of a children programme for COVID-19 (PHE) https://pubmed.ncbi.nlm.nih.gov/35581585/
Main committee 2021.05.04	Please see published meeting minute
Main committee 2021.06.29	PDF attached: Benefits paper_v0.04
Main committee 2021.08.26	Tables 1 to 4 in statement https://www.gov.uk/government/publications/jcvi-statement-september-2021-covid-19-vaccination-of-children-aged-12-to-15-years
Main committee 2021.09.02	Tables 1 to 4 in statement https://www.gov.uk/government/publications/jcvi-statement-september-2021-covid-19-vaccination-of-children-aged-12-to-15-years
Main committee 2021.10.19	Tables 1 to 3 in statement https://www.gov.uk/government/publications/covid-19-vaccination-in-children-and-young-people-aged-16-to-17-years-jcvi-statement-november-2021
Main committee 2021.11.12	PDF attached: JCVI benefit estimation_11.11.21
Main committee 2021.11.18	Please see published meeting minute
Main committee 2021.11.25	Tables 1 to 3 in statement https://www.gov.uk/government/publications/covid-19-vaccination-in-children-and-young-people-aged-16-to-17-years-jcvi-statement-november-2021
Main committee 2022.01.13	Please see published meeting minute Table 1 in statement https://www.gov.uk/government/publications/jcvi-update-on-advice-for-covid-19-vaccination-of-children-aged-5-to-11
Main committee 2022.02.03	Table 1 in statement https://www.gov.uk/government/publications/jcvi-update-on-advice-for-covid-19-vaccination-of-children-aged-5-to-11

	PDF attached: 220203_Estimating vaccine benefits in 5-11 yr olds_v1.3
Main committee 2022.06.28	Annex A in meeting minute https://app.box.com/s/9tifbhldibpbsg9b0h2gddvam4bue1kf/file/1313436203267



3. International Comparisons

3a	<i>Any documents or briefings comparing UK policy with that of Denmark, Norway, Sweden, Finland, or Germany, particularly where these nations have restricted or withdrawn mRNA COVID-19 vaccines for low-risk individuals.</i>
3a	UKHSA / the JCVI does not hold the information you have specified.

4. Vaccine Injury Data Consideration

4a	<i>Any <u>documentation</u> demonstrating <u>how</u> Yellow Card reporting data or post-marketing safety surveillance influenced JCVI's advice or review of COVID-19 vaccines for the general population.</i>
4a	The MHRA regularly reviews Yellow Card data and provides an online update which is publicly accessible at: https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting#analysis-of-data Presentation of Yellow Card reporting data or post marketing surveillance to the JCVI is captured in JCVI meeting minutes. All JCVI meeting minutes are publicly available on gov.uk. https://www.gov.uk/government/groups/joint-committee-on-vaccination-and-immunisation. Information may also be contained in JCVI statements, which are publicly available. You may be interested in the following: 1. JCVI statement on use of the AstraZeneca COVID-19 vaccine: 7 April 2021: https://www.gov.uk/government/publications/use-of-the-astrazeneca-covid-19-vaccine-jcvi-statement/jcvi-statement-on-use-of-the-astrazeneca-covid-19-vaccine-7-april-2021 2. Use of Astra Zeneca vaccine (7 May 2021): https://www.gov.uk/government/publications/use-of-the-astrazeneca-covid-19-vaccine-jcvi-statement-7-may-2021 3. JCVI statement on COVID-19 vaccination of children and young people aged 12 to 17 years: 4 August 2021 https://www.gov.uk/government/publications/jcvi-statement-august-2021-covid-19-vaccination-of-children-and-young-people-aged-12-to-17-years 4. JCVI statement on COVID-19 vaccination of children aged 12 to 15 years: 3 September 2021

	https://www.gov.uk/government/publications/jcvi-statement-september-2021-covid-19-vaccination-of-children-aged-12-to-15-years 5. JCVI statement on COVID-19 vaccination of children and young people: 22 December 2021 https://www.gov.uk/government/publications/jcvi-update-on-advice-for-covid-19-vaccination-of-children-and-young-people
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5. Policy Reassessment Process

5a	<i>A description of the JCVI's internal procedure for reassessing prior guidance, including:</i> <i>(a) How frequently previous decisions are reviewed, What criteria trigger a policy change, Whether external expert evidence (including dissenting views) is actively sought.</i>
5a	The role of the JCVI is to advise UK health departments on immunisations for the prevention of infections and/or disease following due consideration of the evidence on the burden of disease, on vaccine safety and efficacy, and on the impact and cost effectiveness of immunisation strategies. The JCVI works to develop consensus advice based on consideration of scientific evidence. That advice is provided to Government to inform, develop and make policy. The JCVI is not a policy maker in its own right. Please see the JCVI Code of Practice, found on the JCVI webpage.

If you have any queries regarding the information that has been supplied to you, please refer your query to the Information Rights Team in writing in the first instance. If you remain dissatisfied and would like to request an internal review, then please contact us by emailing InformationRights@UKHSA.gov.uk

Please note that you have the right to an independent review by the Information Commissioner's Office (ICO) if a query cannot be resolved through the UKHSA internal review procedure. The ICO can be contacted by calling the ICO's helpline on 0303 123 1113, visiting the ICO's website at www.ico.org.uk or writing to the ICO at Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely,
Information Rights Team



Public Health
England

Joint Committee on Vaccination and Immunisation meeting
4 May 2021

Societal risk-benefit trade-offs of potential AEFIs with COVID-19 vaccines



LONDON
SCHOOL of
HYGIENE
& TROPICAL
MEDICINE



¹Public Health England, ²London School of Hygiene & Tropical Medicine,
³University of Edinburgh, ⁴Imperial College London

I have no conflicts of interest to declare

Individual vs societal risk-benefit trade-offs

Individual risk-benefit trade-offs (e.g. by MHRA, EMA)	Societal risk-benefit trade-off
Consider risk of mortality and severe health events (e.g. ICU admission)	Consider risk of any health events including mild AEFIs, mild COVID-19, long Covid, weighed using QALYs
Consider short-term risk to the individual being vaccinated only	Consider long-term risk to the community, including change in wider COVID-19 risk due to reduced transmission
Consider health impact only	Consider both health and economic impact (e.g. cost of vaccination, cost of COVID-19 treatment, cost of physical distancing)

Why consider societal risk-benefit trade-offs?

- Societal trade-offs are considered in all other aspects of COVID-19 decision making e.g. over lockdown duration, vaccine prioritisation, travel policy.
- Costs associated with treatment (of both consequences of AEFI and of COVID-19) are opportunity costs that could be used to reduce mortality and severe morbidity in other areas.
- Individuals already (voluntarily) make decisions that involve small net risks of harm to themselves but which benefit society overall e.g. enrolling in clinical trials, working as front line HCWs or emergency responders

Model assumptions (simplified from actual UK situation)

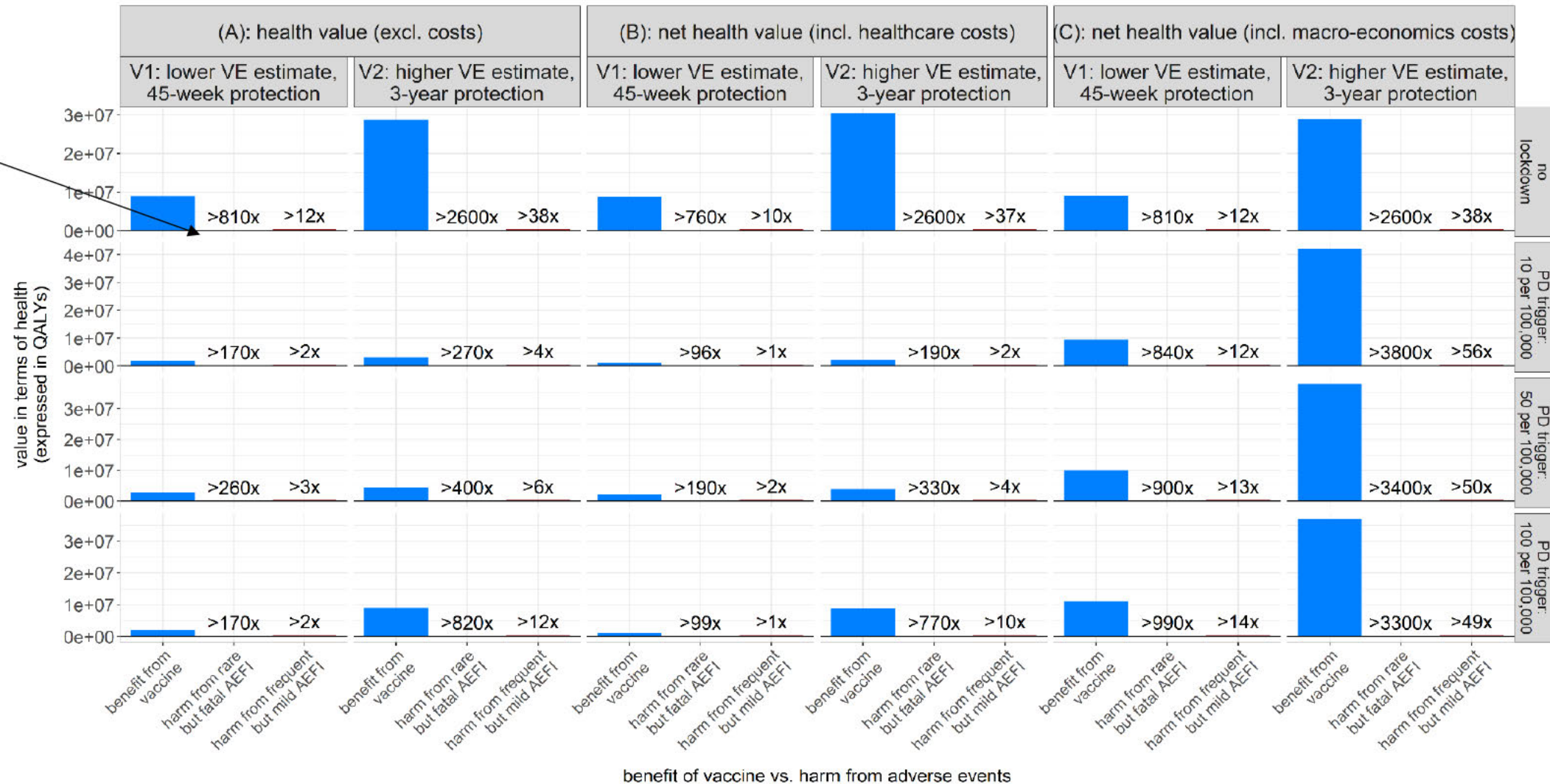
- Uses CovidM (transmission dynamic model) to project long-term (10 year time horizon) impact of vaccination vs no vaccination.
- Follows JCVI prioritisation schedule, and assumes 75% coverage with annual re-vaccination.
- Lockdowns imposed at 10, 50 or 100 cases per 100,000 (or never), with consequences on SARS-CoV-2 transmission and economic output.
- Two efficacy scenarios based on optimistic and pessimistic interpretations of ChAdOx1 trial (62% VE against disease and 4% against asymptomatic infection, vs. 91% and 56%, respectively).

Outcomes considered

	Health value (individual only)	Health value (societal)	Net health value	Net health value + macroeconomic costs
Death/severe disease due to AEFI or COVID- 19 (in vaccinee only)	✓	✓	✓	✓
All health outcomes due to AEFI or COVID- 19 (in vaccinees and community)		✓	✓	✓
Health care costs due to AEFI or COVID-19 (in vaccinees and community)			✓	✓
Wider economic costs due to physical distancing				✓

Results

Implies that QALYs gained from a low efficacy vaccine with 45 weeks protection exceed QALYs lost due to fatal AEFIs by 810x and mild AEFIs by 12x.

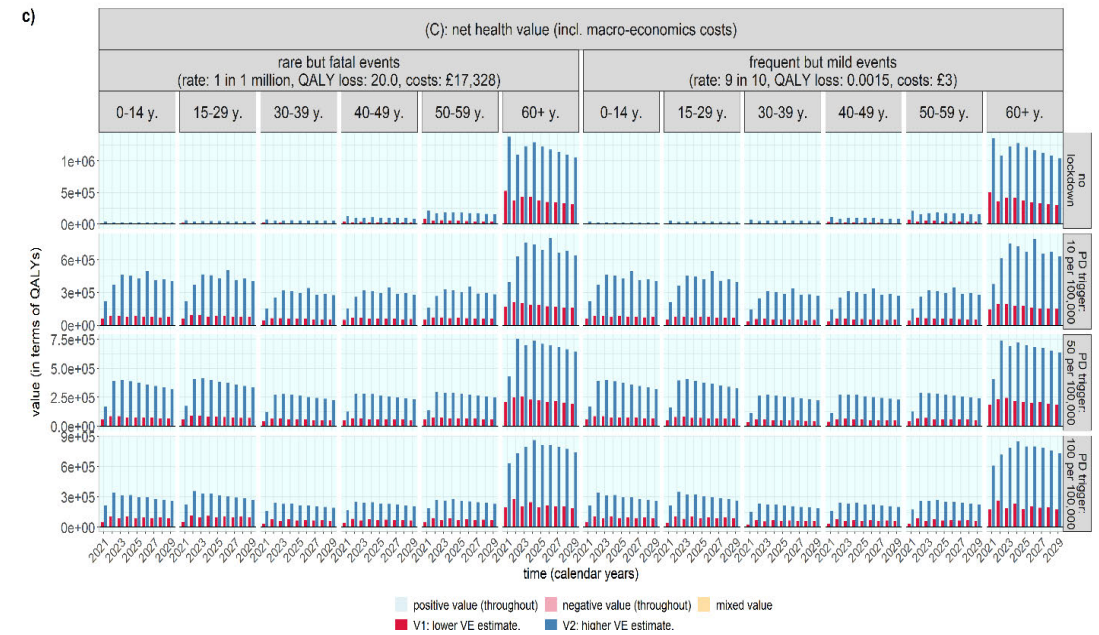
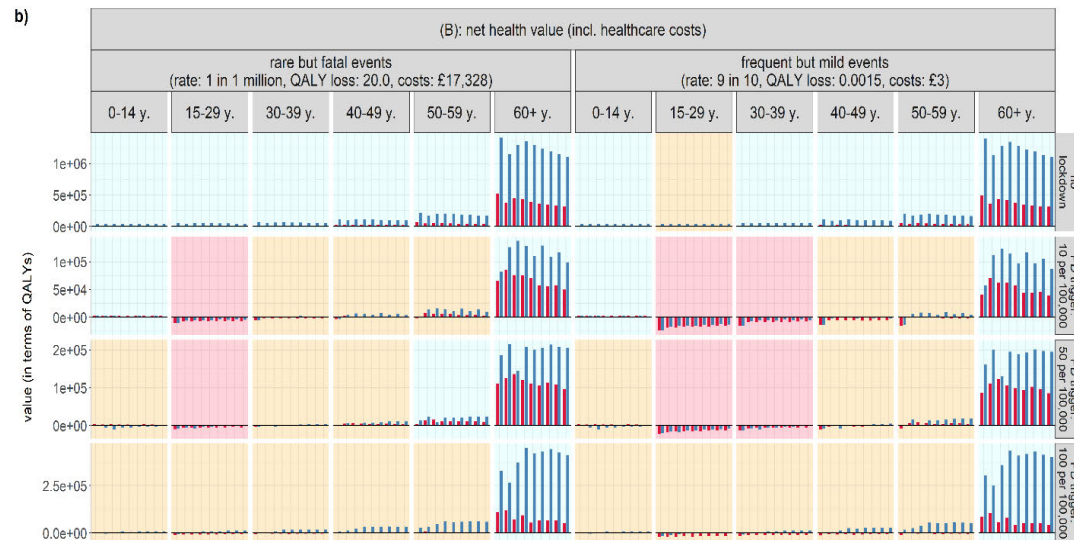
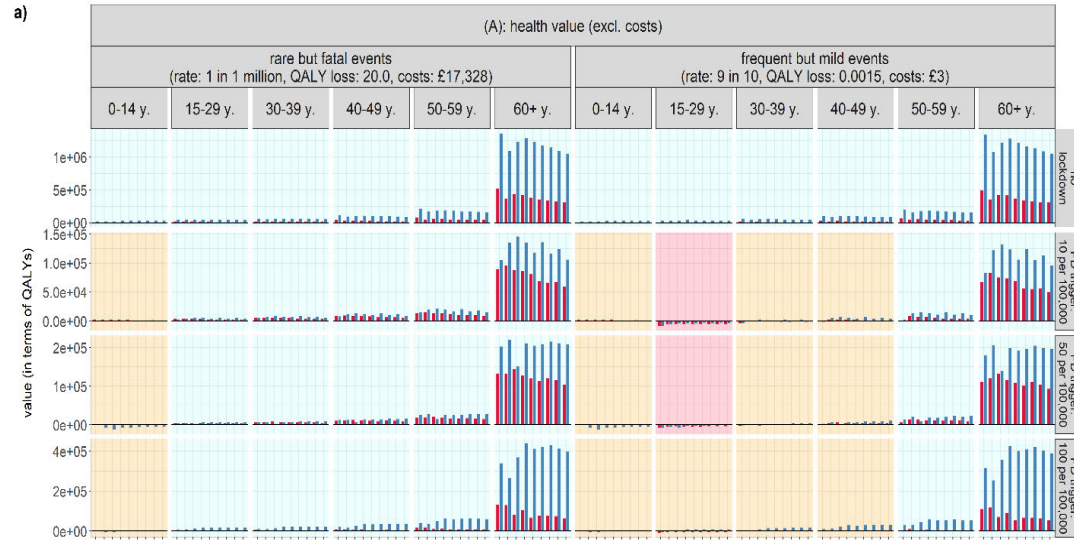


Types of AEFI:

Rare-but-fatal 1 in 1 million risk, 20 QALYs lost, £17,328 cost

Frequent-but-mild 9 in 10 risk, 0.0015 QALYs lost (~1 day of ILI), £3 cost

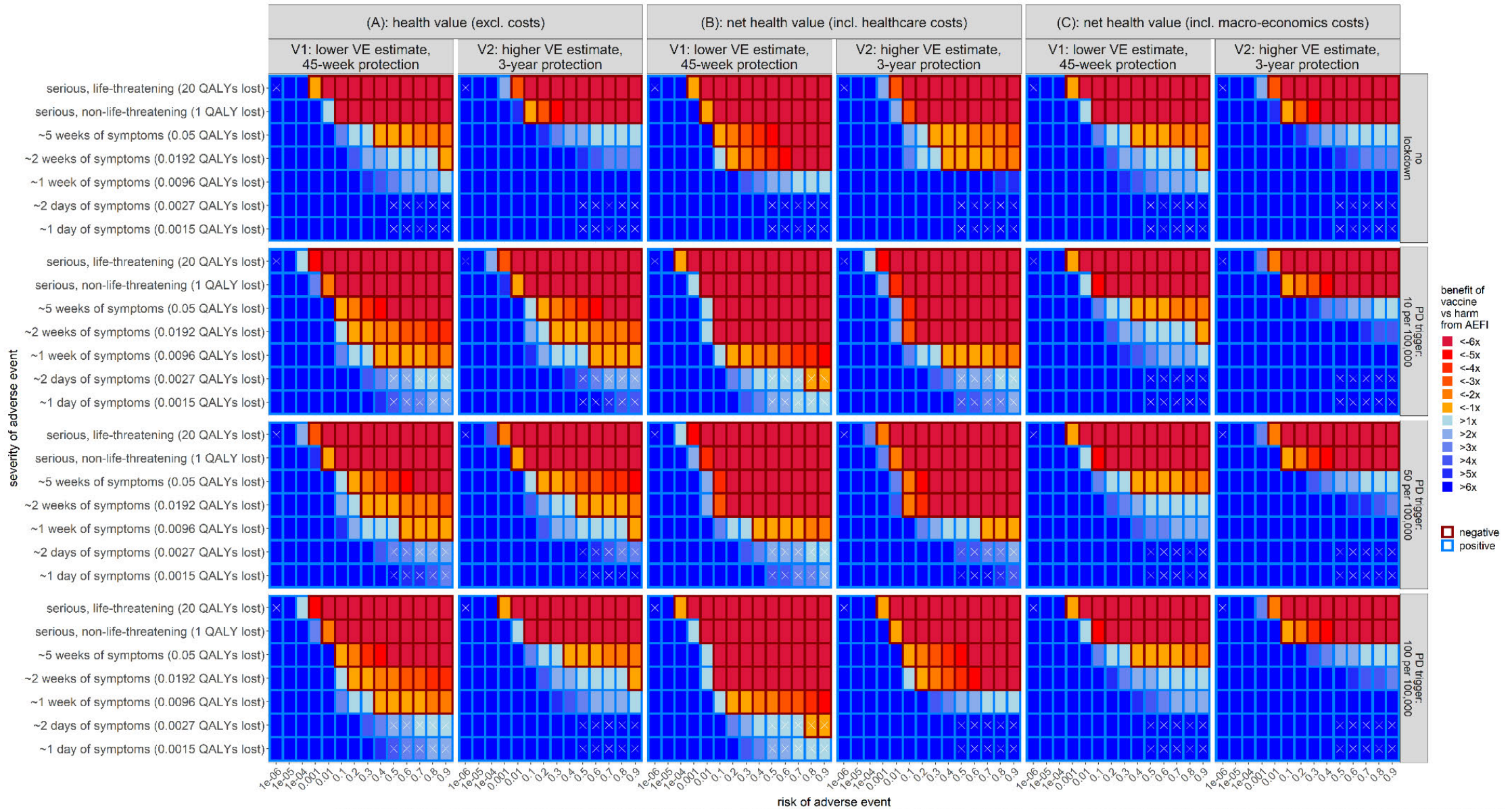
Results



Key messages

- Frequent-but-mild AEFIs cause greater health loss to society measured in terms of QALYs, than rare-but-fatal AEFIs.
- If no lockdowns are imposed, then vaccinating is always net beneficial from a societal perspective, regardless of age of vaccinees and outcomes included (health only / net health value / macroeconomic).
- If lockdowns are expected, then vaccinating is still usually net beneficial from a macroeconomic perspective, but more mixed from other perspectives, especially for younger age groups.

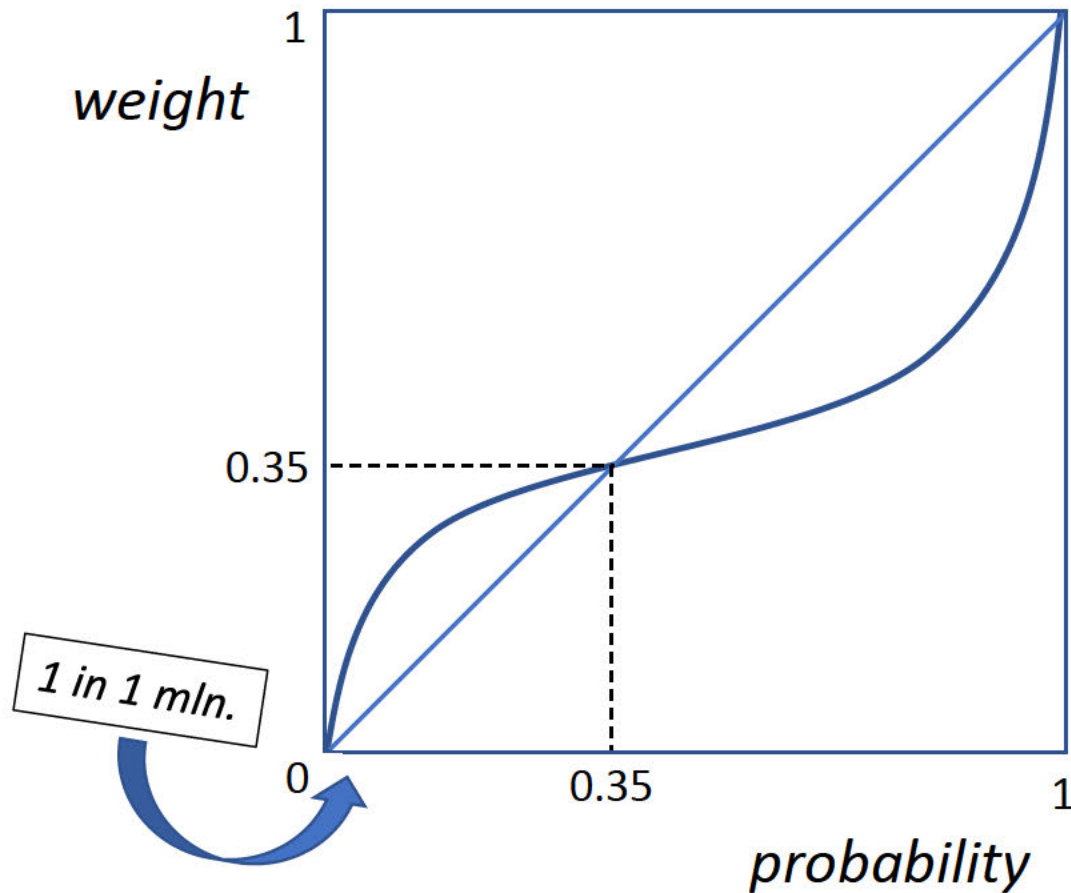
Hypothetical scenarios of AEFIs



Benefit-risk ratios are positive when the benefit (and net benefit; dQALY_loss - dCosts/£20,000) of the vaccine exceeds the (net) harm of AEFIs, and negative when the (net) harm of AEFIs exceeds the (net) benefit of the vaccine.
 V1: vaccination with 62% VE against symptomatic disease, 4% against asymptomatic infection (AstraZeneca-Oxford Uni. vaccine, low estimate); assumed vaccine-induced protection of 45-weeks
 V2: vaccination with 91% VE against symptomatic disease, 56% against asymptomatic infection (AstraZeneca-Oxford Uni. vaccine, high estimate); assumed vaccine-induced protection of 3-years
 X indicate the observed rates and severities of AEFIs of COVID-19 vaccines.

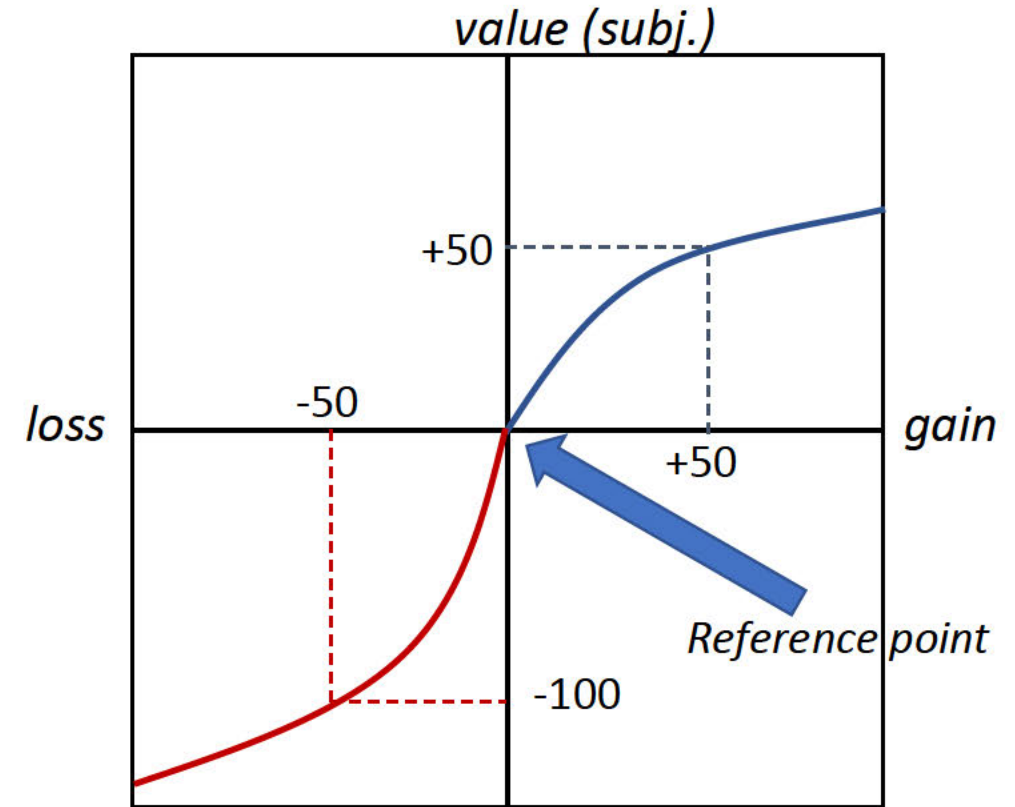
Cognitive biases; 2 examples of relevance here (Kahneman, Tversky)

Probability weighting



Individuals overestimate small probabilities/risks,
but underestimate intermediate-to-high probabilities/risks

Risk/loss aversion



1. We are **risk-averse for gains** (concave), but **risk-seeking for losses** (convex); depending on reference point (eg 25 y. may perceive little gain from vac. but pot. large loss due to lower risk of severe outcomes, if infected)
2. Losses loom larger than equal gains.