IN THE UK COVID-19 INQUIRY

MODULE 8

OPENING SUBMISSIONS ON BEHALF OF
CLINICALLY VULNERABLE FAMILIES

A. INTRODUCTION AND SUMMARY

1. This opening statement is made on behalf of Clinically Vulnerable Families ('**CVF**'). CVF is a grassroots organisation born of the pandemic. It represents those who are clinically vulnerable ('**CV**'), clinically extremely vulnerable ('**CEV**') and severely immunosuppressed, across all four nations (collectively referred to as **'Clinically Vulnerable'**).[1] These individuals have underlying health conditions, or other risk factors, which place them at high risk of severe outcomes from Covid-19, including greater mortality and developing Long Covid.[2] CVF also represents the households and family members of Clinically Vulnerable individuals ('**CV families' / 'CV households'**), in other words households that include at least one member (child or adult) who is either CV or CEV.

2. When CVF was founded in August 2020, children were about to return to schools for the first time following their closure in late March 2020. At that time, Government advice to parents was essentially that schools were safe and that all children must be in school.[3]

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[1] 'Clinically extremely vulnerable' individuals were formally advised to shield due to severe clinical risk and classified as Group 4 under the original Covid-19 vaccine priority list. 'Clinically vulnerable' individuals were not formally advised to shield, although many did so informally. They were classified as Group 6 under the original Covid-19 vaccine priority list, with reference to conditions listed in the UK Health Security's Agency's 'Covid-19: Green Book' [INQ000354471].

[2] Pre-existing conditions of people who died due to COVID-19, England and Wales, Quarter 1 (January to March) 2023, Office for National Statistics, 25 April 2023, [INQ000408875]; All data relating to 'Prevalence of ongoing Symptoms following coronavirus (COVID-19) infection in the UK: 30 March 2023, Office for National Statistics, [INQ000408796].

[3] DfE press release titled "Schools and colleges to reopen in full in September", dated 02/07/2020 [INQ000541143] which stated: "*Schools will need to work with families to secure full attendance from the start of the new academic year, with the reintroduction of mandatory attendance*", and Guidance from the DfE titled "Full Opening – Schools", dated 02/07/2020 [INQ000542954] which stated: "*The public health advice in this guidance makes up a PHE-endorsed 'system of controls' … When implemented in line with a revised risk assessment, these measures create an inherently safer environment for children and staff where the risk of*

However, CVF was concerned about the risks posed to Clinically Vulnerable children in school, and to Clinically Vulnerable people living in households with children who would be attending school. While CVF's work quickly broadened to other issues such as safety in workplaces, healthcare and access to Covid-19 vaccination and treatment, the safety of schools and places of education remained a foundational issue for the organisation, which is one of the reasons Module 8 is so important to CVF.

3. The emergency phase of the pandemic may have passed, but for many Clinically Vulnerable people the pandemic is by no means over, and indeed some still face a significant risk from contracting Covid-19, particularly due to the steady removal of many mitigation measures put in place to protect them. Some Clinically Vulnerable children and children in CV families continue to shield and lead limited lives to this day. As a consequence, the impacts of the virus – and the UK's response to the virus – upon their education, mental, and physical health continue to be acutely felt. CVF's mission to support, inform and advocate for those in CV households remains pressing.

4. CVF will speak for two groups of children in this module. First, children who are themselves Clinically Vulnerable to Covid-19. This is a small group relative to the 65 million people living in the UK, but still a sizable group of many thousands.[4] Between February 2020 and March 2022, 88 children died from Covid-19.[5] This number may well have been higher had many parents of Clinically Vulnerable children not kept their children away from school. In the first year of the pandemic alone, there were 6,338 paediatric Covid-19 admissions. Of those, 259 (4.1 %) needed admitting to a paediatric intensive care unit ('**PICU**').[6] NHS England has recorded that 2,000 children were affected by Paediatric Inflammatory Multisystem Syndrome ('**PIMS-TS**'), a widespread inflammatory response throughout the body which requires hospital admission, with a high proportion of cases requiring admission to a PICU.[7] These are not small numbers, and it is important that they are not undervalued because of their relative size compared to the adult population who were adversely affected. The second group CVF speaks for is the children

transmission of infection is substantially reduced. The system of controls provides a set of principles and if schools follow this advice, they will effectively minimise risks".

[4] Of 3,813,465 children aged 0–4 years, 17.7% were clinically vulnerable (chronic health condition or low birth weight) https://pmc.ncbi.nlm.nih.gov/articles/PMC9271837/.

[5] Paper from David Odd et al titled Deaths in children in England from SARS-CoV-2 infection during the first 2 years of the pandemic: a cohort study, dated 19/08/2024 [INQ000610918].

[6] https://www.medrxiv.org/content/10.1101/2021.07.01.21259785v1.

[7] Duncan Burton, Chief Nursing Officer, NHS England, §296 and §301 [INQ000588020_0088].

who lived in households with Clinically Vulnerable family members. That is a much larger group, involving millions of people. A study published in July 2020 found that a quarter of all school-aged children lived with an adult at high (CV) or very high risk (CEV) of serious illness from Covid-19.[8] Both groups were important in the decision making around school closures.

5. A key question for this module will be what more should have been done, and could be done in the future, to ensure that these children are safely able to rejoin society and re-enter education. CVF hopes to assist the Inquiry at the hearings by giving a voice to a group who have been largely forgotten.

B. SUBMISSIONS

6. During a pandemic some children will need to stay away from schools, either because they themselves face a high risk of a severe health outcome if they become infected, or because they pose a transmission risk to a household member who is at risk of a severe health outcome if the child passes on a pathogen they were exposed to at school.

7. Those children will need to stay at home unless the buildings that they need to access are safe, in the sense that mitigations are in place to protect against the transmission of airborne viruses.

8. What CVF is advocating for – improving the safety of schools against airborne viruses – would protect not only those children most vulnerable to infections and their families; it would protect all children and their families from infection, and it would protect children from the negative and long-lasting impact of school closures by allowing schools to safely remain open. CVF agrees with Professor Jim McManus that being in school or education and being protected from harmful exposure to pathogens are equally important and it is therefore "*false logic to oppose one to the other.*"[9]

9. The ideal, but also achievable, position would be to make all school environments safe enough for Clinically Vulnerable children and children in CV families to attend, even

[8] Home learning during Covid-19: Findings from the Understanding Society Longitudinal Study, National Foundation for Educational Research [INQ000623810_0012].
[9] Professor Jim McManus, §46, [INQ000588160_0010].

during an airborne epidemic or pandemic. This is what CVF submit should be a strong focus of the Inquiry in Module 8. Unless the Inquiry is forward-looking, and focusses on safety, it risks wasting the opportunity to prompt lasting change.

10. CVF is also realistic that it will not always be possible to make schools safe enough. Even if there are drastic improvements in safety against the spread of pathogens in schools, not every educational institution would be able to achieve this. Some children who remain at the most significant risk would therefore need to remain at home during an epidemic or pandemic. In those cases, children must be supported in their decision to stay at home and their right to education must be protected. Support means government guidance which recognises their position, school attendance polices that do not mandate in-person attendance for children in their position, and access to high quality remote and hybrid education options.

11. To summarise, CVF's core submission is that schools must be made safe, and where they cannot be, children must be given appropriate support to continue their education from home.

12. This core submission is based upon CVF's seven key concerns in Module 8 which will be developed in the submissions that follow:

    (1) Clinically Vulnerable children and children in CV families were not identified and included in pandemic planning;
    (2) Protective measures in schools were designed for the wrong pandemic;
    (3) Attendance guidance and policies did not address Clinically Vulnerable children and children in CV families;
    (4) When schools re-opened, Clinically Vulnerable children and children in CV families were excluded from remote education and lost out on learning;
    (5) The particular impact of the pandemic on the mental health of Clinically Vulnerable children and children in CV families has been overlooked;
    (6) Recognition of Clinical Vulnerability must be a priority; and
    (7) Schools must be made safer against airborne viruses.

(1) Clinically Vulnerable children and children in CV families were not identified and included in pandemic planning

13. A large percentage of children live in a household with a Clinically Vulnerable person, whether vulnerable to Covid-19 due to their age or underlying health condition. The likelihood of living with a Clinically Vulnerable person is even greater among certain ethnic minority or lower socioeconomic groups, who are more likely to experience health disparities and live in multigenerational households.

14. Despite the foreseeable risks posed to these households by prolonged exposure to a highly transmittable airborne virus, there is little evidence that Clinically Vulnerable children or children in CV families were meaningfully included in the UK government's pandemic preparedness planning. CVF submits that their absence was a critical omission with foreseeable consequences.

15. CVF notes that pre-pandemic preparedness documents, specifically the 2011 Influenza Pandemic Preparedness Strategy and the 2017 National Risk Register, did not identify children living in CV households as a group needing protection.[10] They provided no pathway for whole-household protection (beyond antiviral prophylaxis) and no consideration for airborne mitigations in schools. These omissions were critical: when Covid-19 arrived, there was simply no plan to keep these children both safe and learning.

16. When the Government's strategy for education started to emerge in early 2020, public messaging was inconsistent and confusing for Clinically Vulnerable people. The voices of Clinically Vulnerable people were largely ignored when trying to clarify the Government's instructions and guidance, and when bringing attention to the fact that they were facing different challenges in educating their families when compared to the general population.[11]

17. An important question for the Inquiry to consider is whether adequate systems existed to amplify the voices of the Clinically Vulnerable when they raised concerns over new guidance and how it would impact their families, and why it was that Clinically Vulnerable people often found it difficult to engage with government.

[10] CVF, [INQ000587993_0133].
[11] CVF, §408-409 [INQ000587993_0124].

18. CVF members often found it necessary to advocate for themselves and their families,[12] for example by contacting their MPs and government departments, launching a petition in December 2020 calling for online education options for CV children, submitting concerns to the All Party Parliamentary Group on Coronavirus, and contacting the Children's Commissioner.[13] Key issues that CVF sought to address included seeking reasonable adjustments for members in public spaces, the safety of indoor spaces, access to Covid-19 vaccinations, infection prevention and control measures and more.[14] However, CVF members reported that engagement with Government departments was extremely challenging and the majority of concerns were brushed aside in the stages of planning for various returns to education. Requests for meetings with ministers or officials to discuss the specific needs of Clinically Vulnerable children and children in CV families were largely ignored or refused. When responses were received, they were often generic, non-substantive, and failed to meaningfully address the concerns raised.[15]

(2) Protective measures in schools were designed for the wrong pandemic

19. CVF noted from early on in the pandemic their concerns that infection prevention and control ('**IPC'**) measures were not being implemented within schools, in contrast to other areas of the world which appeared to be more ably controlling their pandemic infection rates. Covid-19 was recognised as an airborne virus in April 2020[16] but initial IPC measures in schools focused on fomites (transfer of infection via inanimate objects). Significantly, early Department for Education ('**DfE**') guidance and the *"system of controls"* endorsed by Public Health England ('**PHE**') did not reference airborne transmission and did not recommend the use of face masks in schools.[17] The only reference to ventilation was a single recommendation to open windows, which Professor Jim McManus has reported was often not possible due to the age and construction of many school buildings (schools also reportedly challenged this advice as "*being uncomfortable for pupils in the colder winter months*").[18]

[12] CVF, §405-406, [INQ000587993_0123-0124].
[13] CVF, §379, §383 [INQ000587993_0114].
[14] CVF, §9d INQ000587993_0007].
[15] CVF, §408 [INQ000587993_0124].
[16] Environmental Influence on Transmission, SAGE-Environmental and Modelling Group, [INQ000648034].
[17] Guidance from the DfE titled "Full Opening – Schools", dated 02/07/2020, [INQ000542954].
[18] Professor Jim McManus, §21 [INQ000588160_0004].

20. The DfE's "*essential measures*" focussed on hand hygiene, cleaning, social distancing in classrooms (which was not usually practical in school buildings) and the division of students into 'bubbles'.[19] The guidance cited the social distancing and grouping measures in classrooms as the rationale for why face coverings were not needed.

21. Some CVF members attempted to mitigate the risks themselves, for example by offering to supply air filters to their children's school. However, they often met resistance from schools due to a lack of understanding, particularly in the absence of the DfE recommending air filters.[20] Some CVF members reported that devices were redirected away from the vulnerable children who had supplied them.[21]

22. Of the many children who tried to protect themselves by wearing a mask, a significant number reported to CVF that this became a source of social exclusion, bullying, and discrimination at school. Mask use in schools became a visible marker of difference: children frequently felt isolated and harassed, and some were even punished for continuing to wear face masks to protect vulnerable family members. This bullying and isolation persists to the present day for those children who continue to wear masks in order to manage their risks and enable safe school attendance.[22] Many children of CVF families have achieved 100% attendance as a result of effective mask use.[23]

23. The schools reopening guidance took a wholly unrealistic approach to protective measures. Government understood neither the virus they were dealing with nor the practicalities of how schools operate. As one CVF member reported, "*There was no effective infection control in schools. Children could never distance, and this was of little help for an airborne virus anyway. Bubbles were not effective as if a child with siblings caught the virus it was never just the one bubble affected. Masks were initially worn by adults, but they were of poor quality generally and worn intermittently*"[24]. To put it simply, the Government was attempting to make schools safe from the wrong virus.

24. In the absence of effective risk reduction strategies that might have made attendance more viable or safer for children in CV households, the 'reassurances' schools provided when

[19] Guidance from the DfE titled "Full Opening – Schools", dated 02/07/2020, [INQ000542954].
[20] "Schools rejecting offers of air filters that limit Covid spread, say parents", The Guardian, dated 17/01/2022, [INQ000648039].
[21] CVF, §89 [INQ000587993_0031].
[22] CVF, §96 [INQ000587993_0033].
[23] CVF, §105(a) [INQ000587993_0035].
[24] CVF, §81[INQ000587993_0029].

they reopened in September 2020 failed to reassure, and only supplemented the pressure on Clinically Vulnerable children and families to return to unsafe schools. This had a profound impact on Clinically Vulnerable children and children from CV families, many of whom kept their children at home when schools reopened, to avoid the risk of Covid-19 being brought back into the household. As once CVF member described: "*We had anticipated that our daughters would be able to mask in school and that fresh air arrangements would be in place. Instead, in late July 2020, our school wrote to all parents: 'Following the recommendations from Public Health England we are asking students to not use face coverings in school.' We found ourselves in the impossible position of having to choose between our family's health and our daughters being able to attend school.*"[25]

25. The direct result of the Government's inadequate risk reduction strategy was that Clinically Vulnerable children and children in CV families faced effective exclusion from school due to the impossible choice between protecting their health and the health of their family members and advancing their education. Some children are still not in a position to safely return to school,[26] in the absence of meaningful risk mitigation for those who remain vulnerable.[27]

(3) Attendance guidance and policies did not address Clinically Vulnerable children and children in CV families

26. Government messaging was inconsistent and unclear for Clinically Vulnerable children and children in CV families. In contrast to earlier guidance,[28] attendance at schools was mandatory from September 2020 onwards unless the child themselves was formally designated as CEV.[29] There was a lack of clear options or safe alternatives available for CV children who did not have a formal CEV designation, or whose families members

[25] CVF, §76 [INQ000587993_0027].
[26] Report from the Children's Commissioner titled 'New attendance figures for academic year 2021/22', dated 16/03/2023 [INQ000648033] showed that 1.6 million pupils were persistently absent across the autumn and spring terms of the academic year 2021-22, up 22.5% from pre-covid times where this was around 10%-11%. 'Persistently absent' is defined as missing 10% or more of lessons.
[27] CVF, §277-281 [INQ000587993_0083-0084].
[28] Guidance from Department for Education, titled Supporting vulnerable children and young people during the coronavirus (COVID-19) outbreak - actions for educational providers and other partners, dated 15/05/2020 [INQ000648027].
[29] Guidance from the DfE titled "Full Opening – Schools", dated 02/07/2020, [INQ000542954].

were CEV or CV. Non-attendance was only authorised for children who were following clinical advice, or isolating following a positive test for Covid-19.[30]

27. As Professors McCluskey, Lewin and Van Herwegen have recognised in their expert report for Module 8, "*in-person attendance was mandated in England when schools were open … and parents could be prosecuted if their children did not attend*."[31] This was in contrast to the position in Scotland where the government advised schools not to mandate attendance, acknowledging that parents and learners may be concerned about the return to school.[32]

28. CVF submits that there has been no meaningful investigation into the sanctions that were imposed on families who felt that their children could not safely attend school. This is an ongoing issue for CV families. It is important that the Inquiry fills this information gap and highlights the unfairness of such sanctions imposed despite vulnerabilities in families.

29. In CVF's experience, families in England who kept their children at home for legitimate medical reasons, including for short-term absences due to high Covid-19 case rates, were threatened with fines or being criminalised unless the school or local authority accepted the absence as authorised.[33] Some CV families were even prosecuted for non-attendance,[34] while other CVF members were referred to Social Services as a result of their children's absence.[35] CVF members consistently reported that school attendance guidance was applied rigidly, with little consideration of individual risk or even specific clinical advice. Furthermore, in CVF's experience, even those children who were participating in remote education were recorded as absent for the purposes of attendance monitoring. Families were placed in the position of capitulating to these threats and sending their children into environments they considered unsafe, or withdrawing their children from schooling.[36]

30. For CV families, letters threatening prosecution often led to deregistration. To avoid prosecution, many parents were advised (in reality, pressured) to remove their child from the school roll.[37] Professors McCluskey, Lewin, Van Herwegen have reported that "*the*

[30] Guidance from the DfE titled "Full Opening – Schools", dated 02/07/2020, [INQ000542954_0018].
[31] Professors McCluskey, Lewin, Van Herwegen, §147 [INQ000587959_0069].
[32] Professors McCluskey, Lewin, Van Herwegen, §147 [INQ000587959_0069].
[33] CVF, §53 [INQ000587993_0019].
[34] CVF, §53-55 [INQ000587993_0019-0020].
[35] CVF, §39 [INQ000587993_0015].
[36] CVF, §40 [INQ000587993_0016].
[37] CVF, §54 [INQ000587993_0020].

illegal removal of learners from the school roll, informally known as 'offrolling'" continues to be an issue in England.[38] This led to loss of school places, including specialist or competitive places that were extremely difficult to access again at a later date. Some children were removed from school rolls without adequate alternative provision. The consequences of deregistration persist to this day and continue to affect CV families who felt they were left with little to no alternatives during the height of the pandemic.

31. Families who did keep their children away from school, and families who still have a need to do so have often faced being labelled as 'anxious' by educational professionals.[39] CVF does not deny that these families experienced a heightened levels of anxiety due to the possibility of serious medical complications for members of their family. However, their legitimate concerns about their family's wellbeing should not be minimised. This is an example of ongoing failure to consider CV families and the unique challenges they continue to face.

32. CVF is aware of at least one regional example of a local authority taking a different approach. Hampshire County Council issued advice to its headteachers which explicitly acknowledged the risk to life posed by schools, the need to support children in vulnerable families by providing remote education, the need to withdraw unfair penalty notices, and the recognition that school places should be reinstated if such families deregistered for safety reasons.[40] CVF urges the Inquiry to explore why this guidance was not adopted on a national level.

33. CVF submits that a dedicated national attendance code should formally recognise household clinical risk to ensure that Clinically Vulnerable children and children in CV families are supported rather than punished. CVF believes that reforming education attendance law or policy to recognise remote attendance would prevent fines to and prosecutions of families who are attempting to limit the disproportionate health risks they face from Covid-19 and other pathogens.

(4) When schools re-opened, Clinically Vulnerable children and children in CV families were excluded from remote education and lost out on learning

[38] Professors McCluskey, Lewin, Van Herwegen, §461 [INQ000587959_0181].
[39] CVF, §284 [INQ000587993_0085].
[40] CVF, §68 [INQ000587993_0024-25].

34. Clinically Vulnerable children and children in CV families were not given the option to learn remotely after schools reopened as a matter of course, even though temporary remote learning was available and offered to children isolating following Covid-19 infection.[41] In one CVF member's words: "*We were told outright that remote provision would not be provided as it would "open the flood gates" to other vulnerable families. It felt like we were being punished for needing to protect our health*."[42] Another CVF member has reported that *"the school were very resistant to provide remote learning, they said the local authority had advised against it, in case it encouraged us not to come back to school!"*[43]

35. This approach to the provision of remote education was punitive and discriminatory.

36. For the few Clinically Vulnerable children and children in CV families who were able to access remote education, online or remote learning provision was frequently problematic, particularly outside of lockdowns. In CVF's members' experience, parents often had to chase schools or teachers for work or remind them to turn on cameras. Older learners reported to CVF their frustration at not being shown the board or not being included in class discussions. Inadequate access to learning materials, lack of interaction, and technological limitations compounded disadvantage for children in CV families learning from home who were not only out of sight, but effectively out of mind. Presently, remote learning is not offered in England and Wales, unless families are willing and able to pay privately.

37. CVF is also concerned that Clinically Vulnerable children and children in CV families were not prioritised for "catch up" initiatives such as the National Tutoring Programme ('**NTP**'). When the NTP was launched in 2021, a blog by the DfE stated that it was intended to support pupils "*most affected by disruption to their education*".[44] The experiences of CVF members reveal a disconnect between this objective and reality. Children who missed the most in-person education due to shielding (whether formal or

[41] CVF, §137 INQ000587993_0047], see also Guidance from the DfE titled "Full Opening – Schools", dated 02/07/2020, [INQ000542954].
[42] CVF, §146 [INQ000587993_0049].
[43] CVF, §150 [INQ000587993_0051].
[44] 'How the National Tutoring Programme will help pupils most affected by the impact of lost learning during the pandemic', dated 17/03/2021 [INQ000648057_0001].

informal), were not prioritised in this programme. In the vast majority of cases, CVF discovered that these families were not offered NTP support at all.

38. CVF submits that the effective exclusion of its members' children from schools (whether from in-person education, remote education, or catch-up initiatives) was a result of deliberate or reckless governmental policy choices, rather than being unfortunate or stemming from the ignorance of the plight of these children. The obvious consequences of exclusion from education include loss of learning, worse educational outcomes, and lack of access to opportunity, including the opportunity to take critical GCSE and A-level exams.

39. The potential of remote education was highlighted during the early stages of the pandemic, indicating that public policy could be inclusive and flexible. CVF submits that high-quality remote education provision based on health needs (i.e. not just for those self-isolating after infection) should be put in place so that Clinically Vulnerable children who may face long or short-term health risks and challenges, and remain at the most significant risk from infection, can remain at home when necessary, for example during an epidemic or pandemic, without losing out on their education.

(5) The particular impact of the pandemic on the mental health of Clinically Vulnerable children and children in CV families has been overlooked

40. A significant number of Clinically Vulnerable children and children in CV families experienced a decline in their mental health caused by the ramifications of their clinical vulnerability or that of their family members. As identified by the British Psychological Society,[45] these children experienced: prolonged isolation, frustration if shielding continues, the fear of transmitting Covid-19 to vulnerable loved ones, and significant social exclusion. In addition to the extreme disruptions to everyday life which all children naturally struggled to acclimatize to, these children frequently took on further burdens helping to manage healthcare needs and protect their families, emerging as a new type of young carer.[46] Naturally, many children internalised a profound fear that their actions could result in their own severe illness or death, or the loss of a loved one.

[45] British Psychological Society, *Meeting the Psychological Needs of Children in Shielding Families* [INQ000648067].
[46] CVF, §331 [INQ000587993_0099].

41. CVF members have extensively documented the mental health impact of the pandemic on their children: one member reported that "*Mental health was the main issue. My son developed anxiety and phobias that we had to address using a private psychologist.*"[47] Another member described: *"The major issues for [my child] revolved around the pressures of trying to mitigate the risk of carrying infection home... This is/was a huge responsibility on young shoulders and, with the lack of support from school, had a detrimental impact on their mental health."*[48]

42. Another CVF member described the impact of her clinical vulnerability on her son: *"I went into hospital several times during [the] timeframe. ... My son said after he always thought I wasn't coming out – he ended up with severe mental health issues – suicidal thoughts linked to this – still struggles whenever I get unwell now."*[49]

43. As a result of these factors, Professors Newlove-Delgado and Creswell's expert report for this module concluded that CEV children and children who lived with CEV family members "*experienced additional risks to their mental health*".[50]

44. The Children and Young People's Voices report, commissioned by the Inquiry, found that children with health conditions, or in CV families, "*described their feelings of uncertainty, fear and anxiety about the risk of catching Covid-19 and the serious — and in some cases life threatening — implications this could have for them or their loved ones."*[51]

45. There were further mental health impacts on Clinically Vulnerable children and children in CV families who faced judgement, harassment and discrimination for the decisions they took to avoid risk of infection, including school non-attendance and mask-wearing. One CVF member described the impact on her daughter: *"As a direct result of our 12-year-old daughter understanding that the school would not let her mask, a large section of her hair fell out. We explained our family situation to both our school and LEA and asked for flexibility and help with basic infection control measures so that our children could return safely to school. We were met with flat refusals at every turn."*[52] In the words of another CVF member: *"the huge mental toll of keeping a family member safe from infection, of*

[47] CVF, §203 [INQ000587993_0064].
[48] CVF, §324 [INQ000587993_0097].
[49] CVF, §214 [INQ000587993_0066].
[50] Professors Newlove-Delgado and Creswell, §88 [INQ000587958_0039]
[51] Children and Young People's Voices Final Report, 2025, §2.1.2.6 [INQ000587936_0014].
[52] CVF, §318 [INQ000587993_0096].

being the only one still asking for mitigations, the constant arguments, bullying and harassment to the point of us having to threaten reporting to the police was never considered - our children were rarely even acknowledged never mind their mental health considered".[53]

46. CVF submits that these particular mental health impacts which are unique to Clinically Vulnerable children and children in CV families have been almost completely overlooked. As a result there is both a lack of research – Professors Newlove-Delgado and Creswell confirmed that "*high-quality studies of the impact of the pandemic on the mental health of [CEV children] (as opposed to children and young people with long term conditions or disabilities, the majority of whom were not classified as CEV) are lacking*"[54] – and a (perhaps consequential) lack of tailored, targeted mental health support.

47. CVF submits that the paucity of research on mental health impacts is even greater for CV children, due to the Government-imposed definitions of vulnerability which created an arbitrary divide between those classed as CEV and those who were "only*"* CV, despite also facing significantly heightened risk of severe illness or death. A consequence of this division is that many children in CV families were not considered by organisations like the British Psychological Society, due to governmental advice and statistics which did not capture their situation. And yet it is CVF's experience that the mental health of CV children is just as negatively impacted, with the impacts often compounded by the lack of recognition.

48. CVF submits that the foreseeable harm to the mental health of Clinically Vulnerable children and children in CV families has not been accounted for, meaning that no targeted mental health provision has been developed or offered to the thousands of children in need of psychological support. The experiences of these children remained largely invisible within national policy. CVF submits that there is an urgent need for formal recognition and support for these children.

(6) Recognition of Clinical Vulnerability must be a priority

49. Professors McCluskey, Lewin, Van Herwegen have highlighted, "*there is very little large scale research which investigates educational impacts for children identified as clinically*

[53] CVF, §362 [INQ000587993_0108].
[54] Professors Newlove-Delgado and Creswell, §89 [INQ000587958_0039].

vulnerable or living in clinically vulnerable families" and "*the paucity of research gives rise to a significant gap in understanding of current impacts and potential longer-term effects*".[55]

50. CVF agrees with the experts that it is critical to address this gap in understanding in order to ascertain how risks were mitigated or exacerbated by, for example, school closures and re-openings, exam cancellations, face coverings and other non-pharmaceutical interventions.

51. For future planning, these groups must be recognised from the outset and have their needs considered alongside other groups, with specific planning requirements. National and local frameworks for risk assessments should include detailed protocols for CV households enabling more suitable support rather than generalised, and often inadequate, guidelines.

52. CVF submits that the first step towards truly understanding how children in CV households were impacted, and how best to reflect their needs now, and in a future pandemic, is to recognise Clinically Vulnerable people as a distinct group that require inclusion in decision-making, data collection, public reporting and funded research.

53. It is for these reasons that CVF considers it is essential that clinical vulnerability is identified as a specific group/protected characteristic, both under the Equality Act 2010 and in the Inquiry's Equalities and Human Rights Statement, to enshrine in law the ongoing threat to Clinically Vulnerable people from Covid-19 (and other pathogens), and ensure that vital protections for Clinically Vulnerable people can no longer be switched on and off at the whim of public officials.

(7) Schools must be made safer against airborne viruses

54. Unless schools and educational settings are made safer and adapted to significantly reduce the transmission of airborne viruses, the UK risks remaining vulnerable now and in the future, whether to new waves of existing viruses or to future pandemics, and even more so if a future pathogen poses a greater risk to children. Professor Sir Chris Whitty has said that "*the starting assumption [in a future pandemic] should be that children, and especially very young children, are likely to be at greater risk than young adults*" and that had this been the case with Covid-19, "*the risk benefit of … school closures would have*

[55] Professors McCluskey, Lewin, Van Herwegen, §328-329 [INQ000587959_0134].

been very different, indeed the likelihood parents would be happy to send their children to school in this situation would be much lower than for COVID-19".[56]

55. School closures are not an inevitable response to a pandemic; however attendance will continue to be used as a vital lever unless the safety of the school buildings children are educated in are improved to better control viral transmission.

56. CVF submits that schools can be made significantly safer by addressing three key aspects of infection prevention and control: (a) improving air quality, (b) better guidance on masks, and (c) testing and isolation policies.

(a) Improving air quality

57. Covid-19 is an airborne virus. From the earliest stages of the pandemic, ventilation was recognised by scientific advisors SAGE as a critical component of infection control, particularly in high-occupancy indoor spaces such as schools.[57] As Professor Beggs' expert report commissioned for Module 3 outlined in detail, the importance of clean air and adequate ventilation has long been established by robust evidence.[58]

58. There is nothing inevitable about public buildings being unsafe: poor air quality is itself a choice. Air quality can be improved, and as a result buildings can be made safer, by using measures such as mechanical ventilation, air filters, and air quality monitoring. As Professor Noakes identified in Module 3, in order to deal with airborne transmission, mitigation measures must be addressed at an organisational level (e.g. by building owners). Ultimately, ventilation and air cleaning are not within individuals' power to control.[59]

59. CVF supports Professor McManus' recommendation that mechanical ventilation is provided as a necessity in all new build schools.[60] In the meantime, the effectiveness of air cleaning devices such as HEPA filters in removing or inactivating viruses is well-established.[61] As Professor Beggs has previously noted, air cleaning devices are "*relatively low cost and can be rapidly deployed as required to boost effective air change rates*".[62]

[56] Professor Sir Chris Whitty, §7.4 [INQ000588046_0064].
[57] Environmental Influence on Transmission, SAGE-Environmental and Modelling Group, [INQ000648034].
[58] Professor Clive Beggs, §211 [INQ000474276_0079].
[59] Professor Catherine Noakes, §10.11(4) [INQ000236261 0051].
[60] Professor Jim McManus, §49 [INQ000588160_0012].
[61] Although 'HEPA' is a standard of filtration, the term 'HEPA filter' has become a catch-all term for portable air filtration devices (sometimes also referred to as 'portable air cleaning devices' or 'portable air cleaners').
[62] Professor Clive Beggs, §283 [INQ000474276_0101].

CVF submits that these devices should be deployed widely in schools now as a matter of urgency.

60. CVF further urges the Inquiry to consider evidence[63] that current ventilation guidelines BB 101[64]- were developed solely to address air quality, thermal comfort, and CO_2 concentration, without consideration of viral transmission. Covid-19 infection-control guidance was tacked on as a reactive short-term measure, but otherwise ventilation has never been considered in terms of airborne transmission or accessibility need for Clinically Vulnerable people. CVF invites the Inquiry to recommend that these guidelines, last updated in August 2018, be comprehensively reviewed and brought up to date as a matter of urgency to reflect the recommendation that CO_2 levels are kept below 800 ppm, with at least 10 L s^{-1}-person of fresh-air flow.[65]

61. Maintaining the recommended CO_2 levels requires the implementation of air quality monitoring (and supplementation with air filtration if the above-mentioned standards cannot be met). Air quality monitoring is another simple measure which CVF submits can be implemented today to improve safety, as part of a package of measures which would give schools the tool to improve air quality if it was found to be low.

62. The continued lack of investment in clean air for schools remains a source of deep concern for those with health conditions living with elevated risk. However, CVF notes that enhanced ventilation has also been linked to improved academic outcomes and long-term health outcomes. Improving air quality would therefore not only significantly reduce the spread of Covid-19 and other airborne pathogens, but also reduce pupil absence and promote educational attainment, health and wellbeing. Addressing clean air in schools should be recognised as both a public health priority and a vital educational investment.

(b) Better guidance on masks

63. CVF is deeply concerned that a lack of evidence-based guidance in relation to masks has allowed misconceptions to become embedded. Mask-wearing became a needlessly politicised and divisive issue during the pandemic. The effect has been to create a culture in which many Clinically Vulnerable children and children in CV families have become

[63] Professor Clive Beggs, §245-266, [INQ000474276_0091-0096].
[64] BB 101: Ventilation, thermal comfort and indoor air quality 2018, DfE, 23 August 2018 https://www.gov.uk/government/publications/building-bulletin-101-ventilation-for-school-buildings.
[65] CVF, §86 [INQ000587993_0030].

targets of abuse simply for wearing a face mask. And yet the scientific evidence confirms that high-grade masks do protect against the transmission of an airborne virus. As Professor Beggs put it in Module 3: *"wearing masks is better than not wearing masks; respirators are better than surgical masks"*.[66] The Module 3 IPC experts' report describes how FFP3 respirators are designed to protect the user against 99% of respiratory particles when properly fit tested and FFP2 respirators protect the user against 95% of respiratory particles.[67]

64. Just as CVF submitted in Module 3 in relation to healthcare settings,[68] CV people in education settings should be permitted to wear masks as a reasonable adjustment for their protection, given the clear evidence they provide greater safety, without the risk of discrimination or even abuse. Following CVF's advocacy, children's right to wear masks in school was very briefly recognised by DfE guidance published in July 2021 which stated "*no pupil or student should be denied education on the grounds of whether they are, or are not, wearing a face covering",*[69] however this guidance has since been withdrawn.

65. There is therefore a pressing need for DfE and PHE guidance in relation to face masks to be amended to protect the right to mask, including (a) clarification that Clinically Vulnerable children and children in CV families should not be required to remove their own respirator masks; (b) confirmation that any pupil who chooses to wear a mask should be fully supported, and any harassment related to mask-wearing must be clearly addressed through anti-bullying procedures, and (c) policies that support CV families to request that staff in close contact with their children wear FFP2/3 masks particularly where the child cannot mask.

(c) Testing and isolation policies

66. Educational settings must take action to reduce infection risks, particularly where outbreaks occur, however CVF found that Covid-19 testing and isolation policies were some of the first mitigations to be abandoned in schools during the height of the pandemic.[70] Some parents even discovered that their school was *"not allowed to tell parents when COVID cases occurred, even if they knew a child had it whilst sitting next*

[66] Professor Beggs, 11 Sept 2024, 134/2-9.
[67] §1.52 and §1.53, [INQ000474282_0027].
[68] CVF Module 3 Closing Submissions, §95b.
[69] Guidance from Department for Education, titled Schools Operation Guidance, to school leaders, dated 06/07/2021 [INQ000075585_0006].
[70] CVF, §108-110 [INQ000587993_0035-0037].

to my daughter - making it impossible to make informed choices to stay safe as a CEV parent."[71] CVF submits that effective contact tracing, testing programmes and isolation periods should not be prematurely dismantled without clear epidemiological justification, and guidelines specifically tailored to children and schools should be drafted so that these infection control measures can be rolled out at speed.

67. CVF invites the Inquiry to explore how infection control can be enhanced by emerging technologies such as electronic biosensors and assisted by less invasive testing methods. In particular, saliva-based testing that can be used both for pooled and individual testing. This approach makes it easier to test everyone, including younger children and those with special educational needs and disabilities ('**SEND**'), and would allow rapid detection and isolation of only a small number of infectious individuals.

68. For some CV families the safety of schools is not a theoretical or speculative point for the future. The acute stage of the Covid-19 pandemic may be over, but due to the failure to implement measures to reduce airborne transmission in schools, some Clinically Vulnerable children and children in CV families remain effectively excluded from education today, as reflected in the numbers of families choosing to Electively Home Educate ('**EHE**').[72]

69. The need for improvements to the safety of educational settings is therefore an urgent one and interim measures should be implemented now to provide immediate protection for Clinically Vulnerable children and children in in CV families, while work continues to make schools safer for a future pandemic.

C. CONCLUSION

70. Clinically Vulnerable children and children in CV families are the most sensitive to infection risks regardless of there being a pandemic - and they are the most harmed when those risks are ignored. Despite this, Clinically Vulnerable children and children in CV families were insufficiently considered, and have since been overlooked, in the drive to 'move on' and get children back to school.

[71] CVF, §117 [INQ000587993_0040].
[72] CVF, §56-60 [INQ000587993_0021-0022].

71. This is one of the Inquiry's most important modules. The written evidence disclosed by the Inquiry as at the date of these submissions leads to the conclusion that the closure of schools caused serious harms to children. It is possible to make educational institutions safer and this must be done now, to protect children's health and wellbeing before a future epidemic or pandemic. The more that is done to make schools safer for children, the more likely it will be that in a future pandemic children and young people will be able to remain in education, and avoid at least some of the harms caused by school closures. Therefore, in order to have a lasting impact, CVF submits that the Inquiry must make meaningful recommendations to increase the safety of children and young people in educational settings, and reduce the risk of transmission to those in their families and wider communities. If the challenge of making schools safe is not addressed in Module 8, then regardless of what the Inquiry concludes about the harms to children caused by restricting in-person teaching, history will repeat itself during the next pandemic.

72. CVF is grateful for the Chair's care and attention throughout this important module.

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12 September 2025