

Witness Name: Elizabeth Ketch

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UK COVID-19 INQUIRY

SECOND WITNESS STATEMENT OF ELIZABETH KETCH

MODULE 8 CORPORATE STATEMENT B DATA, ADVICE, AND ANALYSIS

INTRODUCTION

I, Elizabeth Ketch of the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, will say as follows:

1. I make this statement in response to a request from the UK COVID-19 Public Inquiry (the Inquiry) dated 9 December 2024 made under Rule 9 of the Inquiry Rules 2006 (the Request) asking for a corporate statement on behalf of the Department of Health and Social Care (the Department) for Module 8 of the Inquiry detailing the impact of the COVID-19 pandemic on children and young people in the United Kingdom between 1 January 2020 and 28 June 2022.
2. This statement addresses questions 50 to 58, 73 and 74 of the Request, by which the Inquiry seeks information on data, clinical expertise and analysis.
3. As this is a corporate statement on behalf of the Department, it necessarily covers matters that are not within my personal knowledge or recollection. As a corporate statement involving many different areas of policy within the Department, information has been gathered from a number of sources. It has been reviewed by a corporate team who have examined a very large number of documents. This statement is, to the best of my knowledge and belief, accurate and complete at the time of signing, in line with responding as far as possible within the Inquiry's deadlines. Notwithstanding this, it is the case that

the Department continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality the additional material will of course be provided to the Inquiry, and a supplementary statement will be made if needed.

DATA AND SCIENTIFIC ADVICE

4. As explained in Statement A of this Module, responsibilities for the wellbeing and development of children and young people have historically been, and continue to be, shared across multiple government departments. The Department's primary purpose is to lead the health and social care system in England and to help people to live more independent, healthier lives for longer. Those purposes apply to the support of children and young people in the same way they apply to adults. In addition, the Department plays a collaborative role in decision-making for some other areas, for example in the general wellbeing of school age children. In respect of matters relating to children's social care (including children's social services), these are beyond the Department's remit as they are within Department for Education's responsibility. Further detail on the Department's responsibilities is set out in Statement A of this Module.
5. There are other aspects of wellbeing and development of children and young people for which the Department does not have lead responsibility and does not provide the relevant functions of state. This includes early years provision, schools, further and higher education, education outside of mainstream settings, online safety, children and young people in contact with the immigration system, children's social care and children in contact with the criminal justice system. We therefore do not address these issues in this Statement.
6. The following is an explanation of the scientific advice and data on children and young people available to the Department during the pandemic, relevant to its functions. This material also describes how the Department used that information to inform decisions within its responsibilities.
7. The Department had access to a range of medical and scientific expertise, data and modelling. This included ongoing information sharing between officials, Ministers and clinical, scientific and data experts across the Department's policy areas, not least the Chief Medical Officer (CMO) and Deputy Chief Medical Officers (DCMOs). It also included the advice that the Department received from: Public Health England (PHE), which had responsibility for public health surveillance, and its successor agency the UK Health

Security Agency (UKHSA), specialist scientific expert groups, including the Scientific Advisory Group for Emergencies (SAGE) and its subgroups, such as Children's Task and Finish Group (TFC) **(EK2/1 - INQ000190678)**.

8. As outlined in Christopher Mullin's Statement to the Inquiry dated 25 August 2023, there were five categories of data that were needed and used across Government throughout the pandemic. These categories of data typically included a breakdown by age and enabled the Department to identify impacts on children and young people sufficient to fulfil the functions relevant to the Department. The five categories of data are listed below and are described in more detail later in the statement:
 - a. Testing data
 - b. Healthcare data
 - c. Vaccine data
 - d. Deaths data
 - e. Non-health data

Testing Data

9. Testing data from clinical pathways and surveillance studies was used during the pandemic to provide estimates of incidence and prevalence of COVID-19 at a national and regional level, along with details of the case composition and demographics. One source of testing data for the Department was the Office for National Statistics (ONS) Coronavirus (COVID-19) Infection Survey publication. It included estimates of positive cases of COVID-19 by age from the very first release, but more detailed breakdowns became available over time. The first release of the Coronavirus (COVID-19) Infection Survey pilot (England) was published on 14 May 2020 and included data by broad age band (age 2 to 19 years, 20 to 49 years, 50 to 69 years and 70 years plus). By June 2020, data were provided for age bands 2 to 11 and 12 to 19. The release on 11 September 2020 included age bands 2 to 11 years, 12 to 16 years and 17 to 24 years. These age bands continued to be used in the published bulletins, although became expressed in terms of school years: 'age 2 to school year 6', 'school years 7 to 11', 'school year 12 to age 24'.
10. The ONS also collated and shared data from the Schools Infection Survey (SIS). This in-school survey, undertaken in 2020 and 2021, assessed the role of schools in COVID-19 transmission and how transmission within and from school settings could be minimised.

The Department was part of the joint steering group to establish the study's objectives and design, along with PHE, ONS, DfE and the London School of Hygiene and Tropical Medicine (LSHTM) (**EK2/2 - INQ000624786**). The information generated was shared within the Department via Operational Response Centre (ORC) departmental sitreps. SIS data was linked to Test and Trace and vaccination data as it became available, as well as GP and hospital episode data, to provide detail on asymptomatic cases, antibody data and information from questionnaires. The linkage of SIS data and Test and Trace data informed discussions between the Department and ONS on how to use school rapid testing data. The SIS also provided DHSC and the COVID-19 Taskforce with the ability to establish regular antibody testing among school age children.

11. As explained in the UK CMOs' Technical Report on the COVID-19 pandemic in the UK, testing data from clinical pathways and surveillance studies was also used to provide estimates of incidence and prevalence of COVID-19 at a national and regional level, along with details of the case composition and demographics. However, the Technical Report also states that large-scale testing was only ramped up in late spring 2020, when an adequate supply of tests became available.
12. NHS Test and Trace was introduced from 28 May 2020. From 11 June 2020, the Department published weekly NHS Test and Trace statistics which provided a breakdown of testing data according to age, as well as other metrics (UKHSA took over the publishing of these statistics from 18 November 2021). Prior to the introduction of NHS Test and Trace, widespread testing had not been undertaken. PHE established (and UKHSA maintained) a COVID-19 dashboard, which was updated weekly and showed the number of people who had received a PCR test. However, this dashboard did not provide a breakdown according to age.
13. With regard to children and young people, the Department supported two testing pilots which were run to understand more about transmission in early years settings and schools:
 - a. From June to September 2020, a surveillance study took place, titled '*Prospective active national surveillance of preschools and primary schools for SARS-CoV-2 infection and transmission in England*' (sKIDs COVID-19 surveillance in school KIDs). This was funded by the Department and launched as a partnership between PHE and DfE. It focused on providing a better understanding of prevalence in educational settings in the last half of the summer term of 2020, after national lockdown restrictions measures ended. It was designed to provide the Government with insights to inform the COVID-19 response and the management of education

settings in a safe and secure way. The study was based on blood and swab tests of children and staff from 131 pre-school and primary schools across England. Following completion of sKIDS COVID-19 surveillance in school KIDs, the study evolved into the sKIDS PLUS study (September 2020 to June 2021), which looked at enhanced COVID-19 surveillance in 20 secondary schools and colleges and the development of 2 larger-scale surveillance, immunity and health and wellbeing studies in primary and secondary schools, SIS1 and SIS2 (Schools Infection Surveys 1 and 2) (**EK2/3 - INQ000611045**).

- b. On 30 October 2020, the Prime Minister directed the Department's Mass Testing team to use the military to conduct a 'Whole Town Test' of Liverpool. Emails exchanged within the Department on 2 November 2020 highlighted that the aim of the mass asymptomatic testing in Liverpool was to identify as many positive cases as possible, so they could isolate and thereby break chains of transmission (**EK2/4 - INQ000611060**). On 3 November 2020, the Department drafted answers to lobby questions from No.10, demonstrating that the testing pilot would also take place in schools. The relevant clinical Standard Operating Procedure (SOP) stated that the aim of testing in schools would *"predominantly be in connection with identifying positive cases and isolating them to reduce overall transmission of the virus."* On 10 November 2020, the Department gave approval for the military, who were set up in 11 secondary schools in Liverpool, to begin testing children between 11 and 18 years old. In November and December 2020, the military conducted *"successful school testing pilots"*, with personnel supporting thousands of tests being carried out at pilot schools, and *"demonstrating the value of lateral flow devices rapidly testing students in a school environment"*.
14. As part of the Government's strategy for managing the pandemic, rapid testing of staff, vulnerable children and the children of key workers began in January 2021 to identify asymptomatic cases of COVID-19. Further information on the decision-making for testing in schools is set out in Statement C of this Module. On 8 March 2021, schools reopened following a national lockdown and pupils at secondary schools were tested on-site over a period of two-weeks before transitioning to home testing.

Healthcare Data

15. As explained in the Technical Report, healthcare data were needed to understand disease severity across different demographic groups and the pressure on the healthcare system.

16. Healthcare data in this context related to the use of healthcare services by individuals affected by COVID-19. Whilst it is true that children and young people were not wholly unaffected, the number of individuals affected did not place a significant strain or pressure on the provision of health and care services. It was therefore the case that routinely collected data focused primarily on adults.
17. The publication of a consensus statement by the four UK CMOs on 23 August 2020 is an example of the type of healthcare data available to the Department and its use. The statement summarised the then-current evidence of risks and benefits to health from schools and childcare settings reopening (**EK2/ 5 - INQ000070460**). The consensus statement expressed the need to balance the risk of children catching COVID-19 with the adverse 'societal' impacts of school closures.

Vaccine Data

18. In general, quantitative and qualitative data on vaccine uptake and attitudes towards vaccines help us understand the extent of vaccine uptake across different communities and demographic groups. These data then guide vaccination campaigns and support studies of vaccine effectiveness. For COVID-19, the dominant risk factor was known to be age, which informed the prioritisation of vaccination rollout. As such, children aged 12 to 15 years were first offered vaccines from 20 September 2021. Those aged 5 to 11 years (who were not in a clinical risk group or a household contact of someone immunosuppressed) were first offered vaccines from 4 April 2022, reflecting their "extremely low risk" of developing severe COVID-19 symptoms. Meanwhile, the JCVI advised against vaccination for children aged 6 months to 4 years who were not in a clinical risk group.

Deaths Data

19. Deaths data were important in situational awareness, particularly where testing was more limited, and in understanding the severity of disease in different groups. Deaths data linked with other data, such as on Clinically Extremely Vulnerable (CEV) or COVID-19 at-risk status and demographic variables, enabled understanding of which groups COVID-19 was impacting most severely as the virus evolved and new medical countermeasures became available. Deaths data were a primary source in the series of publications on the direct and indirect impacts of the pandemic, which included analysis of excess deaths for different groups.

20. Data on deaths due to COVID-19 were available to the Department and across Government from two different sources. Data from PHE, and equivalent sources from authorities across the UK, reported on individuals who had died from any cause following a positive test for COVID-19. Data from this source was published daily from 29 April 2020 and was used to track the overall trajectory of the pandemic on a near to real time basis. This source did not provide data broken down by age group. Separately, ONS adapted and modified their routine weekly reporting of registered deaths to include a count of deaths where COVID-19 was mentioned on the death certificate. This latter source included a breakdown by broad age group (including children under 1 year, children between 1 and 14 years and people aged between 15 and 44 years), but it was clear at a very early stage that the COVID-19 virus disproportionately impacted older age groups.

Non-healthcare Data

21. Transport operators, educational establishments, search engines and telecommunications operators provided anonymised, aggregate data. Non-healthcare data provided insight into mobility, behaviour and social interactions to facilitate assessment of the impact of non-pharmaceutical interventions (NPIs). Behavioural and attitudinal data – for example, from surveys and polling – helped interpret quantitative data and understand interpretations of and adherence to NPIs. The latter data were less directly applicable to children and young people.

22. In addition to the types of data explained above, the Department also collected data on other specific areas. This included data on the rates of usage of Personal Protective Equipment (PPE) in different settings, contracted volumes of Personal Protective PPE, current stock levels, outbound distribution, updates on product assurance and broad sources of supplier. The Department's PPE programme was intended to provide PPE to protect health and social care workers prioritised on the basis of clinical risk, and therefore did not provide PPE directly to children. In February 2021, the Department identified a surplus stock of Type IIR masks (which would be considered PPE if used in a healthcare environment alongside other items of PPE), which was shared with schools to support the return to education on 8 March 2021. These were classed as face coverings rather than PPE and distributed to students, teachers, school staff and school visitors to meet the requirement for face coverings that was in place at the time. The Department emphasised that these were only intended for use as a contingency supply of face coverings and were not classed as PPE (**EK2/6 - INQ000624787**). At the time, the Department carried out no assessment as to the efficacy of PPE in schools as the masks provided to schools were not provided as PPE, but as face-coverings. Further information and data regarding staff

levels among professionals who worked with children is outlined in Statement D of this Module.

Scientific Advice

The Role of and Access to SAGE

23. As explained in Statement A of this Module, SAGE was activated in January 2020 to provide expert scientific advice on COVID-19 to the government. Throughout the pandemic, the frequency of SAGE meetings was determined by the co-chairs: the CMO and the government's Chief Scientific Advisor (GCSA). SAGE does not have a formal or set membership apart from the GCSA. SAGE drew on expertise from across the scientific spectrum and included experts from within government and academia. SAGE was supported by several subject specific sub-groups, including the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) and the Scientific Pandemic Influenza Group on Modelling - Operational sub-group (SPI-M-O), and received evidence and input from additional expert groups and organisations as necessary, with attendees being determined by the co-chairs. As explained below, the Children's Task and Finish Group was established as a sub-group of SAGE in May 2020. The Secretariat for SAGE was provided by officials in the Government Office for Science (GO-Science). As stated in Professor Sir Christopher Whitty's Fourth Witness Statement to the Inquiry dated 22 August 2023, *"for the great majority of major decisions, SAGE remained the principal conduit by which scientific advice to the Government was channelled"*.

24. As was the case across government, the Department was able to access scientific advice provided by SAGE and was also able to propose questions of interest for consideration by SAGE and its subgroups. The Department did not ask any specific questions of SAGE relating to children and young people but did make use of SAGE advice when making decisions relating to children and young people. Further information on decision-making can be found in Statement C of this Module. SAGE asked for information on the direct and indirect health impacts of COVID-19 and this was produced by the Department and the ONS (EK2/7 - INQ000220190; EK2/8 - INQ000220206) as explained at paragraphs 30 and 74 below.

25. SAGE considered both the role that children could play in COVID-19 transmission and the impact of NPIs on children and young people at various points across the specified period. As explained in Statement C of this Module, SAGE reviewed a SPI-M-O paper on 13 February 2020 titled '*SPI-M-O's statement on the impact of possible interventions to delay*

the spread of a UK outbreak of 2019-nCoV, which considered the potential impact of school closures (EK2/9 - INQ000106109; EK2/10 - INQ000051882). It was noted at this point that the severity of symptoms and the role of children in transmission was “*highly uncertain*”. Further SAGE discussions in February and March 2020 regarding COVID-19 among children and in school settings are outlined in Statement C of this Module.

26. In March 2020, the consensus view of SAGE was that while school closures constituted one of the less effective single measures to reduce the epidemic peak, they may be necessary to manage NHS capacity if the spread of the virus remained on an upwards trajectory.

27. On 16 March 2020, SAGE met to consider modelling on school closures. SAGE estimated that closing schools for 8 to 12 weeks could delay the peak of the outbreak by a maximum of 2 weeks and would lead to an approximate 10% to 20% reduction in peak hospital demand (EK2/11 - INQ000610958). On 18 March 2020 it was thought that the UK was now just two weeks behind Italy on the epidemiological curve, and so the consensus of SAGE was that far stricter measures may be needed to make sure case numbers stay within NHS capacity and they were examining options (EK2/12 - INQ000129062).

28. On 17 March 2020, a SPI-M-O meeting was held to reach a consensus view on the impact of school closures on COVID-19. SPI-M-O concluded that the benefits of school closures, in preventing NHS critical care capacity being breached, could be maintained whilst allowing schools to remain open for a select number of pupils. However, school closures would need to last several months to maintain the effect (EK2/13 - INQ000610965).

29. In addition to the SPI-M-O conclusion from 17 March 2020 a paper titled ‘*The impact of adding school closure to other social distance measures*’, published by the LSHTM, was shared and discussed at the SAGE meeting on 18 March 2020. This paper concluded that adding school closures as a countermeasure could be likely to further reduce deaths by 9% (EK2/14 - INQ000610963). A Cabinet Office Briefing Room (COBR) meeting was scheduled for 18 March 2020 and ahead of this meeting DfE circulated a paper alongside an internal briefing for the Department’s Secretary of State, with advice and options on school closures (EK2/15 - INQ000610967). The briefing included SAGE advice on school closures. It was agreed that schools should be closed at the COBR meeting on 18 March 2020 (EK2/16 - INQ000056211).

30. The Department also responded to requests for information from SAGE. At a SAGE meeting on 23 March 2020, excess deaths were discussed and it was stated that, “*the*

science suggests that a proportion of the estimated fatalities from COVID-19 would be among those expected to die within a year". Data from NHSX (a joint unit of NHS England and the Department supporting transformation across the NHS and later merged into the NHS Transformation Directorate) and the ONS needed to be combined by modelling groups to give a picture of deaths caused directly or indirectly by COVID-19. On 2 April 2020, a further action was decided upon at SAGE for the ONS to coordinate agreement with PHE and NHS England and NHS Improvement (NHSEI) on a single method of reporting COVID-19 deaths numbers. Following this, a paper titled '*Initial estimates of excess deaths from COVID-19*', was brought to SAGE's 24th meeting on 9 April 2020. The paper was prepared by the Department, the Home Office (HO), Government's Actuary's Department (GAD) and ONS. It was the first in a series of 5 papers produced collaboratively by the Department over the course of the pandemic that focused on the direct and indirect health impacts of COVID-19. The papers were all submitted to SAGE for discussion and subsequently published (see paragraph 75 below).

31. It should be noted that many of the relevant expert advisory groups, including NERVTAG and the ones set out below, fed directly into the work of SAGE for the duration of the COVID-19 response. The roles of these advisory groups with regards to children and young people during the pandemic are explained below.

New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG)

32. NERVTAG is an expert committee of the Department, which advises the CMO and, through the CMO, ministers, the Department and other government departments. It provides scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory viruses and on options for their management. On 20 March 2020 NERVTAG reviewed a paper on the role of children in transmission. It was noted that there was little data on transmission of COVID-19 by children; and that "*based on the available evidence it is not possible to say if children pose a greater or lesser risk of onward transmission than infected adults*". As explained at paragraph 37, from April 2020 members of NERVTAG joined with experts from SPI-M and SPI-B to create the 'Children's Task and Finish Group' to consider this issue further.

Scientific Pandemic Infections Group on Modelling (SPI-M)

33. The Scientific Pandemic Infections Group on Modelling (SPI-M) is an advisory group providing expert advice to the UK Government on scientific matters relating to the UK's response to a pandemic, based on infectious disease modelling and epidemiology. Before

the COVID-19 pandemic, it primarily focused on pandemic influenza. However, it was formally agreed in 2018 that the group could provide advice on other areas where appropriate. This reflected how the group operated in practice.

34. Between January 2020 and March 2022, the group's operational counterpart (SPI-M-O) was stood up as a sub-group of SAGE. SPI-M-O is a separate group to SPI-M, and it reported exclusively through SAGE structures during the pandemic.
35. At the SAGE meeting on 13 February 2020, SPI-M were asked to *"use DfE data to model scenarios and parameters under which school closures could be useful and not useful in: a) delaying the peak of the UK epidemic, and b) bringing down the peak of the UK epidemic"* (EK2/9 - INQ000106109). This paper, advising on the impact of school closures across the UK, was produced by SPI-M-O and discussed at the meeting on 20 February 2020.

Scientific Pandemic Insights Group on Behaviours (SPI-B)

36. The Scientific Pandemic Insights Group on Behaviours (SPI-B) is a subgroup of SAGE. It provides independent, expert, social and behavioural science advice, and inputted into SAGE regarding children and young people. For example, at the SAGE meeting on 17 March 2020, SPI-B provided a note considering whether the health benefits of school closures could be outweighed by the effects of children being looked after by their grandparents or childminders and/or pupils interacting socially in other locations (EK2/17 - INQ000624784).

The Role of the Children's Task and Finish Group (SAGE Subgroup)

37. The Children's Task and Finish Group (TFC) was established as a subgroup of SAGE in April 2020 to specifically consider COVID-19 with regards to children and young people. The group met for the last time in early 2021. The TFC provided advice focused on the transmission of COVID-19 in children, and within schools. The group membership was drawn from SP-B, SPI-M and NERVTAG, with additional members agreed through the SAGE and SPI-M secretariats. The group was co-chaired by Osama Rahman, the Chief Scientific Adviser for DfE and Professor Charlotte Watts, Chief Scientific Adviser for the Department for International Development. The secretariat for the group was provided by DfE (EK2/18 - INQ000223973).
38. The group provided written papers for discussion at SAGE. On 1 May 2020, SAGE met to discuss infection and transmission in children and the impact of reopening schools. To

inform discussion, the TFC provided a paper on the role of children in transmission, outlining the modelling and behavioural science responses to scenarios for relaxing school closures (**EK2/19 - INQ000074926; EK2/20 - INQ000120510**). The group also met on an ad hoc basis to discuss particular issues. For example, in July 2020 the group met to discuss the possible reopening of schools (**EK2/ 21 - INQ000611652; EK2/ 22 - INQ000611653**).

39. On 17 December 2020, the TFC provided an update to SAGE on children, schools and transmission. This included reference to analysis of DfE school attendance data, which indicated that reported cases in students increased across all tiers during the first two weeks of national lockdown restrictions in November 2020, particularly in secondary schools. After the national lockdown restrictions lifted, cases in students and teachers increased slightly in tier 2 regions but not in tier 3 regions. The update explained there was still evidence of lesser susceptibility to severe clinical disease in children and young people than older people. It also highlighted the negative educational impact of missing school, particularly for younger children, and the negative impact of school closures on children's mental and physical health.
40. On 11 February 2021, the TFC provided an update to SAGE on children, schools and COVID-19 transmission. The update included data on the potential direct health risks to children and staff from COVID-19, the wider impacts of school opening on community transmission, and the direct risks from school closures to children and young people's mental health, wellbeing, development, educational attainment and health outcomes (**EK2/23 - INQ000514343**). The report outlined areas of concern, such as social distancing in staff rooms and canteens, and examples of best practice. The group was not directly asked questions by the Department.

The Role of the Joint Committee on Vaccination and Immunisation (JCVI)

41. Outside the work of SAGE and its sub-groups, the Joint Committee on Vaccination and Immunisation (JCVI) advises UK health departments on immunisations for the prevention of infections and/or diseases 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. It considers and identifies factors for the successful and effective implementation of immunisation strategies and identifies knowledge gaps relating to immunisations, or immunisation programmes, where further research and/or surveillance should be considered.

42. Throughout the pandemic, the JCVI issued advice as appropriate regarding children and young people. For example, on 3 September 2021, the JCVI issued advice that the health benefits from vaccination of 12- to 15-year-olds were marginally greater than the potential known harms. However, it considered the margin of benefit too small to support universal vaccination of healthy 12- to 15-year-olds. As it was not within the JCVI's remit to consider the wider societal impacts of vaccination beyond health, they suggested that *"the government may wish to seek further views on the wider societal and educational impacts from the chief medical officers of the UK 4 nations"*. In response to this, the Department produced a research paper presenting a range of initial, scenario-based estimates of school absences due to COVID-19 infections in 12- to 15-year-olds in England with and without vaccinating healthy 12- to 15-year-olds (EK2/24 - INQ000220194).

BARRIERS AND LIMITATIONS TO MONITORING AND ASSESSMENT

43. At the start of the pandemic, the Department faced limitations in accessing data for the purposes of decision making. This was due to a lack of data, lack of granular detail, delays, inconsistencies and restricted access to data. This assessment of data limitations, although made to refer to population-level data on the whole, are equally applicable for data relating to children and young people. As explained in Chapter 4 of the Technical Report, *"in the initial months data were sparse and there were considerable challenges gaining access to even the most basic data to understand the situation"*.

44. At the start of the pandemic, and in this context, the lead role for the oversight and provision of data relevant to the COVID-19 response sat with different partners in the health and social care system. For instance, PHE was responsible for providing data on disease surveillance and data on the early stages of the testing programme while NHSEI provided operational data on bed occupancy and availability, the number of ventilated beds available or occupied, hospital capacity, staffing numbers and deaths. In his Third Statement to the Inquiry dated 29 March 2023, Sir Christopher Wormald stated: *"In the early stages, data quality and returns provided to the Department by NHSEI were challenging and difficult to use, particularly due to low or non-availability of testing data (for example in respect of regional and national hospital admission rates) which in turn affected policy-making"*.

45. Some of the most significant inter-organisation data challenges were overcome by mid-April 2020. This followed senior Departmental intervention, including from Professor Sir Jonathan Van-Tam, one of the DCMOs, and intervention from SAGE. Following on from the 16 March 2020 SAGE meeting, Professor Sir Jonathan Van-Tam, in his capacity as

DCMO, chaired an urgent workshop on data flows. Agreement was reached with PHE and NHSEI that high quality data and quicker flows of information were necessary to inform timely reporting to Ministers. These data challenges did not affect decision making for children and young people in a disproportionate or age-specific way; where datasets included the age breakdown required to support decision-making for children and young people, those datasets were impacted in an equivalent way for all age groups.

46. Access to information improved throughout in response to demand. In Chapter 3 of the Technical Report, CMO states that:

“Observational data from combined studies were increasingly granular and influential as the first wave progressed and going into the second wave, meaning that the epidemiological and clinical understanding of the disease was substantially better in late 2020 than in March 2020. This also allowed for more accurate modelling... Observational data helped change the scientific consensus on several key variables over this time. Important examples for public health measures included:

- a. the relative contribution of asymptomatic transmission*
- b. the relative contribution of aerosols compared to droplets*
- c. the risks for people from different ethnicities, for children and for those living with obesity”*

47. A further example of data improving through the pandemic is through testing. Initially diagnostic testing was prioritised towards clinical presentations of COVID-19 within hospitals. However, as testing capacity increased, routine asymptomatic testing became possible for school children to inform policymaking. The scaling up of asymptomatic testing, including for children, meant that the quality of the data increased and therefore allowed for more accurate decision-making.

Data Acquisition

48. As explained above, data acquisition at speed, including from arm's length bodies (ALBs), was initially challenging. To improve data acquisition and improve data sharing between different organisations, the Joint Biosecurity Centre (JBC) was established in May 2020 (**EK2/25 - INQ000220221**). This included setting up a dedicated team for data acquisition (in place by the end of May 2020) to map what data sat where, form relationships with organisations to agree access and unblock barriers to access as they arose. Over time,

the understanding of data available, relationships across organisations and relevant formal agreements improved. Progress on accessing data was made prior to the JBC being established: for example, on 17 March 2020, a Control of Patient Information (COPI) notice was served to NHS Digital requesting that it securely share patient confidential data (with appropriate safeguards in place) to support situational analysis and assessment for pandemic response **(EK2/26 - INQ000049660)**. This enabled decisions about which patients were defined as clinically extremely vulnerable and should therefore be included in the Shielded Patient List (SPL). It was also used to target shielding interventions including the decision to add, and ultimately remove, all children from the SPL.

49. As outlined in a briefing document for Helen Whatley MP, Minister of State for Social Care, dated 31 January 2021, the JBC generally was “*not a decision-making body*” – instead, “*decisions [were] informed by JBC products and analysis*”. Its role was to “*gather, interpret and analyse a range of data*” collected by others, such as NHS Test and Trace, PHE and the ONS **(EK2/27 - INQ000623017)**. As such, the JBC helped to improve understanding and awareness of risk for individuals, which would have included those on the SPL **(EK2/28 - INQ000623022)**. A paper produced by the Department for a COVID-O meeting on 11 March 2021 advised that national shielding advice and support should pause after 31 March 2021, and that from this point, children on the SPL should return to school or college. It highlights that the role of the JBC would be to continue to monitor local areas and raise any areas of concern at silver meetings **(EK2/29 - INQ000060258)**. On 15 July 2021, it was recommended that children and young people should be removed from the SPL, following agreement by all UK CMOs **(EK2/30 - INQ000623018)**. As such, on 19 July 2021, children and young people previously identified as clinically extremely vulnerable were advised to follow the same guidance as the rest of the population **(EK2/31 - INQ000066720)**.

Disaggregation by Age (ONS COVID-19 Infection Survey)

50. One of the primary barriers to assessing the impact of COVID-19 on children and young people is the lack of granularity to single out the differences in age groups when considering data and analysis.
51. Where key datasets did not exist at all, these needed to be set up, taking time and at cost. One response to the lack of data was the setting up of the large-scale ONS COVID-19 Infection Survey (CIS), to understand prevalence in the population **(EK2/31a - INQ000220137)**. The initial sample was created through an amalgamation of pre-existing surveys (involving around 4,000 participants per fortnightly round in April 2020). It was

scaled up by autumn 2020 (including the use of financial incentives for participants) with around 116,000 participants per fortnightly round by October 2020.

52. ONS published CIS results every week, with data on infection levels broken down by age categories. These publications drew out differences in infection levels where possible, however data for any subgroups of the population (including age) were subject to a higher level of uncertainty due to smaller sample sizes. For example, on 19 June 2020, the CIS results were aggregated by age, with children divided into two large groups – aged 2 to 11 years and aged 12 to 19 years. A young person would either fit within the latter group or be part of the aged 20 to 49 years group **(EK2/32 - INQ000611651)**.
53. By the release of the ONS CIS results on 4 September 2020, the data had been disaggregated into more detailed categories, with children and young people being divided into three groups: ages 2 to 11 years, ages 12 to 16 years and ages 17 to 24 years. However, the slide pack advised that as the credible intervals were wide (credible intervals being the range of values estimated to be correct using data and prior information), it meant that the modelling for testing positive below the age of 24 could not be used to highlight changes or trends at this point **(EK2/33 - INQ000611655)**.

Physical Barriers

54. Alongside limitations in data reliability and range, the pandemic also created physical barriers to data collection. For example, before the pandemic the Department monitored children's physical and mental health through public health initiatives such as the National Child Measurement Programme (NCMP). The NCMP is a snapshot captured in Reception (4-5 years) and Year 6 (10-11 years) at Primary School of a child's height and weight to create a dataset on body mass index (BMI) and childhood obesity. Part of the wider impacts of school closures and school nursing teams being reprioritised was that NCMP measurements had to be stopped partway through the 2019/2020 academic year **(EK2/34 - INQ000611648)**. This meant that only 25% of the usual full measurement was taken, resulting in a dataset that was less comprehensive than in previous years.
55. The NCMP was planned to recommence in early 2021 following a new set of operation guidance to ensure data collection aligned with COVID-19 safety principles, as agreed with local authorities **(EK2/35 - INQ000611656)**. However, as outlined in an email from PHE on 8 December 2020 **(EK2/36 - INQ000623016)**, some areas reported that it would be challenging to resume NCMP data reporting from January 2021, due to the impact of competing priorities as a result of COVID-19, which meant it was unlikely they would

achieve 80% participation. One area suggested using the NCMP delivered by school nurses as an opportunity for a contact point with children to check in with them on their mental health post COVID-19, as part of the MECC (Making Every Contact Count) strategy **(EK2/37 - INQ000623021)**. NCMP Operational Guidance (2023) and subsequent annual iterations have since reflected that NCMP organisations are uniquely placed to deliver brief interventions as part of the MECC approach **(EK2/38 - INQ000624788)**. The guidance suggests that MECC training as part of continual professional development, such as learning motivational interviewing techniques, can equip staff to both recognise the opportunities for intervention, as well as support healthy conversations with parents, in particular ahead of speaking with parents about the feedback on their child's results from the NCMP assessment.

56. Monthly NCMP board meetings resumed from 10 March 2021. The NCMP itself ran during the 2021/22 **(EK2/39 - INQ000623019)** and 2022/23 **(EK2/40 - INQ000623020)** school years, with annual reports of its findings produced. Further details on the impacts of the pandemic on NCMP data collection are provided in Statement D of this Module.

IMPACTS

57. The COVID-19 pandemic and associated countermeasures had a range of impacts on children and young people. Statement C of this Module sets out the chronological narrative of the Department's understanding, activities, and response with regard to children and young people, including the implementation of countermeasures and consideration of their impact on children and young people. Statement D of this Module covers the general picture of children's health before and after the pandemic, as well as access to children's services during the pandemic. This statement will explain the approach the Department took to assessing and monitoring the impact of COVID-19 on children and young people during the pandemic.
58. Decisions taken by the Department in relation to the pandemic that considered health and wider impacts for the population as a whole, including children and young people, can be categorised as:
- a. Introduction of COVID-19 regulations.
 - b. Procurement, for example in purchasing PPE and antivirals.
 - c. Provision of guidance and support, for example informing the mental health and wellbeing recovery action plan.

- d. Funding decisions, for example in community pharmacy for the introduction of a new medicines delivery service.
- e. Operational decisions, for example to determine numbers of rooms required for the Managed Quarantine Service.
- f. Whether to accept JCVI advice on COVID-19 vaccines.
- g. Lifting or easing regulatory restrictions, for example the decision to support the easing of regulatory restrictions in Step 1 of the 'Roadmap', to allow children's activities to restart.

59. Of the above, the Department was responsible for the introduction of COVID-19 regulations, the provision of guidance and support and whether to accept JCVI advice on COVID-19 vaccines with regards children and young people. The process for the assessment of impact of COVID-19 on children and young people varied according to the types of decisions and the speed with which they needed to be made. The process for assessment was the same for children and young people, as for adults.

Impact Assessments

60. The Department routinely considers economic and wider societal impacts in its decision-making throughout the policy development process and through assessment of likely impacts via regulatory Impact Assessments (IA).

61. An IA is an appraisal of the impacts of different policy options based upon best available evidence. There are multiple stages of IAs. The full process for a policy might entail separate IAs being produced at three different stages of policymaking: policy-development, consultation and the final stage IA (though more typically it is the latter two). IAs generally involve in-depth analysis including, where possible, quantification of the range of likely costs and benefits of the policy options considered; this may include producing new analyses to address evidence gaps. Producing IAs is time-consuming and would typically take a number of weeks to produce, including the scrutiny and approvals process. They are reviewed and ultimately approved by the Department's Impact Assessment Senior Review Committee, on behalf of the Chief Economist and signed off by ministers and the Chief Economist. During the specified period, where a policy regulated business, and the likely cost or benefit to business was greater than £5 million, an IA also required clearance from the Regulatory Policy Committee (RPC); the RPC required 30 working days to provide their opinion. There was also an official requirement

to publish an Impact Assessment for any regulations which were due to last for more than 12 months. Further information about the Department's use of IAs in relation to decision-making during the pandemic, including IAs related to the Department's Public Sector Equality Duty (PSED), is set out in Statement C of this Module.

Impact Statements

62. During the COVID-19 pandemic, the Department had to introduce a range of countermeasures at pace. Under statutory exclusions that were in force at the time, Departments were not required to complete full regulatory IAs for these measures and instead developed impact statements that quickly mobilised known evidence, which, as discussed below, was subject to limitations. Annex 1 of the Better Regulation Framework sets out the general statutory exclusions under the Small Business, Enterprise, and Employment Act 2015 (SBEE Act) which were in force between 1 April 2018 until 28 August 2023 and under which the need for an IA could be bypassed or limited during the COVID-19 pandemic. Additionally, section 22(4)(d) of the SBEE Act (**EK2/41 - INQ000236173**) refers to the specific exclusion applicable to temporary measures which is to have effect for a period of less than 12 months. A document titled 'COVID-19 Regulation and Application of the Civil Contingencies' Exemption' (**EK2/42 - INQ000220220**) stated the following:

"In response to the COVID-19 pandemic many temporary measures were implemented. Under current statutory exclusions departments are not required to complete impact assessments (IAs) for measures in force for less than 12 months. Where measures extend beyond 12-months, these will no longer fall within the statutory definition of temporary measures. Such cases will come within scope of the Better Regulation Framework, but, where clearly in response to COVID-19, departments can then apply the 'Civil Emergencies' administrative exemption which means the impact to business will not account towards the Business Impact Target (BIT)."

63. An essential strength of impact statements was the speed at which they were produced; this timeliness ensured that they were useful and allowed evidence to be brought to bear in decision-making. The key weakness was that they could not always include an exhaustive trawl of evidence or modelling of all uncertainties due to the timescales available. They did, however, seek to reflect the evidence base as known at the time, noting that the evidence base was continually expanding.

64. Examples of impact statements which specifically considered impacts on children and young people include:

- a. Impact statement for the second national lockdown, which included consideration of data broken down by age in relation to COVID-19 deaths, outcomes and related healthcare costs, mental health impacts and impacts on education (**EK2/43 - INQ000110010**). This fed into the Department's decision to support the introduction of COVID-19 regulations in the form of a second national lockdown.
- b. Impact statement for Step 1 of the Roadmap out of lockdown, which eased restrictions, referred to a DfE evidence summary and considered the impact of restarting children's activities on infections and on levels of exercise. It also considered mental health impacts in young adults, aged 18 to 25 (**EK2/44 - INQ000611657**). This informed the Department's decision to support the easing of regulatory restrictions in Step 1.
- c. Impact statement for the end of self-isolation regulations, which included consideration of the impact on school attendance by pupils and teachers and the potential impacts of increasing school attendance. It also considered mental health impacts in younger age groups, 16- to 17-year-olds and young adults aged 18 to 25 years (**EK2/45 - INQ000236082**). This fed into the Department's decision to support amendments to the self-isolation regulations, which allowed exemptions from the duty to self-isolate for close contacts of a positive case providing they met certain criteria.

Standalone Analyses

65. The Department also carried out additional standalone analyses of impacts in relation to children and young people. One example of this was the '*Impact on school absence from COVID-19 vaccination of healthy 12 to 15 year old children*' analysis. This analysis was produced to understand the wider societal and educational impacts of vaccinating 12- to 15-year-olds. This followed advice issued by the JCVI on 3 September 2021 that the health benefits from vaccinating 12- to 15-year-olds were marginally greater than the potential known harms, this margin of benefit being too small to recommend universal vaccination of healthy 12- to 15-year-olds at that time (see paragraph 42 above). The JCVI had recommended in the same advice note that the government "*seek further views on the wider societal and educational impact*". The standalone analysis presented a range of scenario-based estimates of school absences due to COVID-19 infections in 12- to 15-

year-olds in England with and without vaccinating healthy 12- to 15-year-olds (**EK2/24 - INQ000220194**). It used COVID-19 scenarios coupled with epidemiological modelling from the University of Warwick and published data on school absences from COVID-19 to estimate the impact of vaccination on reducing school absences. This analysis concluded that vaccination was estimated to reduce school absences from 320,000 to 220,000 school days from 18 October 2021 to 31 March 2022. It therefore fed into the Department's decision on 13 September 2021 to advise in favour of the universal vaccination of 12- to 15-year-olds.

66. Internal analyses were also circulated regularly, sharing evidence on the impacts of the pandemic. These brought together data and analysis from multiple sources and included consideration of the direct and indirect health impacts of the pandemic. Examples of internal and published analyses are set out below.

Commissioned Research and Analyses

The National Institute for Health and Care Research (NIHR)

67. The Department's Science, Research and Evidence (SRE) directorate and the National Institute for Health and Care Research (NIHR) played a very important role in the Government response to the pandemic by commissioning and prioritising COVID-19 research.
68. The NIHR funds a broad range of health and social care research in adults and children. This includes perinatal care, early childhood development, child health and wellbeing, mental health, long-term chronic conditions, and the effectiveness of various medical and social support programmes. NIHR research in this area informs policy that aims to improve child health outcomes. NIHR offers researcher-led opportunities through its research funding programmes. Applications for programmes are subject to peer review and judged in open competition, with awards being made based on the importance of the topic to patients and health and care services, value for money and scientific quality. In 2020/21, NIHR expenditure on COVID-19 research was over £108 million. The Department continues to fund a broad and impactful portfolio of research into children and young people's health via the NIHR, which is outlined in Statement E of this Module. Between financial years 2019/20 and 2023/24, the NIHR committed more than £353.6 million to research projects and programmes on children and young people's health, and in the 2023/24 financial year committed more than £56.5 million to research projects and programmes on children and young people's health.

69. The Children and Families Policy Research Unit (PRU) brings together academics and is contracted under the NIHR's Policy Research Programme (PRP). With regard to children and young people, the PRU provided advice and undertook rapid research in response to requests from the Department. These included research reports titled '*Assessing the impact of the COVID-19 pandemic on vulnerable children*' and '*The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk or have complex social needs*'. These reports highlighted policy implications and recommendations for future lockdowns, in terms of the provision of guidance, support and funding decisions.

70. The NIHR PRP commissioned the following research exploring impacts of COVID-19 on children and young people. Research projects were also funded through mechanisms such as the Health and Social Care Delivery Research programme as well as a dedicated call for Long Covid research.

Chief Investigator	Contractor	Start/End Date	Award Title
Professor Matthew Snape	University of Oxford	24/3/20 to 24/9/21	Coronavirus STORY (Serum Testing of Representative Youngsters)
Professor Russell Viner	UCL Great Ormond Street Institute of Child Health	15/12/20 to 31/7/23	Understanding the disruption of children and young people's health and healthcare use during and after COVID-19 to inform healthcare and policy responses
Professor Sir Terence Stephenson	UCL Great Ormond Street Institute of Child Health	31/3/21 to 31/12/24	Non-hospitalised children and young people with long covid (The CLoCk Study)
Professor Russell Jago	NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board	1/4/21 to 31/5/23	Assessing the impact of COVID-19 on the physical activity of Year 6 children and their parents: Identifying scalable actions to mitigate adverse impacts and provide rapid evidence to policy makers
Dr Emma Ashworth	Liverpool John Moores University	1/5/21 to 30/11/21	A rapid cross-sectional mixed methods study to scope, understand and co-develop the policy priorities for reducing inequalities and mitigating the long-term impacts of COVID-19 for children and young people with SEND
Professor Lindsay Pennington	University of Newcastle upon Tyne	1/6/21 to 31/5/25	Recovery, Renewal and Reset of Services to Disabled Children

Professor Sue Ziebland	University of Oxford	1/8/21 to 31/1/23	Understanding and using family experiences of managing long covid to support self-care and timely access to services
Professor Maheshi Ramasamy	University of Oxford	1/8/21 to 30/9/24	A single-blind, randomised, phase II multi-centre study to determine reactogenicity and immunogenicity of heterologous prime/boost COVID-19 vaccine schedules in adolescents (COMCOV-3)
Dr Charlotte Lennox	The University of Manchester	1/9/21 to 31/12/22	Recovery from COVID-19 within the Children and Young Peoples Secure Estate (CYPSE): A mixed-methods study of wellbeing
Dr Erica Gadsby	University of Stirling	1/6/22 to 30/11/23	Realist Review: Health visiting in light of the COVID-19 Pandemic Experience (RReHOPE)

71. For further detail on the CLoCk study, focussing on non-hospitalised children and young people with long COVID, and the '*Realist Review: Health visiting in light of the COVID-19 Pandemic Experience (RReHOPE)*', please refer to Statement D of this Module.

PHE

72. In addition to the above, the Department also commissioned PHE to produce surveillance reports from week commencing 13 April 2020 on emerging evidence of the pandemic's impacts on children and young people's mental health and wellbeing (**EK2/ 46 - INQ000624785**). They provided insights from various UK studies, presenting summaries of the best evidence available at the time about the experience of children and young people. Findings showed both positive and negative impacts of lockdown and outlined how impacts differed by age cohort (**EK2/47 - INQ000610977**). Initially these were internal products for officials, the first of which was shared on 25 April 2020. They were subsequently published on GOV.UK from September 2020. Further information on these reports can be found in Statement C of this Module.

Operational Use of Impact Analyses and Commissioned Research

73. As explained above, IAs and impact statements formed a key part of the Departmental decision-making process regarding the introduction of regulations impacting on children and young people, such as the introduction of lockdowns and school closures. Statement C of this Module sets out a detailed chronology of the Department's decision-making, including how monitoring and assessments informed decision-making or advice concerning legislation and regulations which the Department had a role in.

74. A series of five papers produced jointly by the Department and the ONS considered the direct and indirect health impacts of COVID-19. The papers were published and shared with the SAGE working group. These papers used data and evidence from published research and work co-produced with other stakeholders to estimate the total health impacts of the pandemic, the impacts of interventions and the impacts of behavioural change in response to risks.
75. The papers in totality addressed pandemic impacts on children and young people's physical and mental health, their wellbeing and social development, changes in patterns of use of the internet and children's access to healthcare. A brief summary of each paper follows below:
- a. *'Initial Estimates of Excess Deaths from COVID-19'*, published 8 April 2020. This included evidence in relation to a wide range of impacts including domestic violence and child abuse.
 - b. *'Direct and Indirect Impacts of COVID-19 on Excess Deaths and Morbidity'*, published 15 July 2020. This included evidence on child malnutrition, mental health, diet, health and social impacts, domestic accidents and injuries, changes to daily routines, lack of access to school food, lack of access to mental health support, increased social media use and cyberbullying, increased exposure to second-hand smoke in homes where parents are smokers.
 - c. *'Direct and Indirect Impacts of COVID-19 on Excess Deaths and Morbidity'*, published 17 December 2020. This included evidence in relation to child malnutrition, mental health, domestic accidents and childhood obesity.
 - d. *'Direct and Indirect Health Impacts of COVID-19 in England – Short Paper'*, published 9 September 2021. This included discussion of potential health impacts of the loss of education on children as well as the fall in consultation rates for people under 11 years of age as an impact of the pandemic (**EK2/7 - INQ000220190**).
 - e. *'Direct and Indirect Health Impacts of COVID-19 in England: Emerging Omicron Impacts'*, published 4 August 2022. This included evidence on the impact on children's mental health (**EK2/8 - INQ000220206**).
76. The Department also produced an internal *'Outcome Delivery Plan of the Department of Health and Social Care 2021/22'* in April 2021 which outlined the impact of COVID-19 on the demand for children and young people's mental health services. The plan stated that

children and young people's mental health services "*currently operate in the context of significant unmet demand*", with a "*rising prevalence*" in the context of COVID-19. NHS benchmarking data suggested the number of referrals in October 2020 was 22% higher than the 2018/19 average (**EK2/48 - INQ000611101**). Awareness of the increasing demand for children's mental health services during the pandemic helped shape the Department's provision of guidance and support, for instance by informing the COVID-19 mental health and wellbeing recovery action plan. Further information on the impact of the COVID-19 response on children and young people's mental health services is set out in Statement D of this Module.

77. In addition to the above, decision-making was also informed by expert advice shared during roundtables. For instance, on 20 July 2020, the Minister of State for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries MP, chaired the '*Ministerial Roundtable on Children and Young People's Mental Health*'. Details of this roundtable and how it informed decision-making is set out in Statement C of this Module.

INTERNATIONAL ENGAGEMENT

78. The Technical Report outlines that "*science and medicine are international and pandemics by definition cross borders*". The Department engaged frequently with international partners, both bilateral partners and multilateral organisations including the World Health Organization (WHO), WHO EURO, the G7, the G20, the Global Health Security Initiative and the European Commission. In this context, the implementation of NPIs such as school closures demonstrated a common international approach to the pandemic.

International Collaboration

79. International collaboration was important throughout the pandemic to exchange information on other countries' COVID-19 response and identify best practice with international partners. As set out in the Third Witness Statement of Clara Swinson dated 4 September 2023, the Department regularly engaged with international organisations and foreign governments on general matters relating to the pandemic.

80. The Department considered various international data sources to inform policy decisions on children and young people during the pandemic. For example, on 1 May 2020, SAGE considered a technical briefing by Professor Jaap van Dissel of the Netherlands National Institute for Public Health and the Environment which discussed the role of children in the COVID-19 outbreak. This briefing noted that children's role in spreading COVID-19 was

likely to be small, and that children found to be infected with COVID-19 had fewer and less severe symptoms than adults (**EK2/20** - INQ000120510; **EK2/49** - INQ000611649).

81. In addition to reviewing published international evidence, the Department exchanged information of relevance to children and young people with international counterparts through bilateral conversations. The table below sets out the bilateral meetings which Departmental records show took place between the Department and other countries during the pandemic in relation to children and young people. We do not include every single official level contact, nor contacts from the Office of the Chief Medical Officer or our ALBs, as these would be very large in number:

Date	Participants	Details
15 May 2020	UK/China	<p>Purpose: to discuss improving access to vaccines for children. The meeting also raised that data was being sought to understand mortality and COVID-19 related complications in children.</p> <p>Key attendees: China – Minister Ma Xiaowei UK – CMO and the Secretary of State</p> <p>(EK2/50 - INQ000050655)</p>
4 September 2020	UK/The Netherlands	<p>Purpose: to discuss the epidemiology of COVID-19, particularly focusing on the reopening of schools</p> <p>Key attendees: The Netherlands: GCSA's counterpart UK: CMO</p> <p>(EK2/51 - INQ000575828)</p>
26 October 2020	UK/Italy	<p>Purpose: to discuss making the contact tracing app more accessible for children</p> <p>Key attendees:</p>

		Italy: Health Minister UK: Secretary of State (EK2/52 - INQ000058629)
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82. Many other conversations and meetings took place between the Department and representatives from other countries. However, these discussions centred around general COVID-19 matters, rather than those specifically relating to children and young people.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

<p>Personal Data</p>

Signed: Elizabeth Ketch

Date: 12 August 2025