

CLOSING SUBMISSIONS ON BEHALF OF  
CLINICALLY VULNERABLE FAMILIES ('CVF')

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A. INTRODUCTION

1. This is the closing statement 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'**).<sup>1</sup> 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.<sup>2</sup> 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 Clinically Vulnerable.
2. CVF was founded in August 2020, when schools were about to re-open for the first time following their closure to the vast majority of children in late March 2020. As Sir Gavin Williamson confirmed in oral evidence, at this time the government was focused on "*getting all children back into the school system at the earliest possible moment*".<sup>3</sup> However, by that point it was clear that the government was ill-prepared for the challenge of protecting those most vulnerable to adverse outcomes from Covid-19, and 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. Clinically Vulnerable families were unsafe, forgotten and left behind.

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<sup>1</sup> '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 Agency's 'Covid-19: Green Book' [INQ000354471]. Whilst the term 'clinically extremely vulnerable' has been retired by the government following the end of the shielding programme (with reference to those 'whose immune system means they are at higher risk' continuing), the term 'clinically vulnerable' remains in active use today. It encompasses all those who remain at higher clinical risk to Covid-19.

<sup>2</sup> 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].

<sup>3</sup> Sir Gavin Williamson [10/141/2-3].

3. The emergency phase of the pandemic may have passed, but for many Clinically Vulnerable people the pandemic is by no means over. The “Living with Covid-19” guidance issued by the government in February 2022 recognised that there were still people vulnerable to Covid-19, despite the vaccination programme, particularly those with “*weakened immune systems*”.<sup>4</sup> In the education context, government guidance from February 2022 said: “*children and young people with a weakened immune system should follow Guidance for people whose immune system means they are at higher risk from COVID-19*”.<sup>5</sup> Today, continually evolving Covid-19 variants pose an ongoing threat and Clinically Vulnerable people (children and adults) 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. As a consequence, many of those who remain at high risk from Covid-19 continue to lead restricted lives. They are left to shoulder the burden of taking ‘personal responsibility’ for protecting themselves, without society-wide mitigations and in the absence of public understanding that they continue to face very real risks. CV families continue to fight for reasonable adjustments at school, face prosecutions for Covid-19 related school absences, and are discriminated against for the simple act of wearing a mask.
4. This is one of the reasons Module 8 is so important to Clinically Vulnerable people. CVF hopes that the Inquiry will not only make recommendations that will ensure Clinically Vulnerable children and young people, and CV families, are better protected in a future pandemic, but that its evidence will shine a light on the disproportionate impact Clinically Vulnerable people continue to experience, in the hope that their challenges will be better understood and supported now.
5. CVF has advocated for two groups of children in Module 8.
6. First, children who are themselves Clinically Vulnerable to Covid-19, as was the case for David, whom the Inquiry learned about in CVF’s opening statement.<sup>6</sup> This is a small group relative to the 65 million people living in the UK, but still a sizable group of many thousands. Duncan Burton, the Chief Nursing Officer for England, confirmed that “*of the 867,789 patients considered CEV in the first iteration of the [shielded patient list], 93,000 of whom were children or young people.*”<sup>7</sup>
7. Between February 2020 and March 2022, 88 children died from Covid-19, 90% of whom had

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<sup>4</sup> Draft report from HM Government, titled ‘COVID-19 Response: Living with COVID-19’, dated 01/02/2022 [INQ000309523].

<sup>5</sup> SEND and specialist settings- additional COVID-19 operational guidance, dated February 2022 INQ000519794\_0015].

<sup>6</sup> CVF Opening Statement [1/98/18 – 1/99/6].

<sup>7</sup> Duncan Burton, Chief Nursing Officer, NHS England, §715 [INQ000588020\_0233].

an underlying chronic condition.<sup>8</sup> Duncan Burton, agreed that one could infer that 90% of those children were Clinically Vulnerable.<sup>9</sup> This number may well have been higher had many parents of Clinically Vulnerable children not kept their children away from school: Professor Russell Viner agreed that it was a “*very reasonable point*” that lower recorded instances of child mortality may have been affected by the way that Clinically Vulnerable children were shielded by their parents and prevented from going to school.<sup>10</sup>

8. 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'**).<sup>11</sup> 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.<sup>12</sup>
9. There are then many thousands more children who have suffered, and are continuing to suffer, from Long Covid. The expert witnesses commissioned by the Inquiry have highlighted data that estimated 37,000 11–16-year-olds and 22,000 2–11-year-olds in England had symptoms for more than 12 weeks after Covid-19 infection. They estimated that if findings from the Children and Young People with Long Covid (**'CloCK'**) study were extrapolated, they would equate to 17,500 children aged 11-17 with persisting problems two years on from infection.<sup>13</sup>
10. Despite these statistics, there was a concerning tendency by some witnesses to minimise, and even dismiss, the physical harm caused to children by Covid-19. CVF notes that that the Inquiry's Module 2 Report includes the observation: “*The vast majority of children were not at risk of serious harm from Covid-19. ... The decisions to close schools and early years provision to most children and to implement a lockdown were steps taken to protect the adult population*”.<sup>14</sup> CVF would remind the Inquiry that many children suffered significantly, and continue to do so to this day. As Clare Dorer, of the National Association of Special Schools, said: “*We were given lots of information that the virus wouldn't affect children in the same way, that children wouldn't get Long Covid, that children would bounce back without serious problems. I didn't ever see a persuasive evidence base for that being the case, and I think experience has told us since that it wasn't the case.*”<sup>15</sup>

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<sup>8</sup> Duncan Burton, Chief Nursing Officer, NHS England, §84 [INQ000588020\_0088].

<sup>9</sup> Duncan Burton [7/62/7].

<sup>10</sup> Professor Russell Viner [15/41/15 – 15/42/7].

<sup>11</sup> Report titled Risk Factors for Intensive Care Admission and Death Amongst Children and Young People Admitted to Hospital with COVID-19 and PIMS-TS in England During the First Pandemic Year, dated 05/07/2021. [INQ000066784].

<sup>12</sup> Duncan Burton, §296 and §301 [INQ000588020\_0088].

<sup>13</sup> Dr Terry Segal and Professor Elizabeth Whittaker, §29-30 [IN0000587960\_0014-0015].

<sup>14</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §10.89.

<sup>15</sup> Clare Dorer OBE [7/129/25 – 7130/6].

11. The second group CVF speaks for is the healthy children who lived in households with Clinically Vulnerable family members, as exemplified by the case of Lana whose story of trying to teach herself her GCSEs was reported nationally and highlighted in CVF's opening statement.<sup>16</sup> This 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.<sup>17</sup> Although this reality was recognised 'on the ground' by education leaders such as Sir Hamid Patel,<sup>18</sup> CVF submits that this group of children was almost entirely forgotten in the pandemic response, and this was especially evident in government policies on school attendance and the provision of remote education.
  
12. In its opening submissions, CVF submitted that a key question for Module 8 was what more should have been done, and could be done in the future, to ensure that both groups of children are safely able to rejoin society and access their right to education. CVF submits that the answers can be found within the following three overarching principles:
  - (1) **Safety:** School environments must be made safer for children against airborne viruses.
  - (2) **Support:** Where they are not safe enough, children must be given appropriate support to continue their education at home.
  - (3) **Status:** Clinically Vulnerable people need to be recognised as a distinct group: safety and support requires recognition of the impact Covid-19 has had, and continues to have, on Clinically Vulnerable children and families.

## **B. SUBMISSIONS**

### **(1) SAFETY**

#### ***False dichotomy***

13. This Inquiry has heard a great deal of evidence from those responsible for safeguarding children's welfare throughout the height of the pandemic. It is clear that schools serve a variety of purposes for the most socially vulnerable children in society: from providing free school meals, to allowing teachers to pick up on possible abuse, to educating children on the risks of online harm, to name a few. CVF is entirely clear that schools serve a vital role as a social safety net, and ideally, education is provided to children in-person, at school.

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<sup>16</sup> CVF Opening Statement [1/99/7-20].

<sup>17</sup> Home learning during Covid-19: Findings from the Understanding Society Longitudinal Study, National Foundation for Educational Research [INQ000623810\_0012].

<sup>18</sup> Sir Hamid Patel CBE, §73 [INQ000649936\_0020].

14. The reality however, is that infectious diseases can spread easily in schools, whether the common cold or a deadly virus. Professor Sir Chris Whitty was clear that schools had to (largely) close at points throughout the pandemic: *“You can argue about exactly the numbers but it is absolutely certain that the numbers would have been higher had the school closure not happened.”*<sup>19</sup> In fact no witness said that the initial closure of schools in March 2020 was unnecessary, even in hindsight.
15. This led some witnesses to consider the *“political choice, the societal choice, the philosophical choice”*.<sup>20</sup> Professor Sir Chris Whitty posed the question: *“where do you put the emphasis between that substantially increased overall mortality and the substantial lifelong lasting effects of education not occurring for children and all the effects on mental health which have been laid out by other people?”*<sup>21</sup> Worryingly, the answer suggested by the Permanent Secretary to the Department of Education was that *“taking decisions about school closures in a pandemic, there are some things where the impact is so great that it genuinely should be weighed up against the risk of mass fatality”*.<sup>22</sup>
16. It is important not to fall into a false dichotomy. To frame the question as a choice between whether it was right or wrong to close, and later reopen, schools perpetuates this. CVF has instead sought to persuade the Inquiry throughout this module that there is a third option, in which it is possible to focus on both the ‘R Rate’, and the needs of children and families who are most at risk. The key question is: how can schools be made safe enough so that all children can access education in a way that does not compromise their health, or the health of their families? Unless the safety of the buildings where children are educated are improved to reduce viral transmission, attendance (or lack of) will continue to be the main available lever.
17. For those with clinical vulnerabilities, making schools safer is the only way to reduce the dilemma of whether to send children to school in-person during a pandemic or epidemic. This module has highlighted that there is good evidence that many schools can be made significantly safer for Clinically Vulnerable children, those in Clinically Vulnerable families, and in fact for all children. The recommendations proposed by CVF are practical and cost-effective, and will positively impact on the health and attendance of all children, not just those in Clinically Vulnerable families.

### ***Inadequacy of the ‘system of controls’***

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<sup>19</sup> Professor Sir Chris Whitty [13/135/7-16].

<sup>20</sup> Professor Sir Chris Whitty [13/135/10-11].

<sup>21</sup> Professor Sir Chris Whitty [13/135/11-16].

<sup>22</sup> Susan Acland-Hood [11/46/8-11].

18. When the government announced that schools would re-open from September 2020, it had an inadequate understanding of Covid-19 and the means to control it in schools. 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”*.<sup>23</sup> In light of the Inquiry’s conclusion in Module 2 (after describing the ‘Eat Out to Help Out’ scheme launched in August 2020) that *“the government itself was aware of the significant risk that there would be further waves of the virus,”*<sup>24</sup> the fact that no adequate safety measures were put in place at that stage was a serious failing.
19. The system of controls initially recommended by Public Health England (‘PHE’) which accompanied Department of Education (‘DfE’) school reopening guidance published in July 2020 did not reference airborne transmission and did not recommend the use of face masks in schools.<sup>25</sup> The only reference to ventilation was a single recommendation to open windows and a suggestion that schools look to Health and Safety Executive (‘HSE’) guidance on air conditioning and ventilation. When Dr Shona Arora of the UKHSA was asked why the PHE referred schools to general ventilation guidance that applied to businesses, rather than guidance specifically relevant to schools, Dr Arora suggested that the evidence base was stronger in other settings than in schools, and that PHE’s role was limited to *“supporting sectors to produce specific guidance”*.<sup>26</sup>
20. CVF invites the Inquiry to consider whether that was a satisfactory response, given what was known about airborne transmission at the time. As the Inquiry concluded in its Module 2 report, *“the risk of people mixing in poorly ventilated indoor environments was well understood by the time of the endorsement of the importance of good ventilation by SAGE, on 23 July 2020. Ventilation should have been incorporated prominently into government messaging in all four nations from this point”*.<sup>27</sup> The Inquiry found that *“government messaging in all four nations focused for too long on handwashing and failed adequately to communicate the risks associated with airborne transmission.”*<sup>28</sup>
21. Given the arguably obvious features specific to schools that impact upon airborne transmission in school environments, such as the occupancy of classrooms and the activities undertaken in schools that can make transmission of respiratory infections more likely, as

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<sup>23</sup> CVF, §81 [INQ000587993\_0029].

<sup>24</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §12.63.

<sup>25</sup> DfE Guidance titled “Full Opening – Schools”, dated 02/07/2020 [INQ000648028].

<sup>26</sup> Dr Shona Arora [12/24/11-20]

<sup>27</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §12.41.

<sup>28</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §12.40.

identified by Professor Catherine Noakes,<sup>29</sup> the need to translate this risk into the DfE guidance concerning the full opening of school was even more pressing. Most classrooms breach all three of the World Health Organisation's ('WHO') "Three Cs" for Covid-19 transmission in that they are often "crowded", involve "close-contact settings" and are "confined and enclosed spaces with poor ventilation". The WHO explained that the risk is higher where these factors overlap.<sup>30</sup> The Module 2 report highlights Professor Jonathan Van-Tam's reference to the Three Cs when, in mid-June 2020, he suggested "*I really think people now need to be told that with our new found freedoms these (attached) are still the main risk factors*".<sup>31</sup> However, such messaging was notably absent from the guidance on schools reopening. As the Inquiry has now emphasised, communication with the public about risk is an important lesson to be learned: "*the public can and must be trusted with both knowledge and uncertainty*".<sup>32</sup>

22. When asked whether the original PHE 'system of controls' would have been effective against an airborne virus, Dr Arora accepted: "*I think they weren't completely effective, but I think it's always going to be hard to be completely effective, but yes, I think there could be other measures under consideration, if your primary focus is aerosol*" [emphasis added].<sup>33</sup>
23. It was not until 22 October 2020 that a later iteration of the system of controls introduced a mandatory action to keep occupied spaces well-ventilated.<sup>34</sup> However CVF urges the Inquiry to consider how schools could meaningfully engage with this preventative action, when the DfE did not provide CO<sub>2</sub> monitors to schools until nearly a year later, in September 2021. HEPA filters were not provided until January 2022.<sup>35</sup> There was also the continuing problem that it was often not possible to open windows due to the age and construction of many school buildings, with schools reporting it "*being uncomfortable for pupils in the colder winter months*".<sup>36</sup> As Professor Noakes identified, there are challenges with measures that rely on human behaviour: "*If you have a mechanical ventilation system, provided it has appropriate maintenance and has somebody looking after it, that is usually far more reliable than a system where you rely on human behaviour to provide good ventilation*".<sup>37</sup>
24. The absence of effective risk reduction strategies had a profound impact on Clinically Vulnerable children and children from Clinically Vulnerable families, many of whom kept their

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<sup>29</sup> Professor Catherine Noakes, §5.6 [INQ000588180\_0009-0010].

<sup>30</sup> See CVF, §187 [INQ000474526\_0086]. CVF notes with interest the Inquiry's conclusion in Module 2 that "a principled-based approach, akin to the one used in Japan" (which mirrored the WHO's "Three C's") would have been an "effective" communication strategy in the UK: at §12.51-12.53.

<sup>31</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §12.52.

<sup>32</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §15.31.

<sup>33</sup> Dr Shona Arora [12/68/22-25].

<sup>34</sup> DfE Guidance titled Full opening: schools", dated 22/10/2020 [INQ000519662\_0007]

<sup>35</sup> Susan Acland-Hood, §10.3 [INQ000587992\_0171].

<sup>36</sup> Professor Jim McManus, §21 [INQ000588160\_0004].

<sup>37</sup> Professor Catherine Noakes [15/80/1-4].

children at home when schools reopened, to avoid the risk of Covid-19 being brought back into the household. As one 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."*<sup>38</sup>

25. As the Inquiry identified in its Module 2 report in the context of the adult workforce: *"occupational exposure to Covid-19 was a key risk factor in relation to the risk of infection and onward transmission but also in subsequent hospitalisation and mortality rates. Conversely, those people in professional occupations ... had greater opportunity to work from home and consequently were less exposed to risk"*.<sup>39</sup> Whereas many adults were protected by their ability to work from home, children's attendance at school was mandated and their exposure to risk accordingly increased. The direct result of the government's inadequate risk reduction strategy in schools was that Clinically Vulnerable children and children in CV families faced effective exclusion due to the impossible choice between protecting their health and the health of their family members, and advancing their education.

### **Standard of evidence**

26. CVF would note with caution the disparity between the high level of proof which some require to show that Infection Prevention and Control ('IPC') measures work, compared to the low level of proof which was used to justify the enormously disruptive school attendance restrictions between 2020 and 2021, or the return to school in September 2020.
27. When Dr Shona Arora was asked which protective measures in schools actually worked to prevent the spread of the virus, she said *"we probably don't know with huge certainty"*.<sup>40</sup> When pressed as to why she still could not say, several years on, which measures worked, Dr Arora cited the limitations of observational or modelling studies when compared to the *"gold standard"* of randomised clinical trials for clinical measures such as vaccinations.<sup>41</sup> She suggested that *"in the context of strength of evidence and the science and evidence base it is not gold standard by any means and was lesser so pre-pandemic"*.<sup>42</sup>

<sup>38</sup> CVF, §76 [INQ000587993\_0027].

<sup>39</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §10.66.

<sup>40</sup> Dr Shona Arora [12/6/16].

<sup>41</sup> Dr Shona Arora [12/6/17-21] and [12/7/8-9].

<sup>42</sup> Dr Shona Arora [12/6/4-7].

28. CVF submits that searching for the “gold standard” of proof that that ventilation and air cleaners work is the wrong approach in this context. There will never be such evidence in dynamic environments with many confounding factors. As Professor Beggs said in Module 3, *“there has been a tendency to place great emphasis on randomised controlled trials (RCTs) ... with evidence obtained from observational and modelling studies often downplayed or ignored.”*<sup>43</sup> However, *“RCTs are notoriously difficult to conduct for a host of operational and ethical reasons, with results often compromised by the multiple confounding factors”*.
29. Attempting to apply testing standards that are designed for assessing medical treatments, rather than the measures generally used for evaluating engineering controls, decision-makers risk setting an unreachable bar for evidence on ventilation and air cleaning measures. There is sufficient evidence to make decisions on the use of ventilation now, as demonstrated by the engineering and IPC experts to this Inquiry.
30. CVF invites the Inquiry to recall Professor Catherine Noakes’ view expressed in Module 2 – *“I feel that transmission via the air was not taken seriously enough, and the demand for more definitive evidence hampered mitigations being applied in a timely manner”*<sup>44</sup> – and to ask whether the hesitation, delayed action and insistence on more evidence from the DfE and PHE was indicative of this view. As the Inquiry has recognised in its Module 2 report, the importance of acting early *“may mean taking action before definitive evidence is available in order to retain a choice about how to respond and to avoid being forced to take more extreme measures later. Delaying or failing to act quickly will have an impact, since days and weeks matter in an emergency.”*<sup>45</sup>

### **Improving ventilation in schools**

31. Looking to the future, the written and oral evidence in Module 8 strongly supports the need for better ventilation in schools. CVF urges the Inquiry to consider this evidence in conjunction with the Module 3 expert evidence. The starting point is for the Inquiry to acknowledge the premise that good ventilation in highly-populated environments is a way to mitigate against the spread of disease. Professor Catherine Noakes said: *“The evidence base is all pointing in the same direction: that better ventilated environments provide a healthier environment for children and adults. They help you mitigate against disease, they help you mitigate against other respiratory conditions.”*<sup>46</sup>

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<sup>43</sup> Professor Clive Beggs, §329 [1NQ000474276\_0111].

<sup>44</sup> Professor Catherine Noakes §10.12 [1NQ000236261\_0051].

<sup>45</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §15.25.

<sup>46</sup> Professor Catherine Noakes [15/89/20 – 15/90/2].

32. Of schools in particular, Professor Sir Chris Whitty said: *“It’s an uncontroversial statement from an epidemiological point of view to say that improving ventilation in schools would be a good thing. If it would not just for future pandemics, hopefully we won’t have to face one of them for a long time, of a respiratory sort like this one but also just for year-on-year flu and other respiratory infections which cause a lot of trouble in schools lead to individuals not having their schooling, lead to outbreaks locally.”*<sup>47</sup> CVF submits that his evidence is particularly pertinent today in the context of the current influenza epidemic, which is recognised as a serious risk for Clinically Vulnerable people.

33. The wider benefits of improving ventilation in schools are also well recognised. Professor Catherine Noakes also highlighted to the Inquiry:

*“Improving ventilation is not just about reducing Covid transmission; it’s also about improving those environments for other respiratory infections, improving them for children who might have asthma, improving them in terms of cognitive performance of children in schools, and the learning environment. So there are much wider benefits to creating better-quality environments in schools than simply looking at Covid transmission.”*<sup>48</sup>

34. Kevin Courtney, representing the Trades Union Congress agreed: *“having ventilation, filtration, in place in schools would be a real benefit, I think, every year around cold and flu it would be a benefit in the summer, you know, in the summer of 2022 when children lost time in schools because it was too hot, and the schools didn’t have enough ventilation and they had to close because it was too hot.”*<sup>49</sup>

35. This is precisely CVF’s point: that improving ventilation in schools will have significant health benefits to *all students and their families*. Clean air should be just as important as healthy school lunches and safe playground equipment.

36. It is significant that educators ‘on the ground’ have already recognised that the benefits of clean air and ventilation on staff and students go beyond health. John Barneby, CEO of Oasis Community Learning, stated that ventilation is likely to link to outcomes and attendance of learners in school, meaning that there are wider benefits than simply preparing for the next pandemic:

*“The thing I think we need to learn is that the environment of classrooms is critical*

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<sup>47</sup> Professor Sir Chris Whitty [13/141/11-20].

<sup>48</sup> Professor Catherine Noakes [15/79/11-19].

<sup>49</sup> Kevin Courtney [5/203/9-15].

*to children learning. And so ventilation during Covid is one issue of managing that, but there is a bigger picture issue around having effective school buildings, having classrooms where the temperature is right, and suitable for learning, and I think we could probably, if we went and looked back at the data, start to trace correlational between outcomes and attendance based on the quality of school buildings and the environments”<sup>50</sup>*

37. CVF would endorse Sir Hamid Patel’s suggestion of linking CO<sub>2</sub> data with learning outcomes, to provide further evidence of the effects of ventilation on academic achievement:

*“...schools in disadvantaged areas are the ones that often have the poorest infrastructure, they are the poorest buildings. So a national ventilation standard for schools linked to health and learning outcomes would make a difference. One of the things that we argued with the universities and with the Department was to say why don’t you link the CO<sub>2</sub> data with learning outcomes? Because if CO<sub>2</sub> - if ventilation, good ventilation is important for health, if we can establish that good ventilation is important for learning, for concentration, then that means that schools that don’t have good ventilation, poorer ventilation, their kids are disadvantaged even before they step into an exam hall.”<sup>51</sup>*

38. Linking this data would build upon existing evidence that CO<sub>2</sub> levels impact learning outcomes,<sup>52</sup> including evidence identified by Professor Noakes: *“There is also evidence from a number of studies that better ventilation is likely to have ... a positive impact on learning for children”*.<sup>53</sup>
39. The work of improving mechanical ventilation is not something that can be undertaken during a crisis itself: it is important preparatory work, and the Covid-19 pandemic demonstrated how woefully underprepared schools were with regards to ventilation. CVF submits that there is sufficient evidence and consensus before this Inquiry for it to recommend that clean air is prioritised in schools and that work is done to change the culture of schools to ensure that clean air is prioritised.
40. Kevin Courtney agreed that preparatory work to improve ventilation throughout schools is a necessary and proportionate step to be taken for future infection prevention and control, and

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<sup>50</sup> John Barneby [7/200/21 – 7/201/5].

<sup>51</sup> Sir Hamid Patel CBE [5/141/13 – 5/142/5].

<sup>52</sup> Report from the “Lancet Covid-19 Commission Task Force on Safe Work, Safe School and Safe Travel”, titled “Designing infectious disease resilience into school buildings through improvements to ventilation and air cleaning”, dated April 2021 [INQ000311117].

<sup>53</sup> Professor Noakes, §8.2 [INQ000588180\_001].

argued that it should be a “massive priority”<sup>54</sup> for the government:

*“If we agree that closing schools was a necessity in this pandemic for at least some time, but that it has had very serious consequences for young people as a result of that, then we should be prepared to invest to try to stop that happening in the future...There is a need for a thoroughgoing programme of work in schools, part of which should be improving the ventilation and the air filtration in schools”*<sup>55</sup>

41. Dr Shona Arora confirmed that: *“Five out of the six pandemics that have occurred since the 20th Century have been respiratory and airborne. And I think our National Risk Register also signals that’s still the highest risk. So it would certainly make sense to start with prioritising that.”*<sup>56</sup>
42. CVF supports Professor Jim McManus’ recommendation that mechanical ventilation is provided as a necessity in all new build schools.<sup>57</sup> CVF notes that schools leaders are echoing these calls: *“I do feel that there is a need to go and retrofit a solution, whether that’s a mechanical ventilation upgrade or HEPA filters or something”*.<sup>58</sup>
43. For existing school buildings, the effectiveness of air cleaning devices such as HEPA filters in removing or inactivating viruses is well established.<sup>59</sup> As Professor Beggs has noted, air cleaning devices are *“relatively low cost and can be rapidly deployed as required to boost effective air change rates”*.<sup>60</sup> CVF submits that these devices should be deployed widely in schools now as a matter of urgency where sufficient ventilation cannot be demonstrated.
44. CVF notes that maintaining the recommended CO<sub>2</sub> 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 tools to improve air quality if it was found to be low.
45. The next pandemic is an inevitability. Clinically Vulnerable people face a consistently higher risk from infectious diseases in both ordinary times and during pandemics. As the Inquiry has highlighted in its Module 2 report, *“the next pandemic may well look very different from both those for Covid-19 and influenza, with key differences in how and how quickly the virus is*

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<sup>54</sup> Kevin Courtney [5/204/16].

<sup>55</sup> Kevin Courtney [5/203/10-25].

<sup>56</sup> Dr Shona Arora [12/12/22 – 12/13/5].

<sup>57</sup> Professor Jim McManus, §49 [INQ000588160\_0012].

<sup>58</sup> Sir Hamid Patel CBE [5/141/13-15].

<sup>59</sup> 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').

<sup>60</sup> Professor Clive Beggs, §283 [INQ000474276\_0101].

*transmitted and the severity of illness it causes. There may also be differences in the groups that are clinically vulnerable – for example, the vast majority of children were not at serious risk of health harm during the Covid-19 pandemic, but may be more susceptible to other viruses*".<sup>61</sup> CVF urges the Inquiry to recommend that steps are taken to improve indoor air quality in schools, so that children are less likely to miss out on in-person education, and schools are safer for all children. Moreover, it is important that Inquiry makes clear that the primary responsibility for making schools safer lies with the DfE, not the child, the parent or the teacher. As Professor Catherine Noakes confirmed in Module 2, mitigating airborne transmission requires "*tak[ing] the responsibility from the individual to the organisation, because it's the organisation that tends to deal with the environment*".<sup>62</sup>

### **Ventilation building standards**

46. Professor Noakes has explained that school ventilation in new buildings or major retrofit is covered by Building Bulletin 101 ('**BB101**') which was last updated seven years ago, in 2018. This guidance includes recommended CO<sub>2</sub> levels as a proxy for ventilation, and allows average CO<sub>2</sub> levels in naturally ventilated classrooms up to 1,500 ppm, whereas HSE guidance for indoor spaces treats CO<sub>2</sub> levels below 800 ppm as indicating good ventilation and levels above 1,500 ppm as indicating poor ventilation. As Professor Noakes explained:

*"If you have a building at the moment, a school building that complies with BB101, it is probably at the bottom end of that HSE recommendation if not slightly below it. So our standards actually set out ventilation conditions [for schools] that are not as good as every other building and that's even if they're complied with."*<sup>63</sup>

47. Professor Noakes recommended that better ventilation standards are introduced for new build and major retrofits.<sup>64</sup> In terms of older school buildings, whilst it is normal for all buildings that they do not need to be retrospectively updated if standards are updated, Professor Noakes nevertheless recommended that there should be a mechanism for schools and other public buildings like hospitals, for improving those environments, "*recognising new evidence and recognising the importance of improvements*".<sup>65</sup>

CVF urges the Inquiry to take forward Professor Noakes' recommendations that the guidance should be revised to both reflect new evidence (including changes to the building regulations and new research that considers airborne risks) since the last revision of BB101, and to ensure that children and staff in schools are able to access ventilation that is designed to be at least

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<sup>61</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §15.4.

<sup>62</sup> Professor Catherine Noakes, 19 October 2023 [13/16/1-7].

<sup>63</sup> Professor Catherine Noakes [15/92/1-7].

<sup>64</sup> Professor Catherine Noakes [15/92/10-11].

<sup>65</sup> Professor Catherine Noakes [15/92/17-25].

comparable to standards for other environments such as workplaces. Professor Noakes warned that “*if standards are not updated, there is a real risk that any new school building programme will “lock in” outdated requirements*”.<sup>66</sup>

### **Guidance for schools on CO<sub>2</sub> levels**

48. Schools should be given clear guidance on when to take action regarding air quality and what actions to take. They should be given the resources to take those actions.
49. The Inquiry has sufficient evidence in relation to CO<sub>2</sub> levels in schools to make a recommendation in respect of that issue. CVF has set out in its proposed recommendations the levels that it considers are the minimum needed to ensure safety. CVF also requests that the Inquiry recommends that a comprehensive study is commissioned to report on safe CO<sub>2</sub> levels in schools to be undertaken within a specified, short timeframe.

### **Masks**

50. The topic of masks received minimal scrutiny in the public hearings and CVF is conscious that the Inquiry has received more extensive evidence on this issue in Module 3. However, masks remain a critical safety measure for Clinically Vulnerable children and children in Clinically Vulnerable families. CVF remains deeply concerned that mask-wearing became a needlessly politicised and divisive issue during the pandemic, and welcomes the Inquiry’s conclusion in Module 2 that “*proportionate and sustainable interventions ... (such as ... face coverings and respiratory hygiene) may have avoided or minimised the need for harsher measures later*”.<sup>67</sup> The effect was that many Clinically Vulnerable children and children in Clinically Vulnerable families have become targets of abuse simply for wearing a face mask. Even though all children of a certain age were required to wear masks during periods of high community transmission, once those measures were lifted, the continuing risks to Clinically Vulnerable families were not recognised: masks were treated as a ‘net negative’ for everyone rather than a reasonable adjustment which could be a tool to protect Clinically Vulnerable children and families.
51. 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

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<sup>66</sup> Professor Catherine Noakes, §8.4 [INQ000588180\_0020].

<sup>67</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §15.25.

school attendance.<sup>68</sup> In CVF's experience, many children from Clinically Vulnerable families have achieved 100% attendance as a result of effective mask use.<sup>69</sup>

52. The expert scientific evidence confirms that high-grade masks 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*".<sup>70</sup> 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.<sup>71</sup>
53. CVF maintains that children in education settings should be permitted to wear masks as a reasonable adjustment, whether for their own protection or the protection of their family members, 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*",<sup>72</sup> however this guidance has since been withdrawn.

54. ***Proposed recommendations***

Recommendation 1: Air quality in schools should be recognised as a public health priority.

Recommendation 2: Ventilation guidance for schools (BB101) last updated in August 2018, must be comprehensively reviewed and brought up to date as a matter of urgency – both in respect of ventilation *and* the control of airborne infections, including through the use of air filters.

Recommendation 3: Guidance should be issued to schools to reflect the recommendation that CO<sub>2</sub> levels are kept below 800 ppm, with at least 10 L/s per person of fresh-air flow. Air cleaning devices, such as HEPA filters, should be deployed to all schools where sufficient mechanical ventilation cannot be demonstrated.

Recommendation 4: Mechanical ventilation should be a requirement in all new build schools.

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<sup>68</sup> CVF, §96 [INQ000587993\_0033].

<sup>69</sup> CVF, §105(a) [INQ000587993\_0035].

<sup>70</sup> Professor Beggs, 11 September 2024, [3/134/2-9].

<sup>71</sup> Expert Report by Dr Gee Yen Shin, Professor Dinah Gould, and Dr Ben Warne titled Infection prevention and control: the challenges of protecting everyone in healthcare settings from the threat of Covid-19, dated 08/08/2024, §1.52 and §1.53 [INQ000474282\_0027].

<sup>72</sup> Guidance from Department for Education, titled Schools Operation Guidance, to school leaders, dated 06/07/2021 [INQ000075585\_0006].

Recommendation 5: DfE and PHE guidance in relation to face masks should 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 including the provision of safe eating arrangements during breaks, 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.

## (2) SUPPORTING ACCESS TO EDUCATION

### *England's strict and punitive approach*

55. In September 2020, when schools reopened in England to all children, school attendance at schools was mandatory unless the child themselves was formally designated as CEV.<sup>73</sup> There was a lack of clear options or safe alternatives available for CV children who did not have a formal CEV designation, or whose family members were CEV or CV. Many of CVF's children faced impossible choices between their education, and their health or the health of a loved one. To this day, the bravery of those children has been overlooked. Sir Hamid Patel recognised the reality that many families faced:

*“You're told that their children must stay home to protect vulnerable relatives. Then they're told that their children must return to school regardless of family vulnerability. Then they're told that they could request leave of absence but only at school's discretion. So this inconsistency places families in a moral and ethical dilemma. Do you protect your loved ones? Do you comply with attendance rules? And it also places schools in a policy vacuum, expected to enforce attendance while managing real trauma.”<sup>74</sup>*

56. As was seen in multiple arenas throughout the scope of this module, the voices of children themselves were often unheard. The Inquiry heard from many educators who dealt with the fears faced by children in this impossible situation, which were entirely accurate and grounded in the unfortunate reality of the effects of the pandemic on those who were Clinically Vulnerable. Mark Drakeford, the Former First Minister of Wales, gave evidence that:

*“And if you talked to children at the time, they did not have a view that somehow*

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<sup>73</sup> Guidance from the DfE titled “Full Opening – Schools”, dated 02/07/2020 [INQ000648028].

<sup>74</sup> Sir Hamid Patel CBE [5/139/20 – 5/140/6].

*their rights were being subjugated to the rights of other people, they talked to you all the time about their fear for their grandparents, a fear for their father who worked away, their fear for their sister who had an underlying health condition.”<sup>75</sup>*

57. Whilst the peak of the pandemic has passed, these fears remain to this day the reality that many children in this country are living with on a daily basis, in a society that has largely forgotten that Clinically Vulnerable people exist. The dilemma of education versus health is a choice that many families have to make every single day. Sir Hamid Patel’s evidence noted the possibility for schools to undertake a risk assessment where a child was not being sent in to attend school and take appropriate steps as a result. CVF would endorse this as a sensitive, yet pragmatic approach: recognising that many Clinically Vulnerable families are continuing to balance their children’s right to education with the need to protect health, yet also acknowledging that safeguarding the welfare of all children is a critical role that schools play. As Vicky Ford, former Parliamentary Under Secretary of State for the Department for Education, said: *“there had to be individual risk assessments. I really strongly believe that parents should be involved”*.<sup>76</sup>
58. CVF submits that no satisfactory answer has been provided by the DfE as to why the flexible approach to attendance set out in the May 2020 guidance<sup>77</sup> was not continued in September 2020. Susan Acland-Hood<sup>78</sup> and Dr Shona Arora pointed to the changing advice on the clinical vulnerability of children. However, this is a flawed approach. Clinically Vulnerable children were later prioritised for vaccination on the basis that they had underlying health conditions that put them at higher risk of severe Covid-19. If a child is vulnerable enough to receive priority vaccination, they will also be at greater risk of infection in a school environment.
59. Sir Gavin Williamson simply relied on the *“element of flex”* which he said existed within the system on a local level that was *“able to deal with any specific cases that were particularly difficult”*.<sup>79</sup> This response – which suggests a handful of difficult cases here or there – reveals a fundamental underestimation of the extent of the issue faced by CV families: it had been estimated in July 2020 that 1 in 4 school-aged children lived with an adult at high (CV) or very high risk (CEV) of serious illness from Covid-19.<sup>80</sup> It is important to remember that while CEV adults could continue shielding informally, children with CEV family members had no choice but to attend school. As CVF has set out in its evidence, in reality there was no such flexibility

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<sup>75</sup> Mark Drakeford [15/134/11-17].

<sup>76</sup> Vicky Ford [9/164/3-5].

<sup>77</sup> 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 [INQ000075733].

<sup>78</sup> Susan Acland-Hood [11/117/4-18].

<sup>79</sup> Sir Gavin Williamson [10/140/4-6].

<sup>80</sup> Home learning during Covid-19: Findings from the Understanding Society Longitudinal Study, National Foundation for Educational Research [INQ000623810\_0012].

offered to its members.

60. In any event, this was not something that should have been left to individual headteachers to “deal with”: schools should have been supported by DfE guidance which incorporated flexibility, in the manner adopted by Hampshire County Council.<sup>81</sup> CVF maintains its request for the Inquiry to explore why Hampshire’s guidance was not adopted on a national level.
61. The Inquiry found in Module 2 that no detailed equality impact assessments – or children’s rights impact assessments – were conducted by the UK government or the devolved administrations in advance of the decisions to close schools<sup>82</sup> and concluded that even during an emergency, impact assessments should be carried out as soon as time allows. CVF supports the Inquiry’s Recommendation 7 that the UK government should introduce legislation to place child rights impact assessments on a statutory footing in England. As the Inquiry observed, impact assessments “*may not change a decision but they may lead to steps to mitigate the effects of the decision, such as guidance or making exceptions to a policy*” [emphasis added] and would have “*helped in the evaluation of the mitigating actions which had been taken*”.<sup>83</sup> This point also highlights why clinical vulnerability should be included as a protected characteristic (‘PC’) in the Equality Act 2010: the public sector equality duty requires impact assessments relating to the PCs – if clinical vulnerability is not a PC, then even where equality assessments *are* conducted, there will remain a serious blind spot.
62. The DfE’s guidance on attendance should have included the following:
- a. Recognition that a large number of children were living in a CV household.
  - b. Recognition of the state’s duty to protect the right to life, the right to family life, and the right to education, without discrimination.
  - c. Risk assessments to be completed for Clinically Vulnerable children and children in CV families, based on national public health guidance, but with input from both children and their parents.
  - d. Personal choice must be afforded significant weight in the assessment.
63. Instead, many of CVF’s members were subject to an overly punitive policy, which was in place in England throughout the peak of the pandemic, and was seemingly not relaxed by anyone with the power to do so. Families who had entirely legitimate concerns around the health of their loved ones were encourage to ‘off-roll’ their children, and were fined and prosecuted for non-attendance at school.<sup>84</sup>

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<sup>81</sup> CVF, §68 [INQ000587993\_0024-25].

<sup>82</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §10.95 and 1.104-1.107.

<sup>83</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §10.100 and 10.108.

<sup>84</sup> CVF, §31 [INQ000587993\_0014].

64. By definition, off-rolling is a practice whereby children are removed from the official school roll without being permanently excluded (which triggers a formal process that can be appealed), that is for the benefit of the school rather than the child. CVF notes that the definition provided by Matthew Coffey, Chief Operating Officer and Deputy Chief Inspector at Ofsted, did not address the crucial fact that off-rolling is a practice that is initiated by, and benefits the school, and is not a step taken by families without significant pressure upon them to do so: *“The definition of off-rolling is that a child that is taken away from the school register but without an exclusion code or any obvious reason.”*<sup>85</sup>
65. Professor Gillian McClusky, the Inquiry’s education expert, brought this to the Inquiry’s attention: *“It felt as though England, in this particular point, was emphasising a strict and punitive approach whereas the other three [nations] weren’t. They were talking about the need for understanding, support, flexibility.”*<sup>86</sup>
66. This was in contrast to the approach taken in Scotland and Wales. Mark Drakeford gave evidence that even outside of a pandemic:

*“We’ve always had a different approach on the issue of compulsion in Wales. I do not believe, myself, that struggling families find it easier to cope with the struggle if you threaten them that if they don’t do as they’re told the state will be along to punish them for not doing so. And we’ve never taken that attitude in Wales. We very rarely, for example, use powers to prosecute parents who fail to present their children at school. It could be absolutely a last resort and only those cases where you’re sure that parents are doing so in a way that’s clearly culpable.”*<sup>87</sup>

67. When questioned about fines and prosecutions imposed, of which CVF provided examples to the Inquiry,<sup>88</sup> Sir Gavin Williamson initially stated that there was flexibility within that system.<sup>89</sup> However, when pressed about the fact that the English approach was far stricter than the approach of both Scotland and Wales, he stated:

*“When the policy was devised, it seemed to be the right policy. They’re one of the reflections in terms of the Inquiry is, was our approach correct or was the Welsh or Scottish approach correct? And that would certainly be something I’d be very keen to learn from and understand better, if we didn’t get that correct.”*<sup>90</sup>

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<sup>85</sup> Matthew Coffey [5/4/10-12].

<sup>86</sup> Prof. Emerita Gillean McCluskey [6/182/15-19].

<sup>87</sup> Mark Drakeford [15/149/16 – 15/150/2].

<sup>88</sup> CVF, §53, §55 [INQ000587993\_0019-21].

<sup>89</sup> Sir Gavin Williamson CBE [10/142/21 – 10/143/6].

<sup>90</sup> Sir Gavin Williamson CBE [10/142/2-8].

## **Remote education**

68. Support also involves the provision of effective and technologically sound remote education. CVF is concerned that remote education has been demonised to an extent in this module, as being unsuitable for learning.<sup>91</sup> CVF accepts that remote provision is rarely as effective as in-person education, but submits that it can be a powerful tool in helping to equalise access to education for those who would otherwise have no access to educational provision at all. The systems and practices developed in schools during the pandemic mean that remote education is now a viable option which can be, and is currently, used for unplanned emergency school closures, for example on 'snow days'.
69. Educators have echoed CVF's calls for flexibility within the education system to allow for greater access for all children. Sir Hamid Patel said: *"We need a hybrid model. We need some face-to-face, some online. It can't only be online. There needs to be some face-to-face. Of course, we're in a pandemic, schools were closed, so face-to-face wasn't possible. But a hybrid model is more effective."*<sup>92</sup>
70. CVF would encourage the Inquiry to look to Scotland's model of remote education for consideration of how it could work alongside regular face-to-face education when the need arises. Nicola Killean, the Children and Young People's Commissioner for Scotland highlighted the national e-learning school in Scotland – "e-Sgoil" – as a best practice model that she would like to see further expanded. She regarded the provision as a *"huge opportunity"* for children who are not currently attending school. She also explained that there are wider benefits, for example to provide children with access to different subjects.<sup>93</sup> John Swinney MSP, First Minister of Scotland, agreed that remote education has a place in future options for educating children and young people outside its role as an emergency measure, saying that remote provision should be used: *"As a complement to face-to-face learning, yes."*<sup>94</sup>
71. Professor Catherine Davies, the Inquiry's expert on child development specifically suggested making education more accessible:

*"Children will have different requirements, of course, but there may be some more accessible ways to do that. What I haven't mentioned is sort of online provision, as well, and I'm not saying that should be the entirety of a child's educational*

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<sup>91</sup> Susan Acland-Hood [11/102/11-5].

<sup>92</sup> Sir Hamid Patel CBE [5/134/8-13].

<sup>93</sup> Nicola Killean [16/36/19 – 16/37/9].

<sup>94</sup> John Swinney MSP [8/202/18].

*experience but where those nurseries were providing appropriate online content for very young children, and that's not easy, but particularly for those who are clinically extremely vulnerable, we can see greater confidence in those early years practitioners and greater engagement by those children. So I would recommend a kind of mixed provision, I suppose, of different ways of educating and stimulating all of our children safely.*<sup>95</sup>

72. The possibility of flexible learning that incorporated both face-to-face education and remote learning should have been more seriously considered after schools fully reopened, instead of restricted to children who were at home isolating following Covid-19 infection. If it had been, a large number of children could have benefitted and lost out less on their education. 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."*<sup>96</sup> 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!"*<sup>97</sup>
73. It would be wrong to view remote education as simply "better than nothing". The pandemic has proven that the delivery of remote education is viable, and in CVF's submission this proof has not been taken seriously enough. Going forward, it is critical to identify and evaluate what worked well during the pandemic, particularly in schools and colleges which were more successful in their delivery of remote education, so that these practices can be retained and developed, not lost.

### ***The importance of flexibility***

74. CVF is not advocating for whole school closures, or any approach that places children in a position of no contact with their school and teachers, undermining the vital educational and safeguarding role of in-person education. CVF submits, however, that there should be more flexibility to support those children who are either at higher clinical risk themselves, or live with a high-risk family member. Lara Wong, CVF's CEO and founder, gave evidence that: *"Flexibility could mean a number of different things. It might mean, obviously, learning remotely as a potential. It might mean hybrid learning. And by hybrid learning, I mean in class, to an extent, but maybe in an outdoor classroom. They have things like forest schools for younger children."*<sup>98</sup>

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<sup>95</sup> Professor Catherine Davies [2/200/24 – 2/201/13].

<sup>96</sup> CVF, §146 [INQ000587993\_0049].

<sup>97</sup> CVF, §150 [INQ000587993\_0051].

<sup>98</sup> Lara Wong [3/123/14-19].

75. The benefits of a flexible approach were quickly apparent to those that utilised creative approaches throughout the peak of the pandemic. Nicola Dickie, giving evidence on behalf of the Convention of Scottish Local Authorities, spoke about services that had access to outdoor learning being able to recover quicker, and support children better by incorporating outdoor learning into their education: *“The learning from the pandemic was that those services that had access to an awful lot of outdoor learning facility were the ones that were able to recover quicker. They were also areas where we could supply with social distancing, and I suppose the collective wisdom is that when children are learning through outdoor play, they're getting more out of it in the longer run.”*<sup>99</sup>

76. Indra Morris, formerly of the Department for Education, advocated for a flexible, individual approach to educating students balancing these risks rather than mandating attendance for all: *“I think discretion, although it has its down sides, I think that was the right thing to do.”*<sup>100</sup>

77. Sir Hamid Patel gave evidence to the Inquiry that a flexible approach was possible, and that when families were offered compassion by their school, they were more likely to feel reassured that their concerns were being taken seriously:

*“That was the sort of balancing situation. And that's why we decided that we needed to take a compassionate approach. And we took compassionate approach. Where we provided reassurances to parents, and some parents were reassured by the infection control measures that we'd put in place. They did send their children back. Some parents didn't feel reassured so we took a risk assessment. We offered them online lessons, and we carried on doing it home visits, because these were intergenerational households and, as you say, many parents who were clinically vulnerable.”*<sup>101</sup>

78. CVF's members experienced varying approaches depending on individual headteachers' understanding of the risks and their willingness to go against national guidance, leading to inconsistent decision-making and differing approaches in response to government guidance on attendance.

79. Susan Acland-Hood said that the approach should have incorporated dialogue with families:

*“the vast majority of children who'd been previously identified as clinically vulnerable or clinically extremely vulnerable were effectively removed from that*

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<sup>99</sup> Nicola Dickie [8/31/20 – 8/32/2].

<sup>100</sup> Indra Morris [9/30/24-25].

<sup>101</sup> Sir Hamid Patel CBE [5/139/4-14].

*designation and told "We think it is now safe for you to attend school ... we reflected that position in our guidance and we sought to strongly encourage attendance for those for whom it was safe to attend. We did reflect in the guidance that position for children who were still under the care of a health professional and we also reflected that there might be a period of adjustment for children so there is advice in our guidance about managing that and encouraging head teachers and teachers to talk to families who might be anxious about it."*<sup>102</sup>

80. In CVF's experience, there was no 'dialogue', only pressure from schools to attend. However, in any event, CVF submits that "*talk[ing] to families who might be anxious*" is inadequate. It was a fact, not a feeling, that Clinically Vulnerable people faced higher risks of severe outcomes from Covid-19. Language about "anxiety" and "fear" felt by families who are still facing difficulties in trying to educate their children safely was used throughout Module 8 hearings by those giving evidence. Susan Acland-Hood said, "*I think sometimes people continued to feel vulnerable, including clinically vulnerable, when they didn't quite meet that designation*".<sup>103</sup> This is dismissive of the underlying issue. If Clinically Vulnerable people "*didn't quite meet the definition*" then they would not be Clinically Vulnerable. In reality, many families did meet clinical vulnerability thresholds, or lived with household members who did, and their continuing sense of vulnerability reflected ongoing risks of exposure to a potentially fatal infection in inadequately mitigated school settings. Concern that Covid-19 might kill your child or vulnerable family member is a legitimate assessment of risk; it should never have been described as 'anxiety', which instead implies an emotional overreaction or unfounded worry. CVF is concerned that characterising families as "*continuing to feel vulnerable*" sounds like an attempt by the government to shift responsibility away from their duty to protect life and not discriminate.
81. Thus, the clinical vulnerability of children and families needed to be taken more seriously, and not minimised as being about "fear" or anxiety", and decisions needed to be based on clinical risk to the child and household, not on a headteacher's opinion. The consequences of leaving it to individual schools was a postcode lottery and a lack of any formal mechanisms to enforce the supposed dialogue.
82. The former Prime Minister, Boris Johnson, emphasised in his evidence the importance of "*momentum*" when children were returning to schools in September 2020.<sup>104</sup> However, the reality was that in the rush to get all children back to schools, the risks faced by Clinically Vulnerable families were minimised – and this was the wrong approach that has had lasting

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<sup>102</sup> Susan Acland-Hood [11/117/4 – 11/118/6].

<sup>103</sup> Susan Acland-Hood [11/129/22-25].

<sup>104</sup> Boris Johnson [14/95/15-16].

and serious consequences for children’s safety and education to this day.

83. Boris Johnson also said: “*There was always going to be an argument against reopening schools from that position: that you were going to create a situation in which vulnerable parents would be exposed to the virus picked up by kids in schools.*”<sup>105</sup> CVF notes that he implicitly acknowledged the risk for vulnerable households in this statement. However, that was not an argument against reopening schools. The “argument” pointed to the need to protect a particular group, as CVF has consistently advocated. The risk to vulnerable households – including the fact that children in Clinically Vulnerable families faced unique challenges and it was often not safe enough for them to attend school – should have been recognised and managed through mitigating measures, such as remote or hybrid education, not ignored. By failing to address this known risk, the government failed to protect CV families’ right to life, health, education and family life.

84. ***Proposed recommendations***

Recommendation 6: A dedicated national attendance code should be introduced that recognises household clinical risk to ensure that Clinically Vulnerable children and children in Clinically Vulnerable families are supported rather than punished when an absence is due to a known underlying health issue or risk.

Recommendation 7: 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. Each nation should set up national systems for remote schooling.

Recommendation 8: Comprehensive research should be commissioned to analyse what worked well in terms of remote education provision so that lessons can be learned and good practices can be retained, which can begin by analysing the Scottish e-Sgoil approach.

**(3) STATUS**

85. As became evident throughout the evidence heard in this module, the needs of CV families went unaccounted for. As outlined by Matthew Coffey from Ofsted, children in Clinically Vulnerable households were not often at the forefront of policy makers’ minds:

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<sup>105</sup> Boris Johnson [14/102/15-19].

*“we were concerned about these children all the [way] through. Our role during the pandemic was to be the critical friend to the policymakers to say, “But what about these children?” I worked very closely with my social care colleagues in Ofsted who spent an awful lot of time saying, “But what about the clinically extremely vulnerable children?” And we were concerned that, you know, there was not enough thought going into, you know, children within those families, and that was the role that we played.”<sup>106</sup>*

86. CVF’s members required specific strategies to manage the foreseeable risks their children faced in returning to schools in August 2020, as identified by Lara Wong, CVF’s CEO and founder:

*“It was an incredibly scary time. I mean, you have to remember that Eat Out to Help Out had been driving up infection rates just before schools were reopening. So everyone was very aware of the fact that the risks were increasing, schools were not doing anything to manage airborne risks so our families felt particularly exposed at that time. No particular risk management was in place for those children, to support them... our concerns, which were really obvious to [the DfE] because they had already identified them in their previous guidance, left us in an incredibly dangerous situation. And people had no option of flexibility.”<sup>107</sup>*

87. Until those people identified as being at higher risk of severe health outcomes from an infection like Covid-19 are recognised and afforded protected status, their needs will neither be properly understood or fully met. Whether children or adults, it will tend to be the same people who are Clinically Vulnerable in a pandemic or epidemic, namely those with certain underlying health conditions.
88. CVF notes ‘Recommendation 8’ in the Inquiry’s Module 2 report, namely that the UK government and devolved administrations “*should each agree a framework that identifies people who would be most at risk of becoming infected by and dying from a disease and those who are most likely to be negatively impacted by any steps taken to respond to a future pandemic. The framework should set out the specific steps that could be taken to mitigate the risks to these people. Equality impact assessments should form part of this framework*”.<sup>108</sup> CVF supports this recommendation and requests that the Inquiry goes further to protect clinically vulnerable people not just during pandemics but during ‘peace time’ too, when

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<sup>106</sup> Matthew Coffey [5/30/16-25].

<sup>107</sup> Lara Wong [3/114/21 – 3/115/11].

<sup>108</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at p.317.

infectious disease in settings such as schools is still a serious, life-limiting issue for Clinically Vulnerable families.

89. To properly understand how Clinically Vulnerable people (children and adults) were and continue to be affected in the education system, they must have status as a distinct group which is included in decision-making, data collection, public reporting and funded research. To that end, recognition should include making clinical vulnerability a protected characteristic in the Equality Act 2010. This would go some way towards embedding their protection in law and in decision-making. As things stand, many Clinically Vulnerable children and children in Clinically Vulnerable families are not offered reasonable adjustments, either to support their attendance at school or to provide alternative provision, because their clinical vulnerability is not treated as giving rise to protection under the Equality Act. Clinically vulnerable people are not protected by the Equality Act as it is currently drafted, as many – perhaps even most – do not have a disability within the meaning of the Act.
90. There is a serious gap in the data which needs to be filled. CVF agrees with the Inquiry's finding in Module 2 that *"the lack of comprehensive, equality-disaggregated data led to a general failure by the UK government and devolved administrations to understand who was most vulnerable to the pandemic and how the governments' interventions could be better calibrated"* and its conclusion that *"the collation of relevant, equality-disaggregated data is necessary to enable both mitigation against unintended inequalities and the advancement of equality in the event of future pandemics"*.<sup>109</sup>
91. Professor Catherine Davies addressed this lack of data and the need for targeted data collection given the particular combination of variables that CV families experienced, meaning that their unique experiences were unlikely to be captured adequately via other data collection methods:
- "We haven't really mentioned the clinically extremely vulnerable children, whether themselves or members of their family. Those children will have experienced much longer isolation, higher anxiety, a lack of specific guidance. So yes, I would really welcome and encourage more data tracking, more advocacy for those groups of what is quite a specific set of circumstances during the pandemic."*<sup>110</sup>
92. In particular, the mental health needs of Clinically Vulnerable children and children in CV families have been overlooked. They require tailored care. The Inquiry's mental health expert, Associate Professor Tamsin Newlove-Delgado, supported further research into the impact of

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<sup>109</sup> Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at §10.48-10.49.

<sup>110</sup> Professor Catherine Davies, expert in child development: 30 September 2025, 195/5-13

the pandemic specifically on Clinically Vulnerable children:

*“... the experiences of those children who were clinically extremely vulnerable is probably still fresh in the minds of those children and family, and so I think there would be opportunities now, if that hasn't been done ... to hold interviews or focus groups or data gathering exercises now with them to learn lessons and to hear their voice. So I think that would be important. And I think it would be important to get their recommendations and thoughts about how, if there were to be another pandemic, how we could support them better, but also how we would know who they are, so that if we did have another pandemic and we needed to do rapid research with them to find out about what the issues were, that we could spring into action quite quickly.”<sup>111</sup>*

93. 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.”<sup>112</sup>* 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.”<sup>113</sup>* 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.”<sup>114</sup>*
94. As a result of these factors, Professors Newlove-Delgado and Creswell's expert report concluded that CEV children and children who lived with CEV family members *“experienced additional risks to their mental health”<sup>115</sup>*. 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.”<sup>116</sup>*
95. Many children in CV families experienced increased burdens of caring for sick loved ones, took on the responsibility and anxiety of trying to protect vulnerable family members from

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<sup>111</sup> Associate Professor Tamsin Newlove-Delgado [4/165/4-20].

<sup>112</sup> CVF, §203 [INQ000587993\_0064].

<sup>113</sup> CVF, §324 [INQ000587993\_0097].

<sup>114</sup> CVF, §214 [INQ000587993\_0066].

<sup>115</sup> Professors Newlove-Delgado and Creswell, §88 [INQ000587958\_0039].

<sup>116</sup> Children and Young People's Voices Final Report, 2025, §2.1.2.6 [INQ000587936\_0014].

harm, and grieved family members who had died from Covid 19. For some children this was with the devastating knowledge that they had infected that family member. They were also subject to restrictions for a far lengthier period of time than their peers in an effort to shield. These were just some of the factors contributing to the unique mental health profiles of these children. Clinically Vulnerable children and children in CV families required, and still do require, recognition of their mental burdens and help from their schools, teachers, and wider health professionals. Lyndon Lewis, a Headteacher in Wales, recognised how common this situation was and gave the following evidence:

*“We had some children who would not come out of their bedrooms, and their parents couldn't get them out of their bedrooms because they were so scared. So we have some specialist staff who have particular sort of relationships with some of our most challenging youngsters, and they were able to coax them to come out and talk with them, and get them to sit in the garden, and, you know, talk to them about the pandemic and the family and these sorts of things. Anything, really, to improve their wellbeing and to reassure them and lower their rates of anxiety.”<sup>117</sup>*

96. Associate Professor Newlove-Delgado, after explaining that living in a household where everybody was in good health provided a “*protective factor*” against mental health impacts,<sup>118</sup> went on to identify children in Clinically Vulnerable Families as particularly vulnerable to developing a mental health condition: “*I think absolutely, they may already be more vulnerable to experiencing a mental health difficulty, and then when you add into that the additional distancing or isolation measures that might be needed, along with the concern and worry about their health, then that would be a group that we would be concerned about.*”<sup>119</sup>
97. CVF submits that the inequality gap is going to widen unless decisive action is pressed for by the Inquiry to address the mental health recovery provision needed to help CVF’s children and young people overcome the traumas they encountered as a specific group during the peak of the pandemic, and which are ongoing in many cases. As put by Mark Drakeford in his evidence to the Inquiry: “*I have huge sympathy for those young people whose own health is compromised, or who have high anxieties about the possibility that they will take the virus back home where there are other people who have difficult health issues to face. I think that must be a terrible dilemma for a child, and a child absolutely should be supported to make sure that if they need special attention, that they get it in the most positive way.*”<sup>120</sup>
98. It is further submitted that the DfE’s data on school attendance and attainment is also missing

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<sup>117</sup> Lyndon Lewis [6/31/6-18].

<sup>118</sup> Associate Professor Tamsin Newlove-Delgado [4/124/11-17].

<sup>119</sup> Associate Professor Tamsin Newlove-Delgado [4/145/1-7].

<sup>120</sup> Mark Drakeford [15/191/25-192/1-8]

this crucial information about clinical vulnerability, particularly when the results from CVF's surveys indicate that persistent and severe absence from school has been significantly higher among children in Clinically Vulnerable families than the national average or other vulnerable groups, including children eligible for Free School Meals, or children with an Education, Health and Care plan.<sup>121</sup> When asked by CVF, key witnesses including Susan Acland-Hood and former Children's Commissioner Baroness Anne Longfield OBE agreed that this was something to take forward.<sup>122</sup>

#### 99. ***Proposed Recommendations***

Recommendation 9: Steps must be taken to address the gaps in data on the impact of Covid-19 on Clinically Vulnerable children and children in Clinically Vulnerable families. Existing data collection, for example on school attendance, school exclusion, educational attainment, alternative education provision, and mental and physical health outcomes, should be routinely disaggregated by factors including those in clinical risk groups.

Recommendation 10: Clinical vulnerability should be 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 heightened risk to Clinically Vulnerable people posed by infectious diseases (such as Covid-19).

#### C. **CONCLUSION**

100. The story of one child who lived with Clinically Vulnerable family members encapsulated the experience of a majority of CVF's members and the terrible choices they were faced with during the peak of the pandemic about their children:

*"People often refer to Covid as a period in time. In the past sense. Not the damaging virus that it is. But for families like mine, it continues to be an ongoing risk and has led to inequalities and unnecessary health risks. Families can choose to avoid crowded indoor settings where there is a higher risk, but schools and healthcare settings cannot be avoided and therefore need to be made safer for everyone."<sup>123</sup>*

101. There is an urgent need to restore trust and confidence that the lives and wellbeing of all Clinically Vulnerable people matter, and that their distinct concerns and needs will be

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<sup>121</sup> CVF, §277-280 [INQ000587993].

<sup>122</sup> Baroness Anne Longfield OBE [4/102/6-11] and Susan Acland-Hood [11/129/17-18].

<sup>123</sup> See Northern Ireland Commissioner for Children and Young People Opening Statement [1/116/15-22].

addressed, both now and in a future pandemic or health emergency. While the scale of the challenge faced by the Chair is considerable, given competing demands and entrenched attitudes, CVF submits that its recommendations are simple to introduce, and will go an enormous way to addressing the needs of Clinically Vulnerable people.

102. Accordingly, on behalf of Clinically Vulnerable people, CVF urges the Inquiry to (1) focus on improving **safety** in schools for Clinically Vulnerable people and all pupils, (2) make recommendations which would increase **support** for Clinically Vulnerable children and families to access education equitably, and (3) enhance the **status** of Clinically Vulnerable people, including their legal status as an equality group, to ensure their needs are better recognised, understood and addressed. CVF invites the Inquiry to take forward the ten recommendations outlined above in relation to these three overarching principles.

103. CVF is grateful for the Chair's willingness to understand CVF's issues of concern. CVF looks forward to receiving the Inquiry's report and reading the Chair's recommendations.

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