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UK COVID-19 INQUIRY
MODULE 8 – CHILDREN AND YOUNG PEOPLE

CORPORATE WITNESS STATEMENT OF DR GIRI SHANKAR ON BEHALF OF PUBLIC HEALTH WALES NHS TRUST

I, **Dr Giri Shankar** c/o Public Health Wales NHS Trust, 2 Capital Quarter, Tyndall Street, Cardiff, CF10 4BZ will say as follows:

1. This Corporate Witness Statement is provided in my role as Director for Health Protection at Public Health Wales NHS Trust ('Public Health Wales') which I have held since April 2022. Prior to this and during the pandemic, I was employed by Public Health Wales as a Professional lead Consultant in Health Protection from September 2016. I was also an Incident Director during the period January 2020 – September 2021.

2. Public Health Wales is not a core participant in this module.

3. As this is a Corporate Witness Statement, where matters raised by the Inquiry for a corporate response have fallen outside my areas of expertise or knowledge, input has been sought from others within the organisation.

The System Role and Functions of Public Health Wales

4. Public Health Wales was established as an NHS Trust in Wales in 2009 by bringing together four distinct pre-existing entities:

    a. the National Public Health Service for Wales,

b. the Wales Centre for Health,
c. the Welsh Cancer Intelligence and Surveillance Unit and,
d. Screening Services.

5. This meant that, for the first time, an independent NHS body was created in Wales with a clear and specific public health remit to provide professionally independent public health advice and services.

6. Since 2009, Public Health Wales has grown considerably and the organisation has taken on, and internally developed, additional and new functions. This has included developments in the areas of:

    a. policy, research and international collaboration (reflected in our designation as a World Health Organization Collaborating Centre in Investment for Health and Well-being).
    b. data, knowledge and research with the establishment of a directorate specifically focused on maximising the use of digital, data, research and evidence to improve public health.
    c. our core public health services, particularly microbiology and health protection, along with adopting new diagnostic methods such as molecular diagnostics and whole genome sequencing, through our Pathogen Genomics Unit.

7. An overview of our latest organisational structure can be found at **EXHIBIT GS2/1 INQ000520913.**

8. Public Health Wales protects and improves health and well-being and reduces health inequalities for the people of Wales. It is an NHS Trust, established for the purpose specified in section 18(1) of the NHS (Wales) Act 2006 and has four statutory functions set out in Part 3 of its Establishment Order. These are to:

    a. provide and manage a range of public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases.
    b. develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the

public in Wales; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters.

c. undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival, and prevalence of congenital anomalies.
d. provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health-related matters.

9. Since its establishment in October 2009, Public Health Wales has been, and continues to be, a provider of public health related specialist advice to the Welsh Government and its Ministers. The role is implicit within the four statutory functions (as set out in The Public Health Wales National Health Service Trust (Establishment) Order 2009).

10. In addition, Public Health Wales is a Category 1 responder as defined by the Civil Contingencies Act (2004) and therefore plays a key role in relation to the preparation for, and response to, any emergency and major incident. This requires us to meet a range of civil protection duties as set out by the Act.

11. Over the years, we have expanded the core public health functions of the organisation in order to ensure that we are best designed to deliver our statutory functions and the strategy of the organisation, which is informed by the challenges and opportunities facing the nation, the policy and legislative environment and international developments.

12. The Public Health Wales Board is a unitary Board and functions as a corporate decision-making body, with Executive Directors and Non-Executive Directors being full and equal members and sharing corporate responsibility for all decisions. It comprises a chairperson, seven Non-Executive Directors (also known as independent members), all of whom are appointed by the Cabinet Secretary for Health and Social Care in the Welsh Government, and six Executive Directors, including the Chief Executive.

13. The Board has responsibility for:

    a. Setting the strategic direction of the organisation
    b. Setting the governance framework

c. Setting organisational culture and development
d. Steering the risk appetite and overseeing strategic risks
e. Developing strong relationships with key stakeholders and partners
f. Ensuring the successful delivery of the Strategic and Operational plans of the organisation.

14. In addition to their role as Board Members, Executive Directors also have responsibility for discharging Public Health Wales' corporate and public health functions.

15. The Chief Executive (and Accountable Officer) of the organisation has responsibility for maintaining appropriate governance structures and procedures. The Chief Executive has established an Executive Team for the collective execution of delegated responsibilities (in addition to the delegated individual accountabilities and responsibilities that each Director in the Executive Team has with their respective portfolios). Since 2014, the Chief Executive has also operated a corporate level Business Executive team structure where collective decision making at a corporate level is a key feature, in addition to each Director having clear accountability and responsibility for their specific portfolio.

16. In terms of the role of Public Health Wales in preparation for a public health emergency, Public Health Wales is a Category 1 responder as defined by the Civil Contingencies Act (2004). This places a number of legal duties on the organisation, including:

a. assessment of risk to inform planning
b. developing a Public Health Wales Emergency Response Plan
c. putting in place business continuity management arrangements for Public Health Wales
d. putting in place arrangements to make information available to the public about civil protection matters and maintaining arrangements to warn, inform and advise the public in the event of an emergency
e. sharing information and co-operating with other local responders to enhance co-ordination.

17. The organisation has also continuously supported the Emergency Planning Advisory Group, currently chaired by NHS Performance and Improvement. In particular, the

Emergency Planning and Business Continuity Team has developed and maintained the NHS Wales Lessons Identified Register under the direction of this group.

Public Health Wales' roles specifically in relation to children and young people

18. Public Health Wales has a number of dedicated functions and services aligned to our statutory functions set out in The Public Health Wales National Health Service Trust (Establishment) Order 2009. Our role in relation to children and young people is set out below.

Health Protection Response

19. Public Health Wales' Health Protection Division provides advice and support in preventing and responding to cases and incidents of infectious disease, such as measles and meningitis, involving children and young people, including close work with the education sector from pre-school through to higher education.

Health Improvement Programmes

20. Public Health Wales provides strategic leadership and delivery of health improvement programmes. which contribute to improving the health of children and young people:

    a. Our Educational Settings programme leads and co-ordinates several national programmes of work which aim to improve the health and well-being of children and young people in Wales:
        i. Public Health Wales leads a programme to embed a Whole-School Approach to Emotional and Mental Well-being (WSAEMWB) across all schools in Wales. Since 2021, this has been delivered through a local workforce of skilled co-ordinators who support schools and gather data on school's progress in implementing the statutory framework.
        ii. The Healthy and Sustainable Pre-School Scheme (HSPSS) is a Welsh Government developed programme that is strategically led by Public Health Wales and delivered in local areas. Local co-ordinators support childcare and pre-school settings to embed a whole setting approach to health and well-being. This can include direct support to the setting as well as training and accreditation.
    b. We have published a framework for action in the early years - building from the First 1000 days Programme for Wales that was established in 2016.

c. We run *Every Child Wales* – a health information resource for parents available online and through midwives and health visitors.
d. We are working to improve child health though a whole systems approach to healthy weight, providing leadership for a programme of work that includes health board workstreams, focussed on creating a healthier food, and activity environment for healthier lives, with a focus on children and their families and aligned national workstreams for healthier food and activity. In addition, we have led the development of Healthy Children Healthy Weight "PIPYN" pilots in three areas of Wales. These pilots are focussed on early preventive interventions for families of young children who are above a healthy weight. The pilots comprise a whole systems approach for a healthier food and activity environment, to support family health and a nested family-based intervention for families of children who are above a healthy weight. Following evaluation, the PIPYN model is being developed to guide the further development of this work.
e. Our focus on school food environments, underpinned by the Well-being of Future Generations (Wales) Act, aims to support school food systems to deliver children's nutritional requirements, and support children in developing healthy relationships with food. To date we have facilitated the Welsh Government's Theory of Change for the Healthy Eating in Schools Regulations, undertaken primary research and provided advice and evidence to ensure policy and systems support healthier diets and improved health outcomes for children and young people in Wales. We are supporting local authorities with pre-consultation testing of the proposed standards.
f. We lead the implementation of the All-Wales Breastfeeding Action Plan on behalf of Welsh Government.
g. We have led the development of a maternity pathway for healthy weight and has reviewed the children's weight management services in Wales. We will continue to support the development and implementation of the healthy weight pathway.
h. We are leading the development of a pathway to support postnatal obesity prevention and leading the development of a pathway for women experiencing gestational diabetes into the All-Wales Diabetes Prevention Programme.
i. Healthy Working Wales is our programme which seeks to enable employers to improve and protect the health of their workforce. We are currently working with employers on women's health including supporting women through pregnancy and early years parenting.

j. We provide public facing information and strategic advice and guidance to system partners to support children and young peoples' mental health and wellbeing. Post-pandemic the Hapus programme was launched to provide evidence-based information to adults and families on ways to protect and improve mental wellbeing. Public Health Wales worked closely with Welsh Government to develop the new Mental Health and Wellbeing Strategy 2025-25 and is currently working with NHS Performance and Improvement, amongst other partners, to support its implementation. A Children and Young People's Mental Health Needs Assessment is currently underway to ensure service developments take account of population needs.

k. We provide national leadership and co-ordination (including protocols, guidance etc) for the Dental Public Health programmes as follows:

   i. Designed to Smile is a national programme to improve the oral health of children in Wales. It is a preventative programme for children from birth and involves a wide range of professionals, including health visitors and other early years services. The aims are to help start good habits by giving advice to families with young children, providing toothbrushes and toothpaste and encouraging regular dental check-ups. For nursery and primary school children living in the deprived areas in Wales, this involves the delivery of nursery and school-based supervised toothbrushing and fluoride varnish application for children to help protect teeth against highly prevalent tooth decay.

   ii. Dental Epidemiology Programme (DEP) includes dental inspection and survey of School Year 1 and School Year 7 children to understand the extent, severity, impact of tooth decay and level of oral health inequalities in the child population.

   iii. We are responsible for the All-Wales elements of this programme, with health boards being responsible for local delivery.

l. We deliver programmes to prevent smoking uptake, such as the JUSTB Smoking Prevention Programme, which is an evidence-based smoking prevention programme developed and delivered by Public Health Wales to schools across Wales. It aims to prevent smoking among secondary school pupils, particularly in areas with high smoking prevalence. The programme incorporates peer influence and educates young people about the risks of smoking and tactics used by the tobacco industry.

First 1000 days

21. The First 1000 Days is a health improvement programme led by Public Health Wales. It was established in 2016 in response to strong evidence that suggests the period during pregnancy and up to the child's second birthday offers the greatest potential for impact in both improving outcomes and reducing inequalities. The programme aims to make the case for action at this critical time, providing system leadership and support to enable stakeholders to understand and act on the best available evidence and help create the conditions for babies, young children and their families to thrive.

The Welsh Network of Health and Well-being Promoting Schools (WNHWPS)

22. The Welsh Network of Health and Well-being Promoting Schools (WNHWPS) programme aims to create a healthy and supportive environment in schools across Wales. Established since 1999, the programme focuses on embedding whole-school approaches to health and well-being including the school environment, curriculum, and community engagement through a network of local health and well-being promoting school's coordinators. During the pandemic, this network was also mobilised and supported to work with schools during the pandemic, particularly in relation to safe working in schools following return to learning and in relation to learner and staff wellbeing.

Screening and Vaccination Services

23. Public Health Wales provides leadership, delivery, monitoring and evaluation of dedicated screening programmes such as antenatal and newborn (bloodspot and hearing) screening and leadership, monitoring and evaluation of the childhood vaccination programmes.

24. The aim of the Newborn bloodspot screening programme is to offer all eligible babies screening for rare but serious conditions that would benefit from early intervention and reduce mortality and or morbidity from the condition.

25. The newborn hearing screening programme is offered to newborn babies. The aim of the screening test is to identify those babies who may need more tests to determine if they have a hearing loss.

26. Public Health Wales does not commission or deliver any childhood vaccinations. These are primarily delivered through GP practices, or school nursing teams. Our role

includes but is not limited to the provision of system and strategic leadership of childhood immunisation programmes in Wales, support the Welsh Government through the provision of scientific evidence, clinical advice and epidemiological surveillance and the provision of training for professionals and public facing information in Wales.

27. Public Health Wales also tracks childhood vaccinations uptake. During the pandemic, this was tracked, in the COVID-19 Recovery Profile and noted that the pandemic appeared to have no impact on uptake of childhood vaccinations delivered in the first year of life.

28. Public Health Wales provided specific advice in relation to eligibility in Wales for vaccination of children aged 5-11 years and 12-15 years with no underlying health conditions and develop child specific information resources (such as comic strips and videos) to explain vaccination to the appropriate age groups.

Surveillance Registries

29. Public Health Wales collects data on children and young people in accordance with its statutory functions contained within its Establishment Order and other applicable regulations. Details of our surveillance registries can be found below.

Congenital Anomaly Register and Information Service (CARIS)

30. The Congenital Anomaly Register and Information Service (CARIS) undertakes surveillance of congenital anomalies with the aim of providing reliable data on congenital abnormalities in Wales which can be used to assess patterns of anomalies, including possible clusters and their causes and to inform the work of health services, including antenatal screening. A congenital abnormality is defined as an anomaly involving structural, metabolic, endocrine, or genetic defects, present in the child / foetus at the end of pregnancy, even if not detected until after the birth. This programme sits with Public Health Wales' Research, Data and Digital Directorate and it releases an annual official statistics update. Staff members from this team were redeployed during the pandemic to support the health protection response. Notifications from the wider NHS in Wales were delayed due to the wider impacts on the NHS resulting from the pandemic. This resulted in some backlog of cases for registration. However, this backlog has now been addressed.

The Child Measurement Programme for Wales

31. The Child Measurement Programme for Wales measures the height and weight of children in reception class in accordance with the Child Measurement Programme (Wales) Regulations 2011. The programme's aim is to understand how children in Wales are growing so that the NHS in Wales can better plan and deliver health services. Public Health Wales is responsible for the coordination of the Child Measurement Programme and every health board across Wales is taking part in the programme. The Child Measurement Programme relies on measurements being taken in schools and produces an annual official statistics update. This programme was impacted due to school closures, school nursing teams' capacity and school nurses prioritising other areas (namely immunisations and vaccinations and safeguarding) as the school's re-opened following closure.

The Child Death Review Programme

32. The Child Death Review Programme (CDRP) collects information about all deaths of children in Wales or Welsh children who die elsewhere, where the death occurs before the child's 18th birthday. It looks at national and regional patterns and trends to identify factors contributing to deaths that may help prevent future child deaths. Although we receive information and review every child death in Wales, we do not have the remit to investigate individual cases as our function is population-based mortality surveillance to identify issues which can reduce childhood mortality through national interventions. The programme continued to collect information on child deaths during the pandemic and PRUDiCs (Procedural Response to Unexpected Deaths in Childhood) continued to be undertaken (chaired by the Police) which is the main source of information for unexpected deaths.

Adverse Childhood Experiences Hub (ACE Hub Wales)

33. The Adverse Childhood Experiences (ACE) Hub Wales in Public Health Wales, was founded in 2017 by a collaboration of organisations who were members of a multi-agency collaboration established by Public Health Wales and the Welsh Local Government Association called Cymru Well Wales. The ACE Hub has been funded by the Welsh Government grant funding since inception and is led by a Programme Director (who is Director of the Hub as one part of their overall role). The work of the ACE Hub is to raise awareness of the risk of negative impacts across the life course of ACEs and focus on supporting approaches on prevention and mitigation of harm. One of the first sectors that the ACE Hub Wales worked with was education. The ACE

Hub has trained staff in over 600 primary and secondary schools across Wales in ACE awareness and trauma-informed practice. The ACE Hub also ran public awareness campaigns to support national awareness of the importance of kindness in supporting young people experiencing ACEs (#Time to be Kind) and has worked with a range of sectors to develop resources and toolkits to support awareness and practice.

34. The ACE hub works with sectors including housing, policing and criminal justice, education, social care, sport, and substance use as well as collaboration on specific projects with specific organisations. Examples of these include Secondary School Compassionate Schools project, youth work, and young people experiencing domestic abuse. The ACE Hub Wales are also jointly responsible, with Traumatic Stress Wales, for the implementation of the Trauma-informed Wales Framework published in 2022. This all-age, all-of-society framework, coproduced with organisations and people across Wales, sets out the ambition for Wales to be a trauma-informed nation.

35. The ACE Hub has a particular focus on the experiences of marginalised children and young people including undertaking a range of research and reports on the experiences of migrant and asylum-seeking children and young people. The ACE Hub is working with the Welsh Government to implement the Trauma and ACE(TrACE) informed organisational toolkit in schools following successful implementation across the further education sector.

The Violence Prevention Unit (VPU)

36. The Wales Violence Prevention Unit is a partnership between the South Wales Police and Crime Commissioner, Public Health Wales and South Wales Police. Each of the above organisations contributes funding and expertise to support a whole-system, public health approach to preventing violence and the unit works closely with sectors including health, policing, education, local authorities, governments and the third sector. Public Health Wales is a founder member of the Wales Violence Prevention Unit and has a team of Researchers responsible for developing resources and guidance to support organisations and people in Wales to help prevent and mitigate the impact of violence. They are also responsible for the implementation of the Wales Without Violence Framework which seeks to prevent Violence amongst children and young people in the primary prevention space. Primary prevention aims to prevent disease or injury before it ever occurs. This is done by preventing exposures to hazards that cause disease or injury, altering unhealthy or unsafe behaviours that can

lead to disease or injury, and increasing resistance to disease or injury should exposure occur examples of interventions include legislation and education

37. Public Health Wales has signed a partnership agreement with policing and criminal justice partners in Wales to take a Public Health Approach to policing and criminal justice, which includes ACEs and trauma-informed approaches.

The National Safeguarding Service (NSS)

38. The National Safeguarding Service (NSS) provides coordinated, strategic leadership to improve safeguarding across the NHS in Wales. The NSS provides the strategic focus and professional lead to NHS Wales in order to promote the welfare and safeguarding of children (including those children and young people looked after by their Local Authority) and adults at risk. Designated professionals provide a source of independent expert health advice from an 'All Wales' perspective. The Service has particular skills as a source of independent health expertise in undertaking case reviews of serious abuse and neglect as well as child suicide.

Involvement in National Strategies

39. Public Health Wales also has specific duties towards children and young people as outlined in key national strategies relating to health improvement, such as Healthy Weight Healthy Wales and Smoke Free Wales.

40. During the early phase of the pandemic response, and in line with other areas of work across the organisation, a number of these core responsibilities and services were temporarily paused to allow redeployment to the pandemic response, although key critical services, such as the Antenatal Screening Programme, Newborn Bloodspot Screening Programme and Newborn Hearing Screening Programme were not paused and continued throughout the pandemic, (these screening programmes are time critical and could have had significant implications for mothers and babies if paused) and responding to childhood infectious disease notifications (health protection notifications), were maintained.

Health Impact Assessments (HIA)

41. The HIA process, as practised in Wales, fully considers the impact of policies, plans or proposals on children and young people. At the different stages of the HIA process, a population groups checklist is used to identify potential impacts through the lens of

the wider determinants of health, including for babies, children and young people. The process identifies ways to maximise positive impacts or opportunities and mitigate for negative or unintended negative impacts.

42. For each HIA undertaken during the pandemic, a steering or reference group was established or liaised with to provide strategic oversight, guidance and stakeholder engagement throughout the HIA process. The steering group provided assurance that the assessment undertaken was robust, inclusive and aligned with priorities and provided feedback on any report or outputs produced. They included key representatives from the Welsh Government, Public Health Wales, NHS Trusts, public bodies and third sector organisations in Wales.

43. Detail on the Health Impact Assessments undertaken by Public Health Wales during the pandemic can be found in paragraphs 110 to 152 below.

Public Health Wales's role in the provision of healthcare and mental health services to children and young people in Wales

44. Public Health Wales is not responsible for the direct provision of healthcare and mental health services to children and young people in Wales, this responsibility sits with the seven health boards, each of which is responsible for the provision of healthcare and mental health services to children and young people within their local areas. Public Health Wales is therefore not best placed to comment on the following matters:

a. the structures of children's healthcare in Wales prior to the pandemic and their condition.
b. whether any new or different structures were activated in response to the pandemic.
c. decisions made in relation to the health development and general wellbeing of children in Wales.
d. challenges in providing mental healthcare to children and young people prior to the pandemic.
e. how the pandemic impacted the provision of these services, save as to what is contained within this statement.

Structures established by and/or attended by Public Health Wales during the pandemic

Public Health Wales established groups

The Public Health Support to Education Settings COVID-19 Group

45. Public Health Wales established the Public Health Support to Education Settings COVID-19 Group, which met weekly from 15 July 2020 until June 2021. **[EXHIBIT GS2/2** INQ000651394 **].** It was convened as schools returned following the first lockdown, and it was noted that there was a lot of anxiety about what activities they could and could not do safely. The purpose of this group was to provide public health support to educational settings (pre-schools, schools, higher and further education) to 'operationalise' scientific advice on COVID-19 and to:

    a. provide a vehicle for developing policy which is based on science/technical advice.
    b. provide a mechanism for information sharing and coordination.
    c. develop implementation support.

46. The group was focused on the practical implementation of guidance and policy in educational settings and was chaired by Public Health Wales' Director of Health Improvement and included representation from the Welsh Government and Public Health Wales specialists in areas such as health protection, infection prevention and control and microbiology. The group supported the development of dedicated Welsh Government guidance for the education sector on contact tracing and exclusion **[EXHIBIT GS2/3** INQ0000651405 which was published by the Welsh Government; Activities in Schools (supporting schools to work safely on return to face-to-face learning) [**EXHIBIT GS2/4** INQ000651424 implementation of lateral flow testing and interpretation of results **[EXHIBIT GS2/5** INQ000651437 **].** Minutes from the group were shared with the Children and Education subgroup of TAG.

47. The group was stood down in June 2021.

The Enclosed Settings Cell

48. The Enclosed Settings Cell (ESC) produced specific guidance for residential settings involving children in addition to strengthening the children specific elements of the

primary guidance for the care sector. The ESC provided specific advice to residential schools and secure facilities for children and young people. Specific guidance was produced including a Standard Operating Procedure for managing cases and incidents in residential settings for children **[EXHIBIT GS2/6** INQ000513924 **]** and a set of Frequently Asked Questions **[EXHIBIT GS2/7** INQ000651462 **]** for children's settings that addressed some of the challenges being faced in that sector.

Behavioural Science

49. Specific work was also undertaken during late summer and autumn 2020 to look at attitudes and beliefs relating to COVID NPIs among young people. This took a behavioural science approach and considered published international literature at the time. Specific advice on communicating with young people was produced **[EXHIBIT GS2/8** INQ000651473 **]** and shared extensively with Communication leads across Local Resilience Fora and key agencies.

50. Between April 2020 and March 2022, Public Health Wales conducted a national public engagement telephone survey called "*How are you doing?*'. The surveys were conducted with adults aged 18 years and over living in Wales. One of the routinely included topics in the surveys asked all participating adults about their perceptions of COVID-19 measures that related to children (e.g. re-opening of school, re-opening of children's activities). In addition, adults who reported having children living in their household were also asked about their level of worry for their children's wellbeing and education, their worries of their children returning to school, their attitude to vaccinating their children, and the impact of COVID-19 lockdowns on their parent-child relationships. Between September and October 2020, a follow-up survey was undertaken with a sample of parents and caregivers of school-aged children who had previously participated in the national survey. Topics of the survey included asking about their perceptions of the impacts of COVID-19 restrictions on child health and well-being, their feelings about children returning to school and their children's schools management during lockdown. **[EXHIBIT GS2/9** INQ000651484 **]**

CDSC Surveillance Reports

51. From September 2020, Public Health Wales' Communicable Disease Surveillance Centre (CDSC) produced reports on COVID-19 in schools and young people. These reports described COVID-19 cases by school for students and staff and compared to

the incidence in the general population of the relevant local authority. There was also a summary report with conclusions. Overall, there was not strong evidence that school staff were at increased risk of infection compared to the local population.

52. Regarding schools, it was important to set the risks in context, given the relatively low severity and burden of COVID-19 in children and the negative effects of school closures may have had on children and young people. Therefore, Public Health Wales set up a school's report to monitor trends in students and staff and also to compare the risks of infection in staff with comparable individuals in their local area. **(EXHIBITS GS2/10 INQ000224040 and** GS2/11 **INQ000224051** are examples of these reports**)**

53. In addition to (and complementing) the schools report, Public Health Wales also obtained data from the Welsh Government on both daily school absence and daily absence for COVID-19 reasons. The Welsh Government obtained permission for the collection, processing and use of these data to support operational and policy decisions in the education sector. Collection of these data required parents/carers to inform schools of reasons for absence, for schools to record the responses using predefined codes and the subsequent extraction and processing of data by the Welsh Government.

54. The information collected was incorporated into Public Health Wales COVID-19 weekly surveillance reporting and provided important triangulation against other case-based metrics tracking COVID-19 amongst the school population in Wales. Analysed data was fed back to the Welsh Government and helped inform decision making in the education sector. Public Health Wales' school's reporting was influenced by feedback from TAC/TAG and the TAG children and school's subgroup. For example, Public Health Wales recalls that the comparison of staff incidence vs the local area came from concerns raised by the Welsh Government about teachers' risk of infection, and discussion they had with unions. The Public Health Wales report listing all new cases by school was also a request from the Welsh Government.

55. Public Health Wales also produced a weekly incident and outbreak report which documented COVID-19 incidents in schools and nurseries. This report was established in 2015 to monitor reports of outbreaks and documented all incidents and outbreaks irrespective of pathogen cause or syndrome, location, case numbers and the pathogen or syndrome. The respiratory outbreaks section tracked the flu season but were helpful during the pandemic as an indicator of community transmission in schools. Reports

were (and still are) shared with the Welsh Government and health protection teams for awareness and further action, if necessary.

56. School specific reports produced by the Public Health Wales CDSC are summarised below:

    a. Breakdowns of case numbers/ incidence/ positivity/ vaccination uptake and other indicators were provided by age-group, including breakdowns for children and young people, in all surveillance outputs (including daily dashboard updates, weekly epidemiological reports and twice-weekly summary reports).
    b. Detailed report for stakeholders on staff and student case and contact numbers at school level.
    c. School COVID-19 dashboard report (a briefer report available publicly on the dashboard website). **[EXHIBIT GS2/12 INQ000651383 and GS2/13 INQ000224051]**
    d. Enhanced report for stakeholders including rates in pupil and staff groups by school type, comparison of school epidemiological curve with all-Wales and Local Authority level epidemiology curves and funnel plots comparing numbers at school level with Local Authority average and confidence intervals. **[EXHIBIT GS2/14 INQ000651386 and GS2/15 INQ000651387]**
    e. Narrative summary of executive report (updated every 3 weeks) – **[EXHIBIT GS2/16 INQ000651388 and GS2/17 INQ000651391** are examples of these summaries**].**

57. Age-group breakdowns of COVID-19 infection incidence were present in all our CDSC surveillance reports, noting that there was a change in our recording/reporting method from April 2022 when we no longer used data from the CRM system to compile these because the recording of school linkages through this system was incomplete. In addition, we could also not attribute transmission to a particular setting reported by a case or contact, as they may have been exposed to infection in another setting.

58. Additionally, changes to contact tracing processes related to the school location over time (and possible variation of these processes by place) was likely to have had an impact on data completeness and accuracy where counts of COVID-19 cases were based on information entered in the contact tracing system. We were alerted to this when we recommenced school surveillance in Autumn 2021, after the school summer

holidays, and noticed that for August 2021 cases were linked to schools despite it being school holidays.

59. Children were part of our daily monitoring through surveillance, which included monitoring case numbers, hospitalisations, ICU admissions and mortality. All these indicators were summarised by age-group in outward-facing and internal Public Health Wales surveillance reports.

60. Surveillance reports were sent to partners including the Welsh Government and health boards, in order for them to understand how schools were being affected. They were also used in Ministerial briefings. The Public Health Wales CDSC schools report was used to regularly brief the Minister for Education. Public Health Wales was invited to attend an internal Welsh Government meeting to share this information. Attendance was initially weekly but as the pandemic progressed, this was moved to fortnightly.

61. Public Health Wales also published its findings on school surveillance of the incidence of COVID-19 infection in teaching staff in primary and secondary schools. **[EXHIBIT GS2/18** INQ000651392 **]**

62. We are unable to comment upon what actions the Welsh Government or health boards took in response to receiving these reports from Public Health Wales.

Structures/groups attended by Public Health Wales

Welsh Government's Vulnerable Children, Young People and Safeguarding Advisory Group

63. The Public Health Wales National Lead for Safeguarding was invited to be part of an expert advisory group to the Welsh Government on Vulnerable Children and Young People. The group was chaired by the Deputy Director, Children and Families Division at the Welsh Government. The Public Health Wales hosted Violence Prevention Unit (VPU) and ACE Hub teams were also part of this group from time to time. The group was established in 2020 and met regularly and areas such as application of non-pharmaceutical interventions and the impact of them were discussed following presentations and updates from the various relevant areas. Public Health Wales presented research and information at this group when requested **[EXHIBIT GS2/19** INQ000651393 **]**. The Children's Commissioner for Wales was part of the group, and we were able to consider the real-time surveys conducted with children and young people

by the Children's Commissioner for Wales during the pandemic. The National Safeguarding Lead for Public Health Wales also provided regular briefings to the Wales Safeguarding Network which were then disseminated across the NHS as well as providing access to the public Welsh Government briefings from this group.

Children and Education Subgroup of TAG

64. The Children and Education subgroup of TAG was established by the Welsh Government on 5 May 2020. The subgroup was chaired by Dr Heather Payne, Child Health Senior Medical Officer for the Chief Medical Officer at the Welsh Government. Public Health Wales joined this subgroup in July 2020.

65. During the relevant period, Public Health Wales provided advice to the group on matters such as surveillance and testing in educational settings. Public Health Wales contributed to the following advice produced by the group:

    a. Technical Advisory Group: Advice on Return to School, 7 July 2020 **[EXHIBIT GS2/20 INQ000312424]**
    b. Technical Advisory Group: Advice on school transport, 11 August 2020 **[EXHIBIT GS2/21** INQ000312035 **]**
    c. Technical Advisory Group: Evidence review of data and monitoring to support childcare, schools and FE operations up to age 18, in light of raise to Alert level 4, 6 October 2020 **[EXHIBIT GS2/22** INQ000312049 **]**
    d. Technical Advisory Group: Evidence review on children and young people under 18 in preschool, school or college following the firebreak, 9 November 2020 **[EXHIBIT GS2/23** INQ000299692 **]**
    e. Technical Advisory Group: Considerations for changing the operation of schools to allow more face-to-face learning, 5 February 2021**[EXHIBIT GS2/24** INQ000066327 **]**
    f. Technical Advisory Group: Consensus statement: The use of face coverings in childcare and educational settings for Under 18's, 27 May 2021 **[EXHIBIT GS2/25** INQ000082064 **]**

Education Groups

66. Public Health Wales also responded to and provided advice on a range of Welsh Government guidance and policy documents to ensure that the advice on infection prevention and control was consistent with policy at the time.

67. Public Health Wales also participated in meetings with sector representatives along with Welsh Government officials. Public Health Wales also attended the Higher Education Guidance and Task and Finish Group and the National Schools and Childcare Group.

68. Public Health Wales considers that the structures and systems established during the pandemic were able to address the specific needs of children and young people. For example, the Enclosed Settings Cell was able to provide specific and tailored advice to address specific issues relating to safeguarding of children and young people on a risk assessed basis and recognising the specific needs and issues identified. The dedicated Public Health Support to Education Settings COVID-19 Group provided rapid access to advice and was focused exclusively on children and young people and informal feedback from members of the group and policy leads on the advice given and the responsiveness of the support, indicated this was highly valued.

The Four Harms Approach

69. Public Health Wales was not involved in the drafting of the Welsh Government recovery Strategy '*Leading Wales Out of the Covid Pandemic'* which first introduced the four harms approach in decision making. However, from October 2020 in providing Chief Medical Officer (for Wales) Advice Notes, Public Health Wales did itself provide comment in relation to and highlighted the impact of the wider harms from COVID-19 on individuals (including children and young people), as it was important to consider the impact of wider harms when considering planning options including advice on the ongoing use of NPIs. This can be seen in our CMO Advice Note Number 5: ''*post-Christmas next steps in COVID-19 response''* dated 11 December 2020, which is referred to in more detail at paragraph 213 below. **[EXHIBIT GS2/26INQ000056302]**

Pre-pandemic planning in relation to children and young people

70. Public Health Wales engaged in regular system wide emergency planning prior to January 2020. While these efforts were primarily designed to address the needs of the general population, they also incorporated recognition of vulnerabilities within the population. This was particularly evident through multi-agency risk assessment and preparedness planning across Wales, which included specific consideration for vulnerable groups, especially in relation to age, mobility, and health conditions. These factors were integrated into planning for evacuation, sheltering, and responses to adverse weather events.

71. Pre-pandemic preparations did not include a specific focus on:

    a. pandemic planning for children and young people.
    b. school closures as part of a response to the pandemic (or any other civil emergency).
    c. the maintenance of children's services (such as the provision of social care and healthcare) during a pandemic (or any other civil emergency).
    d. how the welfare and/or safety of children could be protected in the event of a pandemic (or any other civil emergency).

72. The updated Public Health Wales Emergency Response Plan (2020) has formalised this approach by referencing three broad categories of vulnerability, including dependants such as children, reinforcing the importance of inclusive planning through coordinated exercises and inter-agency collaboration.

Data and scientific advice about children and young people

SAGE

73. In the first few months of the pandemic, Public Health Wales did not have any access to the deliberations (papers and discussions) of the Scientific Advisory Group for Emergencies (SAGE) until the Welsh Government through its Chief Scientific Advisor for Health, secured a formal mechanism by which Public Health Wales would be better sighted on technical information from SAGE. Initial access was provided through the Welsh Government and then Objective Connect (a secure file sharing and collaboration used by the Welsh Government) to TAG members.

74. In April 2021, Public Health Wales was admitted as an observer to SAGE; it is not a voting member and cannot ask questions but now had direct access to papers and discussions. This remains the position to date.

75. The focus of early discussions was very much on those at risk including clinically vulnerable and older ages. In the later stages of the pandemic there was an increasing focus on children and school transmission in these discussions.

76. Public Health Wales did not pose any questions of interest to SAGE for consideration during the relevant period for the reasons set out above.

77. The general message from SAGE, based on evidence available at the time, suggested that COVID-19 infection tended to be milder in children in comparison to older adults.

78. This information gathered at SAGE was used by the TAG, which regularly produced its own reports (that were published on the Welsh Government website) as well as in briefings for Welsh Government policy officials, the Chief Medical Officer and Welsh Ministers. The information was used by TAG to assess the risk to the Welsh population. It was also used in Public Health Wales' public facing communications and at our internal IMT/Gold meeting discussions, again to assess the risk to the Welsh population.

TAC/TAG

79. The Welsh Government Technical Advisory Cell is the core team of Welsh Government civil servants that provides a secretariat function for the Technical Advisory Group and its associated subgroups. The Technical Advisory Group was an advisory group which formulates advice to the Welsh Ministers to support their decision-making processes. Public Health Wales was a member of the Technical Advisory Group and some of its associated subgroups. Our role was to provide advice and to contribute to summary situation reports and technical briefings. Public Health Wales also independently produced epidemiology outputs which were used in reports as appendices.

80. There were discussions regarding children and schools in the Welsh Government's TAG. Early discussions at TAG very much focussed on those at risk (including clinically vulnerable and older ages). The TAG subgroup for Children and Education also focused on children and young people and school transmission following its establishment, and considered amongst other matters, the impact of COVID-19 on

children, both in terms of mortality and morbidity, and risk factors for acquisition of COVID-19 in school settings. School closure was also one of the non-pharmaceutical interventions (later termed Behavioural and Social Interventions) included in modelling for the effect of interventions on transmission and population impact and which was considered. In particular, the impact on transmission of closing schools was estimated using the modelling in SPI-M and SAGE early in the pandemic. This was not derived separately for Wales. Public Health Wales did not pose any questions for consideration by TAG or its Children and Education Sub-group. Public Health Wales' role in TAG/TAC was to provide advice in response to questions posed by the Welsh Government.

81. We have identified the following TAG/TAC papers from the defined period which are relevant to children and young people:

    a. A table from May 2020 on the health and social care impacts of COVID-19, including on children and young people. **[EXHBIT GS2/27** INQ000310113
    b. Welsh Government advice on return to school (from the Children and Education subgroup of TAG 6 July 2020). This recognised the uncertainty about transmissibility from children but also stated that real world observations have shown little transmission from children. It discussed the likely impacts and methods for school opening, and recommended planning, Test, Trace, Protect and monitoring. School closure was one of the behavioural and social interventions, and there was concern that with other measures lifted, school opening might have a significant impact on the reproductive number R. **[EXHIBIT GS2/28** INQ000651403 **]**
    c. Technical Advisory Group: Evidence review on data and monitoring to support childcare, schools and FE operations up to age 18 in light of raise to Alert level 4, which recommended additional data collection and analysis to support school opening. **[EXHIBIT GS2/22** INQ000312049 **as above]**

82. Public Health Wales recalls that there was a debate in TAG and the Public Health England Incident Management Team meetings during the early phase of the pandemic (around summer 2020) about severity, susceptibility and transmission of COVID-19 from children and young people. The evidence around the severity of COVID-19 in children in comparison with adults and elderly at this stage was not conclusive, but it was argued that younger children (pre-adolescent) did not transmit COVID-19 to the same extent as older people. The severity of COVID-19 was mostly assessed as the

proportion of cases requiring hospital admission and the proportion of admitted cases requiring admission to an intensive care unit (ICU). In the TAG paper from July 2020 **[EXHIBIT GS2/20 INQ312424 as above]** the uncertainty in this area is described as follows:

2.There remains some on-going uncertainty in transmissibility of disease by children, but real-world observation of school opening in England and other countries has shown little transmission by children.

Public Health Wales reporting

83. As stated above in paragraphs 51 to 62 above, as the pandemic progressed, Public Health Wales' Communicable Disease Surveillance Centre (CDSC) produced specific surveillance reports for educational settings and a weekly incident and outbreak report which documented COVID-19 incidents in schools and nurseries, a report which dated from before the pandemic. Our own reports gave some indication of transmission and impact in these settings.

84. Additional work by Public Health Wales' CDSC to estimate the risk of transmission of COVID-19 in schools (by type of school) and this was used to inform the Welsh Government and the then Minister for Education and policy officials. The evidence on the risk of transmission changed over different time periods. In some phase(s) of the pandemic, the risk of transmission in school settings were no more significantly greater than that in the community and at a point in time, children in special schools had a slightly higher risk of transmission of COVID-19.

85. Public Health Wales did not undertake any specific studies on the severity of transmission of COVID-19 in children and young people.

86. Public Health Wales' school's reports and other reports on COVID-19, demonstrated that schools were places where transmission occurred, but children were not necessarily major drivers of infection rates within the community. Daily surveillance reports by health boards had age-specific heat maps from which we could gain an insight into infection rates in children and young people. The early modelling papers from SAGE and SPI-M showed effects of school closures but alone these were not sufficient to reduce transmission to R_t<1. The reports also demonstrated that school teachers appeared to be affected to a similar extent as adults of similar ages in the local population.

87. Public Health Wales also had access to information regarding the vaccination of children and young people through its attendance at the Joint Committee on Vaccination and Immunisation (JCVI) meetings. Children were included in the vaccination programme during summer 2021 and were featured in the vaccination uptake surveillance reports from the week they were eligible.

SPI-M

88. In July 2020, we obtained a copy of a paper from SPI-M which had been shared by SAGE, and which confirmed the uncertainty of transmission of COVID-19 by children. The paper concluded that children and younger people have a lower susceptibility to COVID-19 with weak evidence that transmissibility (the ease (or otherwise) of an infection to spread from person-to-person) from this group is also lower, and no evidence on infectivity (the ability of a pathogen to cause infection in a host). **[EXHIBIT GS2/29** **INQ000422047**

89. Outside specific closed settings (such as the Diamond Princess cruise ship), determining the relative role of different sources of transmission through experiment or surveillance data was very difficult. The reason is that everyone had exposures in multiple settings. School children and teachers would have exposures in their household, shops, transport and so on. In epidemiological studies, it is often not possible to determine exposures where they are multiple.

Evidence from international sources about the impact of the pandemic or countermeasures in respect of children and young people

90. Public Health Wales produced International Horizon Scanning Reports throughout the pandemic, many of which considered the impact of the pandemic or countermeasures in respect of children and young people. These reports were shared with TAG and are discussed in more detail from paragraph 96 below.

91. From 2012 to 2016, Public Health Wales was an associate member of the International Association of National Public Health Institutes (IANPHI), and, in October 2016, it became a full and active member. Through its membership of IANPHI, Public Health Wales has access to insights and experiences of half the countries in the world across all WHO regions - 111 national public health institute members in 95 countries (December 2021).

92. Public Health Wales was in close contact with IANPHI from the start of the pandemic. To March 2022, IANPHI delivered 13 webinars and Public Health Wales representatives attended 10 of these and presented at a number of them. The webinars provided useful intelligence and an opportunity for information exchange. For example, the webinar with South Korea and the bilateral discussion with the Robert Koch Institute in Germany, both in April 2020, revealed several insights about the structural preparedness and the requirements necessary for an effective early response including laboratory capacity for testing, human resources necessary for contact tracing and coordination of the response in the first phase. These insights informed the development of the National Health Protection Response Plan, which was submitted to the Welsh Government on 4 May 2020.

Data Challenges

93. There were challenges with the data on which Public Health Wales relied in producing its schools and young people reports. The linkage of cases to schools for both students and staff was particularly challenging and limited the data quality, as not all school-based incidents were notified. The data available for incident reporting was also limited and depended on reporting of these incidents.

94. A key limitation was linking individual cases to a specific school setting. At the time of taking a sample from an individual, there was no data field to identify the school to which either a pupil or staff member belonged to. Public Health Wales initially relied on the "exposure location" field from data obtained as part of contact tracing following the implementation of Test, Trace, Protect in June 2020. However, there were issues with this data as it was not always complete, and the name of schools caused difficulties in that they were not always easily identifiable. Additionally, the recording of a school as an exposure location does not necessarily mean that the exposure to COVID-19 happened at school. This meant that when confirmed cases were identified it was difficult (near impossible) to determine if the infection was acquired in the school setting or in the community. There were changes over time and variation by place in the way that school locations were recorded for cases and contacts (using bulk information) which would have impacted any reporting based on the Customer Relationship Management System (CRM).

95. As a result, Public Health Wales amended its reporting over time to include, and eventually be replaced by, information about testing and rates of COVID-19 in school-relevant population age groups. Changes in the Welsh Government's testing policy also complicated interpretation of rates of COVID-19 in school aged children and staff. For example, the introduction of lateral flow testing (LFT) in a school setting was likely to have increased case ascertainment in these groups compared to groups not routinely undergoing LFT testing.

Public Health Wales' International Horizon Scanning Reports

96. Public Health Wales considered evidence from other jurisdictions that took an alternative approach to NPIs. This was following a request from the Chief Medical Officer for Wales in April 2020 **[EXHIBIT GS2/30 INQ000191679]** for Public Health Wales to take on a greater role on COVID-19 international horizon scanning. In response to this request, we established an International Horizon Scanning and learning work stream as part of our response, to inform the evolving COVID-19 public health response and recovery in Wales.

97. This was a Wales-specific initiative, aiming to provide dynamic overview of and learning from key global health organisations and other countries, which were ahead in the pandemic curve in order to inform Wales' response and recovery measures. The Public Health Wales World Health Organization Collaborating Centre (WHOCC) produced and published a series of reports that focused on COVID-19 international evidence, data, experience, guidance, and measures, as well as recommendations, transition and recovery approaches, to understand and explore solutions to address the ongoing and emerging health, well-being, social and economic impacts (potential harms and benefits) of COVID-19.

98. The International Horizon Scanning and learning reports were intended to dynamically inform the Welsh Government's and Public Health Wales' response to the COVID-19 pandemic, including policy (non-pharmaceutical) and public health measures, transition and recovery approaches. For this purpose, the reports were sent to the Welsh Government's Technical Advisory Group (TAG) Subgroup on International Intelligence, the Chief Medical Officer for Wales and the NHS Wales Chief Executive and to Public Health Wales' Chief Executive, Executive team, Board and Gold Group. To the best of our knowledge, the Chair of the TAG Subgroup on International Intelligence sent the reports to the Welsh Government's TAG and Technical Advisory Cell (TAC).

99. In addition to its use in informing the Public Health Wales' response, the International Horizon Scanning and learning work stream has been aligned with and fed into the:

    a. Welsh Government Office for Science, particularly into the Technical Advisory Group (TAG) subgroup on International Intelligence.
    b. Welsh Government Technical Advisory Cell (TAC), Chief Scientific Advisor for Health, Chief Medical Officer for Wales, Director General for Health and Social Care I NHS Wales Chief Executive, and Chief Scientific Advisor for Wales.

100. Between April 2020 and the 28 June 2022, Public Health Wales published 43 International Horizon Scanning and learning reports. These included a number of International Horizon Scanning Reports (IHSR) on the wider impacts of COVID-19 on children and young people, including, mental health and wellbeing and education.

101. The following International Horizon Scanning Reports focussed on the wider impacts of COVID-19 on children and young people:

    a. Report Number 7, 4 June 2020 **[EXHIBIT GS2/31 INQ0000068187]**: This report included a focus on the long-term impacts of lockdown. It noted the socio-economic implications of school closures and recorded the findings of a Survey undertaken by the Institute of Fiscal Studies and the Institute of Education between 29 April and 12 May 2020 of parents of children aged 4-15 years old. The key findings of the survey were recorded as including higher-income parents were much more likely than the less well-off to report that their child's school provides online classes and access to online video conferencing with teachers.

    b. Report Number 8, 11 June 2020 **[EXHIBIT GS2/32 INQ000068188]:** This report included a focus on Pre-school childcare.
        i. COVID-19 is likely to have greater impact on women and children, due to disproportionate risk; lack of social and labour protections in the informal job sector; and more women having childcare responsibilities
        ii. The use of grandparents as carers was mostly stopped or reduced, however, it remained a concern, as many parents had been forced to continue using them in order to continue working

iii. Many countries have provided financial assistance for childcare to parents and preschool settings, especially to key essential workers
iv. In Italy, nurseries remain closed despite parents returning to work
v. Parents have been forced to leave children with elderly family members who are at high risk, due to lack of childcare options.

c. Report Number 15, 22 September 2020 **[EXHIBIT GS2/33 INQ000068195]**: This report included a focus on COVID-19 and its impact on children and young people.
    i. Children and young people are particularly vulnerable to the changing systems, related to COVID-19 control and prevention measures
    ii. Less than 10% of reported cases and less than 0.2% of deaths are in young people under the age of 20.

d. Report Number 37, 27 January 2022 **[EXHIBIT GS2/34 INQ000068219]**: This report included a focus on the impact of COVID-19 on children.
    i. The COVID-19 pandemic has had a significant impact on children, particularly with regard to mental well-being and child development.
    ii. The economic impact of COVID-19 on household income has an impact on families, and therefore on children. Living in poverty directly impacts upon children's experience of education, health, housing, nutrition and sanitation.
    iii. Food insecurity for children is a serious public health issue, and the provision of nutritious, school meals for vulnerable children is an important measure to tackle this.
    iv. There have been considerable shifts in play activities in children, with active outdoor play being replaced by indoor activities: opportunities to play outdoors need to be re-introduced and bolstered to support child development and mental wellbeing. The decrease in physical activity and increase in sedentary behaviour in children should not become the new norm, urgent and sustained effort is needed to redress this or serious health issues will be stored up for the future.
    v. The confidence that women have in their maternity services being provided in a 'COVID secure' environment is key to boosting attendance at these important appointments and essential to helping children have the best start in life.

vi. Countries such as USA, Canada and Brazil are all vaccinating children from 5 years up, and research is underway on COVID-19 vaccination for children under 5 years. Policy makers will need to consider the broad risk-benefit balance when considering the vaccination of children.

102. There were also references to children and young people in other International Horizon Scanning Reports during the relevant period. **[EXHIBIT GS2/35** INQ000651411 **]**

103. In addition to the above International Horizon Scanning Reports, a thematic evidence summary report was also published by Public Health Wales' WHO Collaborating Centre.

104. The first summary report was *On the impact of COVID-19 on increasing the Health Gap and Vulnerability* dated 11 February 2022. **[EXHIBIT GS2/36 INQ00056291].**

105. The impact of COVID-19 on children and young people has been observed worldwide, with rising unemployment rates among young people, with 15–24-year-olds three times more likely to be unemployed than adults and deteriorating mental health, especially during lockdown. Globally education has been disrupted by partial and full closures of educational institutions, impacting an estimated 1.38 billion learners this included children who rely on schools for food and inhibiting their right to education, increasing marginalisation and social inequity.

Country example: Italy

106. Concerns that reduced access to care may cause delays in childhood cancer care with delays in diagnosis, chemotherapy, and treatment of chemotherapy complications, which may be worse than those posed by the disease itself

COVID-19 impact on violence against children

107. COVID-19 and related restrictions have been a catalyst for the rise in child maltreatment, exacerbating some of the known contributing factors, such as household poverty and overcrowding, social isolation, and substance abuse (figure 5). Victims of sexual and gender-based violence reported that COVID-19 restrictions have caused:

a. Their children witnessing more abuse (53%)
b. An increase in abusive behaviour towards their children (38%)

c. Worsening mental health in their children and behavioural issues
d. Increased risk of exposure to violence during school closures
e. Increased frustration in children with special needs due to disruption of daily routines
f. Disruption in services, related to violence against children, have been reported in 104 out of 157 countries globally, with the highest proportion in South and Central Asia, and Eastern Europe.

Monitoring

108. Public Health Wales did not have a specific role or responsibility to undertake monitoring or assessments of the Welsh Government's policy decisions in relation to their impact on children and young people. Public Health Wales did not undertake any specific monitoring and/or assessment of the impact of the national lockdown in March 2020 and Welsh school closures in March 2020 and January 2021.

109. However, Public Health Wales, as part of its wider statutory functions, did publish a number of reports/ assessments where the impact of lockdown and school closures were considered, and these were shared with the Welsh Government.

Health Impact Assessment (HIA) on Staying at Home and Social Distancing in June 2020

110. Public Health Wales' WHO Collaborating Centre (now the Policy and International Health Directorate) produced and published a Health Impact Assessment (HIA) on *Staying at Home and Social Distancing Policy* in June 2020 **[EXHIBIT GS2/37 INQ000056307].** This assessment commenced in late March 2020 after the first national lockdown and school closures. The Children's Commissioner for Wales provided evidence for the HIA.

111. The HIA on Staying at Home and Social Distancing focused on the first staying at home and social distancing measures in Wales. Whilst it did not focus specifically on the impact of the national lockdown and subsequent school closures on children and young people (it was one element of the assessment) in March 2020, it highlighted several key impacts on children and young people:

a. **Mental Health and Well-being:** The isolation caused by lockdown measures had a notable impact on children's mental health. Many children reported

feelings of anxiety, stress, and loneliness. The closure of schools and extracurricular activities meant less social interaction, which is crucial for their emotional development.

b. **Educational Disruption**: School closures led to interruptions in children's education. While some adapted to online learning, many faced difficulties due to limited access to technology or a lack of support at home. This exacerbated existing inequalities in educational outcomes, especially for disadvantaged children.
c. **Physical Health**: With schools and outdoor play areas closed, many children experienced reduced physical activity, which could negatively impact their physical health. Lack of access to sports and outdoor spaces also contributed to a decrease in overall fitness.
d. **Vulnerable Children**: Children from vulnerable or disadvantaged backgrounds were especially at risk. Those who depended on free school meals, or had less stable home environments, faced compounded challenges. Child protection services also noted an increase in concerns around domestic abuse and neglect during the lockdowns.
e. **Access to Support Services:** The closure of schools and other public services limited children's access to mental health support, counselling, and other health services, which could have addressed issues arising during the pandemic.
f. **Long-term Effects**: The long-term impact on children was a key concern, with the assessment suggesting that disruptions to education and social isolation could have lasting effects on their development, both academically and socially.

112. There was no specific evidence relating to boys versus girls in the HIA of the stay at home and social distancing measures implemented by the Welsh Government.

113. The HIA specifically highlighted the following impacts on children and young people due to school closures:

Disruption to Education

114. **Learning Loss**: The closure of schools caused significant disruption to children's education. Many students, particularly those from disadvantaged backgrounds, were at risk of falling behind academically. The lack of access to in-person instruction and resources such as school-based support services (e.g., special educational needs

support, language development programs) created gaps in learning that were difficult to bridge with remote learning.

115. **Access to Technology**: Not all children had access to the necessary technology or a stable internet connection to engage effectively in online learning. This was especially challenging for low-income families, exacerbating existing educational inequalities.

Mental Health and Emotional Impact

116. **Increased Stress and Anxiety**: The closure of schools and the disruption of normal life caused considerable anxiety among children. Many children experienced stress due to the uncertainty surrounding their education, the broader health crisis, and the lack of a clear timeline for school reopening.

117. **Impact on Social Skills**: School closures deprived children of the opportunity to interact with their peers, which is crucial for social and emotional development. The isolation caused by social distancing led to a sense of loneliness and frustration, particularly among children who rely on social interactions as a source of emotional well-being.

Vulnerable Children

118. **Disproportionate Effects on Vulnerable Groups**: Vulnerable children, including those from low-income families, children with disabilities, and those with additional support needs, were more heavily impacted by school closures. These children often lacked the resources and support to continue their education at home, which compounded existing inequalities.

119. **Child Protection Concerns**: Schools are often a key point of contact for children who are at risk of abuse or neglect. With schools closed, there was concern about children being less visible to social services and other protective agencies, potentially delaying intervention in cases of domestic abuse or neglect.

Physical Health and Well-being

120. **Reduced Physical Activity**: Many children experienced a reduction in physical activity due to the closure of schools and outdoor spaces. Physical education classes,

playtime, and structured sports activities were all interrupted, contributing to a decline in overall physical health.

121. **Limited Access to Nutritious Meals**: For many children, school is a key source of healthy meals, particularly through free school meal programs. School closures left some children without access to these meals, potentially exacerbating food insecurity and nutritional deficiencies.

Long-term Educational and Social Impacts

122. **Widening Educational Gaps**: The longer schools remained closed, the more pronounced the learning gaps became. The HIA raised concerns about the long-term consequences of disrupted education, particularly for children in their formative years, whose academic, social, and emotional development could be adversely affected.

123. **Increased Vulnerability to Mental Health Issues**: The lack of school-based mental health support services meant that many children who were struggling with anxiety or other mental health challenges went without the necessary support during this period, potentially leading to longer-term emotional difficulties.

Inequities in Access to Support Services

124. **Disruption to Support Networks**: For children who rely on schools as a point of contact for health and welfare services (such as mental health support, counselling, and special educational needs), the closure of schools meant they lost access to critical services. This affected not just their academic performance but also their broader well-being.

125. The HIA also noted that school and nursery closures were the main pathway of impact for babies, children and young people, and highlighted the negative impact of not being able to play and socialise with friends recreationally, interact with health and other services (such as child protection) and also interacting with grandparents and wider family outside of school.

126. The overall message from the assessment was that the policies, while essential to protect public health, also required careful consideration of their impact on children and

the need for targeted support to mitigate these effects, especially for the most vulnerable groups.

127. These findings were aligned with those from our Mental Wellbeing Impact Assessment published in 2022 of the mental wellbeing impact of COVID-19 on children and young people which is described further below.

128. The HIA of Staying at Home and Social Distancing was disseminated widely via the Health Impact Assessment Network. This included internally within Public Health Wales and externally to the Welsh Government, including the Chief Medical Officer and the Public Health Directorate. It was also shared with the general population via social media platforms such as X and LinkedIn. Public Health Wales cannot comment on whether any action was taken by the Welsh Government following receipt of this assessment.

129. The HIA informed further work undertaken by Public Health Wales, including two further health impact assessments on home working and housing security and the impact on women and employment, and also the Mental Wellbeing Impact Assessment, Protecting the mental wellbeing of our future generations, learning from COVID-19 for the long term, in July 2022 which is discussed below.

Mental Wellbeing Impact Assessment, Protecting the mental wellbeing of our future generations, learning from COVID-19 for the long term, July 2022

130. Public Health Wales' WHO Collaborating Centre also produced and published a Mental Wellbeing Impact Assessment, *Protecting the mental wellbeing of our future generations, learning from COVID-19 for the long term*, in July 2022, **[EXHIBIT GS2/38 INQ000191877, EXHIBIT GS2/39 INQ000191886, EXHIBIT GS2/40 INQ000191887 and EXHIBIT GS2/41 INQ000191889].**

131. Carried out between November 2020 and September 2021, the Mental Wellbeing Impact Assessment highlighted several significant impacts of school closures on young people aged 10-24, specifically focusing on their mental health and overall well-being. Below are the key findings from the assessment:

Mental Health Strain

132. **Increased Anxiety and Stress**: The closure of secondary schools caused heightened anxiety and stress among students, particularly due to uncertainties surrounding exams, future education, and the broader impact of the pandemic. Many secondary school students, who were approaching exams or preparing for transitions (like GCSEs or A-levels), experienced distress over the loss of structured learning and assessment.

133. **Worry About Health and Family**: Some students reported an increase in worry about the health of family members, as well as concerns about the long-term implications of the pandemic. This was compounded by a lack of social connection with peers, which often helped them process their emotions in normal circumstances.

Social Isolation

134. **Loss of Social Interaction**: Secondary school students, who typically spend a significant amount of time socialising with peers, experienced considerable isolation due to the closure of schools. Many students struggled with the absence of face-to-face social connections and extracurricular activities, which are important for their emotional development.

135. **Loneliness:** The absence of day-to-day social contact with friends led to feelings of loneliness for many teenagers, especially those who did not have strong support networks at home. For some, this isolation exacerbated feelings of depression and low mood.

Impact on Social and Emotional Development

136. **Stunted Social Skills**: Adolescence is a critical period for developing social skills and emotional regulation. With limited interaction with peers and teachers, many secondary school students missed out on essential social experiences that help build resilience and emotional intelligence.

137. **Difficulty Expressing Emotions**: With less opportunity for peer-to-peer interaction, students found it harder to express their emotions or talk about challenges they were facing. This could contribute to feelings of frustration or confusion, especially for those

who might have previously relied on school as a space to process and navigate their emotions.

Disruption to Routine and Structure

138. **Loss of Routine**: Secondary school students, who thrive on structure and routine, faced significant challenges when schools closed. Many reported difficulties maintaining a healthy daily routine, which affected their mental well-being. School provides not only an academic structure but also a sense of normalcy and predictability, which was disrupted during the lockdown.

139. **Sleep Disturbances**: The lack of a structured school day led to changes in sleep patterns for many teenagers. Some students experienced irregular sleep schedules, which could negatively affect mood, concentration, and overall mental health.

Disengagement with Learning

140. **Reduced Motivation**: Many secondary school students, particularly those facing academic pressure, found it difficult to remain motivated without in-person classes. Online learning often felt less engaging, and students struggled with maintaining the same level of focus or commitment to their studies as they would in a classroom setting.

141. **Increased Academic Stress**: The uncertainty around exams and the transition to home learning added extra stress for students in secondary schools. The lack of clarity about whether exams would be held or what the evaluation process would look like caused anxiety, particularly for those with ambitions tied to their academic achievements.

Inequality in Access to Resources

142. **Digital Divide:** Students from lower-income families faced challenges accessing the technology and resources necessary for online learning. This digital divide was particularly pronounced in secondary schools, where students were expected to engage with more complex learning material remotely. The lack of access to devices or stable internet connections further compounded mental health struggles, especially among vulnerable students.

143. **Limited Access to Support Services**: Many students lost access to mental health support services that they would typically receive through school counsellors or other school-based services. This left some students without the emotional and psychological support they needed during a period of heightened stress.

Long-term Impact on Development

144. **Long-term Emotional and Social Consequences**: The assessment raised concerns about the long-term impact of the pandemic on secondary school students, particularly regarding emotional and social development. Prolonged isolation and a lack of social interaction could have lasting effects on their ability to navigate future challenges, particularly in relation to relationships, confidence, and resilience.

Key Recommendations from the Mental Health Impact Assessment:

145. **Improved Mental Health Support**: The assessment recommended the expansion of mental health services for secondary school students, both during the pandemic and in its aftermath, to address the emotional toll of the closures.

146. **Addressing Inequalities**: Specific attention was called for addressing the inequalities in access to resources, including digital devices and learning materials, to ensure that all students could engage meaningfully with their education.

147. **Reconnecting with Peers and Teachers**: There was an emphasis on the need for students to be reintegrated into school life with a focus on rebuilding social and emotional connections. School reopening strategies included measures to help students reconnect with friends and teachers and to address any mental health challenges.

148. This assessment was shared internally and with the Welsh Government, including, but not limited to, the CMO and Public Health Director and leads for Health Inequalities, Education, Children and Young People and Mental Health, the Children's Commissioner and health boards.

149. Whilst this work would not have been used to provide advice during the pandemic, due to its publication in July 2022, it does provide us with learning for the future and will inform pandemic and emergency planning going forward.

150. The MWIA was carried out after the specified period, and as such no monitoring or assessment has been undertaken post publication.

151. Public Health Wales cannot comment upon what action was taken by the Welsh Government following receipt of this assessment.

152. The HIA and Mental Wellbeing Impact Assessment work focussed on the evidence available at the time. It was collected from high quality sources, released and openly available statistics and strategic stakeholder interviews, for example, the Children's Commissioner for Wales. This was triangulated and synthesised and analysed to form the picture of impact.

COVID-19 Recovery Profile Report

153. During summer 2020, Public Health Wales's Research and Development Division began publishing a COVID-19 Recovery Profile Report which provided Wales level figures for each of the indicators included in the COVID-19 Recovery Profile. This report was refreshed monthly up to 28 April 2022. **[EXHIBIT GS2/42** INQ000651427**, EXHIBIT GS2/43** INQ000651428**].** The online interactive COVID-19 Recovery Profile Report included a number of indicators on mortality, service utilisation, screening, immunisation, wellbeing and wider determinants from numerous sources. Indicators of relevance to children's access to healthcare included newborn bloodspot screening coverage and newborn hearing screening:

a) With a few exceptions newborn bloodspot screening coverage remained at around 97-98% coverage throughout the period.
b) for newborn hearing screening coverage was unaffected by the pandemic, remaining at 98-99% throughout.

154. Public Health Wales also tracked childhood vaccinations uptake in the COVID-19 Recovery Profile and noted that the pandemic appeared to have no negative impact on the uptake of childhood vaccinations delivered in the first year of life. There is evidence that there was increased delay in giving vaccine to children at the pre-school stage, but this did not significantly impact overall uptake within 6 months of the due date. There is evidence that for older teenagers who would expect to receive their vaccines in school settings (aged 12-14) during the pandemic period there has been a significant decrease in uptake which has not recovered following the end of school closures.

155. Public Health Wales cannot comment on whether any of the above Public Health Wales assessments or reports were used in the Welsh Government's decision-making processes or advice concerning the legislation and regulations implemented in respect of children and young people, as we were not party to those decision-making processes.

Mental Health and Increasing Vulnerability: Mental health and well-being thematic report

156. The Public Health Wales WHCC also summary report was on the *Impact of COVID-19 on Mental Health and Increasing Vulnerability*: Mental health and well-being and published In March 2022. **[EXHIBIT GS2/44 INQ000056292]**

157. The report highlighted the indirect impact of COVID-19 on children as including the following:

a. **Financial insecurity**, leading to food insecurity, which has a detrimental impact on families children's development and well-being.
b. **Deterioration of mental health and emotional wellbeing due to loneliness**, can lead to higher rates of depression, anxiety and increased risk of self-harm within young people.
c. **Increased domestic violence, abuse or neglect** i.e. Adverse Childhood Experiences (ACEs), which can have a detrimental impact on children's physical health, mental wellbeing as well as further impacts later in life Inequity and school closures. Soft capital (e.g. parental support) and physical capital (e.g. access to home computer) were found to play an important role in students learning outcomes and well-being during the pandemic.

158. The report further highlighted the following additional impacts:

a. impacts of school closures on children and young people during the pandemic, as including:
    i. loss of access to school-based and critical services.
    ii. loss of resources particularly for children with disabilities.
    iii. loss of resources for those living in poorer families.
    iv. increased stress among children and emotional reactions.

v. the longer the school closure, the higher the predicted increase in obesity. Enforced distanced learning has highlighted existing inequalities such as the digital divide between children from different socio-economic groups.

b. Children's worries and anxieties relate to:
    i. loss of accessibility of non-academic support from schools.
    ii. the quality of education received.
c. Contributing factors to increased stress among young people include:
    i. lack of familiarity of the new teaching and assessment modalities.
    ii. lack of clarity in communication.
    iii. distant supervision from teachers.
    iv. perceived poorer quality of online education.
    v. concerns about graduating.

Limitations of Health Impact Assessment

159. Limitations of the Health Impact Assessment (HIA) of the *"Staying at Home and Social Distancing*" policies in Wales are as follows:

a. Evidence was gathered from a wide range of sources. Of note, there was limited peer-reviewed research literature in relation to population health and well-being impacts of pandemics, isolation, quarantine, and social distancing measures.
b. Some of the research literature used in this report was published prior to the peer review process.
c. Public Health Wales' Public Engagement Survey on Health and Wellbeing during Coronavirus Measures data was self–reported.

Surveillance Registries

160. The surveillance registries aim to collect surveillance data at an all-Wales level. Because of the geography of Wales, patients in North and mid Wales may receive medical treatment in England (for example form tertiary services in Liverpool or Birmingham). This can cause difficulties in obtaining all data for all patients. In the evidence provided for the Patient Information Management System (PIMS, now the Welsh Patient Administration System (PAS)) data it was caveated that North Wales data may be incomplete. With regard to the specific PIMS example, a number of different attempts were made to ensure we had captured data on children who had

received treatment in England. However, we either did not receive a response, were signposted elsewhere, or we received inadequate responses.

Impact on children and young people's mental health during the pandemic

161. In addition to the HIA and MWIA described above, the following research was also undertaken by Public Health Wales, either on its own or in collaboration with others.

School Health Research Network (SHRN) survey (DECIPHer, Cardiff University)

162. Data on the rates of mental ill health amongst children and young people were not monitored 'live' during the pandemic. This is because the only existing source of data for this was the biennial School Health Research Network (SHRN) survey (DECIPHer, Cardiff University).

163. SHRN is a collaborative initiative aimed at enhancing the health and well-being of children and young people across Wales. It brings together schools, academic researchers, policymakers, and practitioners from health, education, and social care, to promote evidence-based approaches to improve health and well-being in schools. Public Health Wales has a strategic partnership with SHRN. DECIPHer brings together scientists, policy and practice stakeholders and the public to develop, evaluate and implement interventions to improve population health and reduce inequalities. DECIPHer is funded by the Welsh Government through Health and Care Research Wales.

164. Data from the SHRN survey was reported by Public Health Wales in a dashboard for children and young people aged 11-16 years, and gathered for the periods September to December 2017, 2019, 2021 and 2023.These dashboards are available to view on the Public Health Wales website.

165. The dashboards include a number of parameters that relate to mental health and the following highlights some of the data/information that was obtained through the surveys:

a. A decline in 'life satisfaction' and 'mental well-being' scores in females that reached a low in 2021, with slight increase in 2023.
b. There was a small reduction in 'mental well-being' scores in males that reached a low in 2021, with slight increase in 2023, although, this was to a lesser extent than for females.

c. Total 'Strength and Difficulties' (SDQ) scores rising from 2019 to 2023 for males and females, albeit higher in females (please note, the higher the score, the worse the reported mental health).
d. The proportion 'feeling they can count on friends' declined steadily for females between 2017 to 2023. For males, the decline was steeper from 2021 to 2023.
e. The proportion 'having been bullied' increased post-pandemic from 2021 to 2023. The observed increase was almost 7% points for females and 4.5% points for males.
f. Low Family Affluence Scale (FAS) scores are associated with poorer mental health and wellbeing, for example SDQ scores and Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS) scores.

166. It is difficult to consider these data as providing a trend before the pandemic as there were only two data points prior to the pandemic, 2017 and 2019.

Child Death Review Programme

167. As stated above in paragraph 32, Public Health Wales is also responsible for the Child Death Review Programme.

168. The Child Death Review Programme monitored possible suicides in children (under 18 years) during the pandemic. Early on in the pandemic, Public Health Wales raised a concern with Dr Heather Payne at the Welsh Government about the number of possible suicides since 27 February 2020. This was done by email on 9 April 2020 **[EXHIBIT GS2/45 INQ000651430]**. We were concerned that information from two of the reported possible suicides referenced anxiety or isolation due to COVID-19, and that there could be more incidents of self-harm/anxiety in young people, which did not result in suicide. It was agreed with the Welsh Government that an alert should be sent to the Regional Safeguarding Children Boards informing them of the recent increase in possible suicides. This was sent by the Child Death Review Programme on 9 April 2020 **[EXHIBIT GS2/46 INQ000651431 and EXHIBIT GS2/47 INQ000651433]**. The alert requested that the Regional Boards continue to share information with the team so that work could continue in surveillance, informing policy makers, and in identifying opportunities for prevention of future deaths.

169. Subsequent to the above, Public Health Wales undertook a rapid review of possible suicides from 1 January 2020 to 31 May 2020. **[EXHIBIT GS2/48 INQ000651434]** The review highlighted eight deaths occurring in young children aged 11-17 years up to the

end of May 2020, the average number of probable suicides was typically six to seven per year. A case review was undertaken of the eight deaths and considered issues surrounding circumstances of the deaths and life events.

170. The above rapid review also informed a national review of youth suicides and a review of suicides in the Cwm Taf Morgannwg University Health Board area, undertaken by the NHS Wales Delivery Unit in June 2020, commissioned by the Welsh Government. The review was produced as a collaboration between NHS Wales Delivery Unit, Public Health Wales, Swansea University, the Children's and Adolescent Mental Health Services (CAMHS) advisor to the Welsh Government and the Chair of the National Advisory Group for Suicide Prevention. The national review was shared with the Welsh Government on 16 June 2020. **[EXHIBIT GS2/49** INQ000651435 **and EXHIBIT GS2/50** INQ000651438 **]** The review of suicides within the Cwm Taf Morgannwg University Health Board area was submitted to the Welsh Government on 3 August 2020. **[EXHIBIT GS2/51** INQ000651439 **and EXHIBIT GS2/52** INQ000651441

171. Further, the above rapid review also informed a Public Health Wales briefing paper by the Child Death Review Programme on COVID-19 related deaths in February 2021. **[EXHIBIT GS2/53** INQ000651442 The purpose of this briefing paper was to provide information on the activities of the Child Death Review Programme (CDRP) during the pandemic and a discussion of the findings related to COVID-19 and child deaths. It was shared internally within Public Health Wales and with the Child Death Review Advisory Group.

172. Public Health Wales again raised concerns with the Welsh Government on 23 November 2021 around an increase in the number of suspected possible or probable suicide deaths in children during November 2021.**[EXHIBIT GS2/54** INQ000651443 **]**.Following a meeting between the Welsh Government and the NHS Wales Delivery Unit and the CDRP team on 25 November 2021, the Welsh Government commissioned a further rapid review of cases, which would be undertaken by the CDRP and Professor Ann John of Swansea University. The rapid review on child suicides reported on possible suicides during the period 1 January 2021 to 30 November 2021. **[EXHIBIT GS2/55** INQ000651444 .

173. The Welsh Government also established the Rapid Review Suicide Group in December 2021 in response to this alert. The key purpose of the group was to manage and oversee the response to the above concerns and to provide increased monitoring

and surveillance for the duration of the response. The group met weekly until March 2022. It was chaired by Matt Downton at the Welsh Government and reported to Quality and Delivery Board at the Welsh Government. Public Health Wales was a member of this group. **[EXHIBIT GS2/56 INQ000651445 and GS2/57 INQ000651447.**

174. The rapid review was shared with the Welsh Government, the Suicide Rapid Review Group and with the Director of Public Health Data, Knowledge and Research (now Director of Research, Data and Digital Directorate) at Public Health Wales on 13 December 2021. The review resulted in a number of actions being taken forward by the Welsh Government via its Rapid Review Suicide Group. **[EXHIBIT GS2/58 INQ000651448 and EXHIBIT GS2/59 INQ000651450.**

175. The rapid review was later updated to include 1 January 2021 to 31 December 2021 possible suicides and re-submitted to the Welsh Government on 12 January 2022 **[EXHIBIT GS2/60 INQ000651452]**. The Welsh Government issued a letter to stakeholders on 14 January 2022 following receipt of the review. **[EXHIBIT GS2/61 INQ000270371.**

Research Collaboration

176. In addition to the above, Public Health Wales also used healthcare datasets within the Secure Anonymised Information Linkage (SAIL databank) to examine mental health amongst children and young people (aged 2 to 17 years) from the period March 2019 to January 2021.

177. Research was carried out by Public Health Wales in collaboration with the National Centre for Population Health and Wellbeing Research (Swansea University), titled, *Effects of the COVID-19 pandemic on the mental health of shielded children and children living in shielded households in Wales: a data linkage study* **[EXHIBIT GS2/62 INQ000651454**

178. The research showed that a higher proportion of children who were identified as being clinically vulnerable (and therefore advised to shield) received a new diagnosis or prescription for anxiety or depression in March 2020 to January 2021, compared to children in the general population - but the difference was small (2.0% compared to 1.0%). Over the same period, there was little difference between children in the general population and children who were living in the same household as someone advised to shield.

179. It should be noted that, *before* the pandemic, the proportion of children who had a diagnosis or prescription for anxiety or depression was higher amongst those identified as clinically vulnerable, compared to the general population.

180. Public Health Wales did further analysis to better understand mental health amongst children and young people (aged 2 to 17 years) from March 2019 to January 2021, taking into consideration other factors. The research was also carried out by us in collaboration with the National Centre for Population Health and Wellbeing Research (Swansea Uni), again using the Secure Anonymised Information Linkage (SAIL) databank: *Effects of the COVID-19 pandemic on the mental health of clinically extremely vulnerable children and children living with clinically extremely vulnerable people in Wales: a data linkage study* **[EXHIBIT GS2/63** **INQ000651455**

181. The study showed that clinically extremely vulnerable (CEV) children were at greater risk of presenting with anxiety or depression during the pandemic (2020/2021) compared with the general population. This was because the period prevalence of anxiety or depression increased slightly amongst CEV children but declined amongst the general population. The noted difference in recorded anxiety or depression in healthcare between CEV children and the general population was largely driven by a reduction in presentations to healthcare services by children in the general population during the pandemic.

182. The Public Health Wales Research and Evaluation Division continue to examine children and young people's mental health and wellbeing, and factors associated. This includes:

a. examining the relationship and contributing factors across mental health and wellbeing, using the School Health Research Network (SHRN) survey.
b. examining factors associated with, and patterns of presentation of children and young people in crisis (using the SAIL Databank).

This work is in progress and not yet published.

183. As stated above in paragraphs 162 -166, the School Health Research Network (SHRN) survey (DECIPHer, Cardiff University) identified that for some measures, the pandemic period (2021 data) represents a peak in reporting of adverse mental health/wellbeing,

for others, the adverse trends continue or accelerate. There are no measures where outcomes have improved markedly in 2023 versus 2021. Across almost all measures females exhibit poorer mental health/wellbeing than males. Formal analyses to explore correlations have not been conducted by Public Health Wales. Furthermore, as there is only 1 data point after the specified period, it is not possible to draw firm conclusions around trends.

Impact on children and young people's physical health

184. The Child Measurement Programme (Wales) records the heights and weights of children in reception class year (ages four to five years). It reports annually with an official statistics update. It has noted that the proportion of children with obesity in reception class was observed to have increased statistically significantly during the pandemic period (2020 to 2021 academic year) in two health board regions that were able to collect the measurements data during that year.

185. During the 2021/22 academic year reporting, it was possible to compare changes with 2020/21 data for the two health board regions that provided 2020/21 measurement data. It was noted that the proportion of children with obesity in the most deprived quintile had reduced statistically significantly in 2021/22 across both regions. This suggests that the observed increase in obesity measures reported for 2020/21 may have been driven by changes in the regions with higher levels of deprivation.

186. The 2022/23 data observed that at an all-Wales level the proportion of children with overweight or with obesity had dropped to below the proportions reported pre-pandemic in 2018/19.

187. The biennial School Health Research Network (SHRN) survey (DECIPHer, Cardiff University) gathered data on adolescents aged 11-16 years, for the periods September to December 2017, 2019, 2021 and 2023. The SHRN dashboard includes a number of parameters that relate to physical activity and the following highlights some of the data that are considered to be most relevant to the impact on children and young people's physical health:

    a. Physical activity levels ('Reported at least 60mins of physical activity every day for the last seven days') dropped for both males and females in 2021 and rose back to 2017 levels in 2023. However, less than 15% of females and less than

23% of males reported at least 60 minutes of physical activity every day for the last seven days.

b. 'Reported vigorous exercise outside of school time at least 4 times a week' showed the same pattern.
c. 'Reported sitting down for seven or more hours on a weekday' increased from 2017 to 2019 and peaked in 2021 at approximately 18%, with a slight fall to approximately 17% reported in 2023.
d. A 'high' Family Affluence Scale score was associated with a higher proportion of children reporting 'at least 60 minutes of physical activity every day for the last seven days.

188. No formal analyses, between the pandemic and the current position, have been undertaken by Public Health Wales. Rather, it is suggested that the data sources referred to above, are drawn together to triangulate the evidence potentially with other sources of information. Caution should be exercised regarding the above data in light of the limited number of data points to date for SHRN and the incomplete data for the Child Measurement Programme. Furthermore, it is also important to note that these data are observational in that they provide evidence of the effect. However, they do not explain the reasons why.

189. As referred to above in paragraphs 130 to 151, the *Mental Wellbeing Impact Assessment* also identified some of the differences between the data for males and females as:

a. 'A decline in 'life satisfaction' and 'Mental well-being' scores in girls that reached a low in 2021, with slight increase in 2023.
b. There was a small reduction in 'Mental well-being' scores in boys that reached a low in 2021, with slight increase in 2023. Although, this was to a lesser extent than for girls.
c. Total 'Strength and Difficulties (SDQ) scores rising from 2019 to 23 for males and females, albeit higher in females (please note, the higher the score, the worse the reported mental health).

190. Measures of mental wellbeing and mental disorder collected during the pandemic tend to reflect pre-existing differences, with higher rates of emotional symptoms for girls, adolescents and young women and higher rates of behavioural and attentional difficulties for boys. Studies by academics and organisations such as NHS Digital, tracking children

through the pandemic found that changes over time in behavioural, emotional, and attentional difficulties over the duration of the pandemic have been similar for boys and girls. For all young people aged six to16 years there was an increase in probable mental disorder between in 2017 and 2021 for boys and girls. There is some evidence that girls were more anxious and worried about returning to school.

191. Amongst those aged 17 to 19 years, rates of probable mental disorder rose from 10.1% in 2017 to 17.4% in 2021. The increase was significant in young women of this age (from 13.4% in 2017 to 24.8% in 2021), but not in young men. Rates of possible eating problems also rose significantly in young women between 2017 and 2021.

192. Public Health Wales has not collected or analysed any information regarding referrals into mental health services, medical professionals, social workers, teaching professionals, youth leaders, or other professionals working with children.

Significant decisions which affected children during the pandemic

Lead-up to school closures

193. Public Health Wales provides expert professional advice to inform Welsh Government or Ministerial decision-making in relation to matters of public health. Often, Public Health Wales advice will form only one part of the advice received and considered by the recipient in the making of a decision(s). Of note, Public Health Wales was not (and is not) a decision-making body in the context of decisions made relating to children and young people.

194. During the period January to mid-March 2020, Public Health Wales did not provide any specific advice or monitoring to the Welsh Government which considered:

    a. what might have been needed to enable schools to remain open should the pandemic progress.
    b. the potential impact that closing schools might have on the transmission of COVID-19 in the community.
    c. the impact and/or risk the closure of schools might have on children and young people, in particular in relation to their safety and child protection.
    d. the steps that were being taken in other countries as to whether they would close schools or to keep them open.

195. The closure of schools was a non-pharmaceutical intervention considered by several modelling groups, such as SPI-M, SPI-B, SAGE and TAG in Wales, in March 2020 to reduce transmission of COVID-19 within the community. Public Health Wales was aware of these discussions through our attendance at TAG, with Welsh Government Officials and through discussions at the Public Health England IMT meetings.

196. Information from the Welsh Government's Technical Advisory Cell was shared with Public Health Wales through its membership of TAG and its sub-groups. [Papers from SPI-M and SAGE on the impact of COVID-19 on mortality and the healthcare system were also shared with Public Health Wales through the Chief Medical Officer for Wales' office at the Welsh Government, given that Public Health Wales was not permitted to attend SAGE or SPI-M at that time]. Public Health Wales does not however recall there being a particular focus on schools during this time, nor that advice changed over this period (March – June 2020).

197. A report from Imperial College COVID-19 Response Team, Report 9 from 16 March 2020 **[EXHIBIT GS2/64** INQ000228166 was one such report, shared with Public Health Wales, which considered school closures.

198. We noted that school closure could contribute to suppression of COVID-19 from wider social distancing but that school closures were not sufficient themselves to suppress the transmission of COVID-19. This paper was one of several similar studies from academic groups presented at SPI-M/ SAGE on the use of NPIs to control COVID-19, which Public Health Wales became aware of at the time.

199. Public Health Wales first became aware of the possibility of school closures as a possible means of reducing community transmission on 19 March 2020, when it was announced by the Welsh Government. We were not engaged in any discussions with the Welsh Government prior to this announcement.

200. Public Health Wales was not in discussions with the UK Government's Department of Health and Social Care regarding the possibility of school closures this period and were therefore not aware that such an announcement was imminent.

201. Public Health Wales cannot comment on how the advice in relation to schools changed during the period January to March 2020 given that it was not party to the contemporaneous discussions with the relevant decision makers.

The announcement of the Welsh Government on 19 March 2020 that schools would close

202. Public Health Wales was also not involved in the decision to close schools to most children on 19 March 2020. This was a decision of the UK Government, which was supported by the Welsh Government.

203. As stated above, we were made aware of the decision to close schools to most children on 19 March 2020, when it was announced by the Welsh Government. We were not involved in any discussions with the Welsh Government about this decision, nor were we involved in any discussions about the ability of schools to close at short notice prior to the decision being announced.

204. Between the period January to March 2020, Public Health Wales was not asked to, nor did we, provide any advice to the Welsh Government about the effect that closing schools might have on children and young people, nor did we undertake any work which involved planning for school closures.

205. Public Health Wales is also unable to comment on the following matters:

a. how any expert advice was applied to the Welsh context having regard (for example) to the transmission rates in Wales.
b. The existence of any principal plans in the days leading up to 18 March 2020 as to what would happen, in Wales, in the event that schools had to close.
c. The main factors (relevant to Wales) which contributed towards or justified the decision to close schools to most children.
d. The extent to which there was consideration by the Welsh Government about the options for keeping schools open to more pupils; or the measures which

could potentially be put in place so that schools could remain open to more pupils prior to 19 March 2020.

e. Whether there had been adequate planning for schools to be able to close after the announcement on 18 March 2020.
f. The factors informed the decision as to which children in Wales might continue to attend school in-person.
g. The decision-making process as to what children would be deemed 'vulnerable'.
h. Whether there was any consideration given to requiring that parents send children deemed vulnerable to school.
i. The extent to which any Welsh Ministers were party to or involved in any change in approach to the question of whether schools should close on or around the 18 March 2020.

The announcement of 18 March 2020 by the UK Government that schools would close

206. Up to the 17 March 2020, Public Health Wales was proceeding on the basis that schools would remain open to most children. It was only when the announcements made by the Prime Minister and by the Welsh Minister for Education on 18 March 2020 that schools would close to most children, that we became aware that this position had changed. Public Health Wales was not involved in any discussions, or the decision-making processes undertaken by the UK Government prior to the announcement to close schools on 18 March 2020.

Impact Assessments on the decision to close schools

207. As stated above, the Welsh Government was responsible for the decisions to close schools to most children, and as such would have been responsible for undertaking any impact assessments in relation to its decisions. Public Health Wales did not undertake any specific impact assessments prior to the decision to close schools for most children. We did undertake a Health Impact Assessment and Mental Health Wellbeing assessment; post school closures being announced. Detail of these can be found in paragraphs 110 to 151 above.

The first national lockdown

208. Public Health Wales was not party to, nor were we involved in the UK Government's decision to lockdown. We were also not asked to contribute to any assessment by the UK Government about the impact a lockdown may have on:

a. children's health, including their physical and mental health and their wellbeing and development.
b. the safety or well-being of children.
c. the provision of social services, including adoption and fostering services.
d. the rights of children under the UN Convention on the Rights of the Child.

Lessons learned processes arising out of the first school closures

209. Public Health Wales has not undertaken any specific lessons learnt process arising out of the first school closures in March 2020 or the first national lockdown. Following school closures in March 2020 and the national lockdown, there was no capacity within Public Health Wales to undertake such a process given that our focus was on redeploying our organisational resources to support our core functions, namely relating to infectious disease management and control to support the pandemic response.

210. Furthermore, the impact of school closures and the national lockdown is unlikely to be seen immediately and may manifest itself several years later. Whilst there are no current plans to undertake a formal lesson learnt process, Public Health Wales will keep this under review.

The closure of schools in January 2021

211. Public Health Wales was not the decision maker as to whether schools should close and remain closed after Christmas 2020. This was a decision taken by the Welsh Government. We did however submit the following advice notes to the Chief Medical Officer for Wales between December 2020 and March 2021, which related to schools and the education sector. These advice notes would have been part of a suite of information considered by the Welsh Government when making decisions.

CMO Advice Note 4

212. Public Health Wales CMO advice note No 4 – Public Health Wales submitted an advice note to the CMO on 7 December 2020 titled *Possible next steps in COVID-19 response* **[EXHIBIT GS2/65 INQ000056303].** This advice note included the following:

a. A recognition that any decisions will need to balance different considerations: reducing transmission, protecting essential health and social care services and minimising the wider harm effects including those arising from impacts on the economy and, notably, the wider impact on population health outcomes in the medium/long term (for example, undiagnosed and untreated conditions, and other health harms including mental health) as well as any unintended impacts arising from further interventions.
b. With regard to the current rate of infection of COVID-19 in Wales, a recommendation that urgent additional action before Christmas is required.
c. A recommendation that Schools to move to online learning at the earliest opportunity to reduce the wider risks associated with travel and mixing.

CMO Advice Note 5

213. Public Health Wales CMO advice note No 5 – Public Health Wales submitted an advice note to the CMO on 11 December 2020 titled *Post-Christmas next steps in COVID-19 response* **[EXHIBIT GS2/26 INQ000056302 as above]** The advice note included the following:

a. A recognition that any decisions will need to balance different considerations: reducing transmission, protecting essential health and social care services and minimising the wider harm effects including those arising from impacts on the economy and, notably, the wider impact on population health outcomes in the medium/long term (for example, undiagnosed and untreated conditions, and other health harms including mental health) as well as any unintended impacts arising from further interventions.
b. Our previous advice notes have highlighted the importance of having regard to the wider impacts of the COVID-19 pandemic in Wales and we continue to highlight these points notably in relation to the impact on mental health and well-being (particularly in young people).
c. Key advice for the post-Christmas period was therefore the re-introduction of a suite of national 'additional restrictions' similar to those introduced in March

2020. This intervention needed to be in place for a sufficiently long period to achieve adequate control of the pandemic with a clear exit strategy for easing the restrictions by prioritising key sectors such as education as soon as is practicable.

d. Public Health Wales would work to provide further advice by the end of next week that will encompass strategies for monitoring and evaluating the effect of restrictions, guidance on thresholds for easement of restrictions, and strategies to support safe easement for different population cohorts (e.g. education).

CMO Advice Note 6

214. Public Health Wales CMO advice note No 6 – Public Health Wales submitted an advice note to the CMO on 15 December 2020 titled *Christmas Period 2020 and response to the Coronavirus Control Plan for Wales* **[EXHIBIT GS2/66 INQ00056304].** The advice note included the following advice:

a. The publication of the Coronavirus Control Plan for Wales was welcomed. The indicators for action are clearly laid out and we acknowledge that there is a legislative process to be undertaken.
b. In line with our previous advisory note of the 7 December 2020 we recommend that urgent additional action is required, as soon as practicable, before the Christmas period. Actions taken should be consistent with those described for alert level 4 in the Coronavirus Control plan.
c. Post - Christmas period We further recommend that for the post-Christmas period (immediately following the period of regulated relaxation), we would expect that alert level 4 measures would need to be in place to control the pandemic and the exponential growth of the virus across Wales.
d. The alert level 4 measures may need to be in place for an extended period of time, which will increase the wider impacts of this pandemic.
e. Appendix 4 of this advice note –shared international information, noting that positions in the Netherlands and Germany.

CMO Advice Note 8

215. Public Health Wales CMO advice note No 8 – Public Health Wales submitted an advice note to the CMO on 22 January 2021 titled *COVID-19 Epidemiological update and Return to School and Education.* **[EXHIBIT GS2/67** INQ000068159**]**. This advice note included advice on the following:

a. Transmission risk in school and in relation to community transmission and growth
b. Impact of New variant (VOC202012/01 and others)
c. Current epidemiology, including potential influences and impacts on the epidemiological position
d. Specific recommendations:
e. Reducing the numbers of contacts including mixing of pupils; pupils and staff and staff to staff is key to minimising transmission. Contact "bubble" sizes need to be kept to the lowest possible numbers, both to reduce the total population at risk of transmission, and the disruption to school systems and communities.
f. Reducing the numbers in class / in school can assist with ensuring that social distancing measures are effective.
g. School opening is linked to a range of behaviours and movements outside the school, which all have the potential to increase transmission, therefore we recommend robust communications to parents/guardians and students about the avoidance of contacts outside schools, both for students and for parents/guardians, in line with wider guidance.
h. In general, we recommend strengthening existing practices to reduce person to person contact, in particular indoors, with rigorous adherence to the use of face coverings where social distancing cannot be maintained in accordance with current regulations. This should apply in all areas of the school including the canteen and staff break rooms / offices.
i. To support school opening, Public Health Wales will continue to provide daily reports to the Welsh Government on cases linked to schools, and a published weekly summary, this will be extended to show the incidence in staff and students in the context of community incidence and analyse location of work/study data to detect and measure clusters.
j. Given that school opening is the highest priority measure, we recommend that other sectors are not re-opened at the same time, giving time to assess the impact of school opening.
k. There is evidence to suggest that opening of primary schools would have less effect on the Rt than opening of secondary school as older school students and young adults have different mixing patterns to primary school children.

CMO Advice Note 10

216. Public Health Wales CMO advice note No 10 – Public Health Wales submitted an advice note to the CMO on 22 January 2021 titled *COVID-19 Epidemiological Update and Easing of Restrictions* **[EXHIBIT GS2/68 INQ000056312]**. This advice note included the following in relation to schools and educational settings:

a. Public Health Wales supported the Welsh Government's decision to re-open face-to-face teaching for foundation year groups from 22 February 2021, provided case rates continue to fall further.
b. Public Health Wales recognised that the re-starting of face-to-face learning for other year groups is a matter for the Welsh Government and reinforces the principles outlined in our advice note of the 22 January 2021 (CMO advice note 8).
c. Public Health Wales recommended that re-starting face-to-face learning for older year groups should commence from the w/c 8 March 2021, provided the case numbers continued to fall and that education colleagues felt that schools are in a position to function in a COVID-safe way, including assurance that the points raised in CMO advice note 8 of 22 January 2021 can be complied with.
d. Education of young people is very important and therefore it should be a priority to open schools ahead of other sectors as we emerge from current Level 4 restrictions.

217. These are also the advice notes provided by Public Health Wales to the Welsh Government when the Welsh Government was considering the re-opening of schools in early 2021.

218. Public Health Wales' International Horizon Scanning Reports provided evidence in relation to educational settings for children and evidence on the impact of school closures and re-opening. The relevant reports are listed below:

a. Report Number 3, 7 May 2020**[EXHIBIT GS2/69 INQ000068183]**
b. Report Number 5, 21 May 2020 **[EXHIBIT GS2/70 INQ000068185]**
c. Report Number 22, 22 January 2021 **[EXHIBIT GS2/71 INQ000068202]**
d. Report Number 30, 1 July 2021 **[EXHIBIT GS2/72 INQ000068133]**
e. Report Number 33, 10 September 2021 **[EXHIBIT GS2/73 INQ000068141]**

f. Report Number 44, 24 October 2022 **[EXHIBIT GS2/74** INQ000651467]

The decision to reopen schools

219. In addition to CMO advice notes 8 and 10, which are detailed above in paragraphs 215 and 216, Public Health Wales also provided the following advice notes to the Welsh Government to support its decision-making processes in relation to the re-opening of schools in 2021.

CMO Advice Note 15

220. Public Health Wales CMO advice note No 15 – Public Health Wales submitted an advice note to the CMO on 7 July 2021 titled Considerations regarding alert level 1/alert level 0 (baseline measures) to manage ongoing COVID-19 pandemic **[EXHIBIT GS2/75** INQ000056314 **].** This advice note provided advice on easing/lifting these NPIs. This advice note included the following recommendations in relation to schools and childcare:

a. Move to alert level 1 – we agree that for schools and childcare, this would mean removal of bubbles / contact tracing on that basis. We recommend a return to contact tracing on basis of close contacts e.g. those on same table in school or close friends – as is done to control other infectious diseases.
b. Maintain strong advice re IP&C measures such as good hand and respiratory hygiene and self-isolation and seeking PCR test if symptoms of respiratory disease, but if positive only the close contacts would need to self-isolate.

CMO Advice Note 16

221. Public Health Wales CMO advice note No 16 – Public Health Wales submitted an advice note to the CMO on 16 July 2021 focusing on Moving to Recovery for COVID response **[EXHIBIT GS2/76 INQ000068167].** This advice note focused on moving to recovery of COVID-19 response, highlighted the need to include addressing existing and new vulnerabilities with interventions aimed at children and young people; minority ethnic groups; disabled, those living in/at risk of deprivation and poverty; and those who are marginalised and socially excluded.

CMO Advice Note 19

222. Public Health Wales CMO advice note No 19 – Public Health Wales submitted an advice note to the CMO on 25 August 2021 on the Management of COVID Clusters in Educational Settings **[EXHIBIT GS2/77 INQ000056335]**. This advice note recommended consideration be given to adjusting the approach to cluster management in educational settings. Specific recommendations were:

a. The Local COVID-19 Infection Control Decision Framework for schools from autumn 2021 document be amended to make clear that the risk levels (Table 1) and schools intervention framework (Table 2) will be applied at a local authority level (or suitable other geography agreed by the local authority) and not at an individual school level.
b. The school action card (latest revision 17/8/21) be amended to indicate that contact tracing of cases will be carried out by TTP as per usual practice – this will mean minimal involvement of the school and minimal involvement of the regional / professional health protection response. The FAQs state that contact tracing will follow normal protocols, with the case or their proxy being primary source of information, so the proposed approach is consistent with this.
c. Policy leads consider defining triggers to implement enhanced measures in a setting to ensure providers have clear guidelines on when to act. In England, the Department for Education's Contingency framework: Education and Childcare Settings uses the following:
    i. For most education and childcare settings, whichever of these thresholds is reached first:
        - 5 children, pupils, students or staff, who are likely to have mixed closely, test positive for COVID-19 within a 10-day period; or
        - 10% of children, pupils, students or staff who are likely to have mixed closely test positive for COVID-19 within a 10-day period
    ii. For special schools, residential settings, and settings that operate with 20 or fewer children, pupils, students and staff at any one time:
        - 2 children, pupils, students and staff, who are likely to have mixed closely, test positive for COVID-19 within a 10-day period
d. An investigation of any cluster within an education setting will be limited to situations where the current epidemiology indicates that an emergent variant

may be circulating. This may include increased hospitalisations locally, especially amongst the young; increased transmission / attack rate that indicates increased transmissibility or immune escape.

e. The focus of response shifts away from that the establishment of Incident Management Teams to deal with individual settings, but that Education Services work within established local COVID prevention and response plan structures to apply appropriate measures based primarily on the risks posed by community incidence and other factors.

f. Appropriate discussions with education settings with specific additional needs are recommended on an individual basis / according to need, drawing on relevant guidance and infection, prevention and control advice for similar settings.

CMO Advice Note 20

223. Public Health Wales CMO advice note No 20 – Public Health Wales submitted an advice note to the CMO on 8 September 2021 on the Ongoing Control of COVID-19 during Recovery and Autumn/Winter 2021**[EXHIBIT GS2/78 INQ000056330]**. This advice note included the following advice in relation to children and young people:

a. Schools
    i. Support normal environment – reference need to maintain strong advice re IP&C measures such as good hand and respiratory hygiene and self-isolation and standard testing outlined in Government Policy if symptoms of respiratory disease, but if positive only the close contacts above the age of 18 who are unvaccinated would need to self-isolate. Consideration should be given to a surveillance driven evidence-based identification, testing and management of close contacts. e.g. those on same table in school or close friends – as is done to control other infectious diseases.

b. University Settings
    i. Universities should continue active campaigns on COVID appropriate behaviours as students return from summer break
    ii. A general reinforcing of the need to register with a GP and to ensure vaccinations are up to date would be helpful to include.

CMO Advice Note 23

224. Public Health Wales CMO advice note No 23 – Public Health Wales submitted an advice note to the CMO on 1 November 2021 titled *Non-Pharmaceutical Interventions during scenario 'COVID URGENT' of the Coronavirus Control Plan*. **[EXHIBIT GS2/79 INQ000056305]**. Public Health Wales' recommendations were a staged introduction of NPIs guided by the epidemiology. In Stage 1, concurrent introduction of:

a. Re-introduction of Social distancing
b. Cease all mixing between households, except where single person household can form a bubble with one other household
c. Supplementary actions such as protection of the vulnerable individuals in vulnerable settings (e.g. shielding of the elderly), stricter testing policies, closure of public transport and wider mandated use of face coverings
d. Ban public gatherings and mass events
e. Implement a night-time curfew, noting there is a delicate benefit/harm balance.

225. In Stage 2, sequential introduction of:

a. Closure of non-essential retail businesses
b. Closure of Secondary Schools
c. Closure of Primary Schools.

Overall assessment of the impact of the pandemic on children

226. Public Health Wales has undertaken several pieces of work, all of which have identified a number of impacts of the pandemic on children and young people.

227. In response to the need to understand the wider population harms due to COVID-19, Public Health Wales completed *A Health Needs Assessment: The impact of COVID-19 on children and young people's experiences of violence and adverse childhood experience.* **[EXHIBIT GS2/80 INQ000191891]** This aimed to understand the impact of COVID-19 on children and young people's experiences of violence, explore what works best to mitigate the negative impacts and map the extent to which these services and programmes are being delivered in Wales. Subsequently the consideration of potential future steps provided for COVID-19 recovery planning in order to address the issue of

increased exposure to violence for children and young people due to the pandemic. The report was published in June 2021.

228. The assessment concluded:

> *To reduce the adverse impact of COVID-19 on children and young people there is a need to provide targeted early intervention. A multiagency response will allow organisations to data-share and work together to identify and report risks of children and young people and to provide the best support for each individual child. To ensure this response is of the best quality to mitigate the impacts of COVID-19, ongoing training and continued resources, such as staffing and funding, are required. Furthermore, relevant public health information and other information regarding COVID-19 should be communicated in a child appropriate manner to aid understanding and alleviate fears. Additionally, children and young people should be provided with the opportunity to co-produce policies and other important decisions with the government and non-governmental organisations to allow for a more fitting response.*

229. The assessment also listed a range of key policy considerations and next steps that could inform strategies for the recovery and support children and young people going forward:

a. Re-establish face-to-face support for children and young people and their families.
b. Provide training and refresher training on identifying signs of abuse, safely reporting abuse and where to access support for staff who are in regular contact with children and young people across sectors and within the community.
c. Protect against worsening inequalities by ensuring support measures are directed equitably at communities and groups most impacted e.g. BAME, SEND, low income, LGBT+, NEET, young carers, looked after children, children in the youth justice system, refugee and asylum seekers and those with pre-existing mental or physical health needs.
d. Ensure mental health and well-being is a key consideration for decisions relating to children and young people and recovery from COVID-19.
e. Invest in violence and ACE prevention, including primary prevention to stop violence and ACEs before they occur.

f. Continue to develop multiagency work to enhance sharing of data and good practice, allowing organisations to be better prepared for identification and support of vulnerable children and young people.
g. Services that work with children and young people should consider developing a contingency plan that allows operation on the same scale (i.e. reaching the same number of vulnerable children and young people and offering the same level of support) but at reduced capacity (in terms of staff and resources) in preparation for potential future pandemics or disasters.
h. Communicate advice and information to CYP in an accessible manner to ensure maximum understanding of available guidance and support relating to COVID-19.
i. Actively involve children and young people in the recovery response.
j. Continue to conduct, update and apply research on the impact of COVID-19 on children and young people, particularly in relation to what works at community level to support children and young people and families, including those that sit outside of current support service thresholds, and long-term ongoing issues that may arise as a result of COVID-19.

230. In addition to the above, Public Health Wales also carried out qualitative research to examine the *Emerging Drivers of Vulnerability to Health Inequity in the Context of COVID-19: Perspectives and response from the Voluntary and Community Sector in Wales.* **[EXHIBIT GS2/81** INQ000068136 **]** The report was published in July 2021 and demonstrated how during the pandemic, vulnerability rapidly arose and was often exacerbated when individuals were unable to access support from particular resources, services and local infrastructure. Vulnerabilities were typically also found to cluster together and were often patterned along pre-existing lines of social inequality. Whilst the focus was not on children specifically, there were a number of references to concerns about the current and future impact on children, loneliness and anxiety and support.

231. The School Health Research Network (SHRN) survey (DECIPHer, Cardiff University) is a source of relevant raw data when considering what the principal impacts of the pandemic on children and young people have been. Examples of summary extracts from the survey that are of interest include:

a. The percentage of 11–16-year-olds who score high or very high in the total score for the 'Strength and Difficulties' (SDQ) score (indicating worse mental

health and wellbeing) rose from 25.8% in 2019 to 32% in 2021 and there was a further rise to 35.2% by 2023. There is a stark social gradient with 44.3% of children in families with a low Family Affluence Scale (FAS) score having high or very high scores in 2023 compared with 30.8% in families with a high FAS.

b. Physical activity levels in 11–16-year-olds (per cent reporting at least 60 mins of physical activity every day for the last seven days) fell from 18.3% in 2017 to a low of 16.2% in 2021. This has risen back to 18.3% in 2023. Children in low FAS families are less likely to meet the guideline amounts than those in high FAS families (15.3% and 20.4% respectively in 2023).

232. The Congenital Anomaly registration and Information Service (CARIS) team collected surveillance data on paediatric multisystem inflammatory syndrome (PIMS-TS) for the period 1 March 2020 – 28 February 2021. In collaboration with the Communicable Disease Surveillance Centre (CDSC) in Public Health Wales and with Cardiff University it produced a provisional rapid summary report, *PIMS-TS Surveillance Wales 1 March 2020 – 28 February 2021*. **[EXHIBIT GS2/82** INQ000651476**]** The purpose of the report was to provide timely information on the headline paediatric multisystem inflammatory syndrome surveillance numbers given the current rise in cases amongst children.

233. This report was shared with senior staff in Public Health Wales and colleagues in the Welsh Government on 12 July 2021. Subsequent discussions with Welsh Government colleagues led to an additional request that included time trends and numbers of cases of PIMS and Kawasaki disease were also provided. **[EXHIBIT GS2/83** INQ000651477 **and EXHIBIT GS2/84** INQ000651478**]** This work was caveated at the time it was shared with the Welsh Government. Whilst the data provide surveillance information on the numbers of cases of PIMS-TS across Wales, this alone does not provide a complete picture of impact as per the explicit ask of the question, as this required more clinical data with clinical interpretation, which Public Health Wales was unable to progress with at the time due to capacity constraints.

234. The United Nations published a policy brief on *the Impact of COVID-19 on Children* on 15 April 2020 **[EXHIBIT GS2/85** INQ000250256**]**. This highlighted that the harmful effects of the pandemic are not equally distributed. There are three main channels through which children are affected by this crisis at a global level: infection with the virus itself; the immediate socioeconomic impacts of measures to stop transmission of the virus and end the pandemic; and the potential longer-term effects of delayed implementation of the Sustainable Development Goals. Four main areas have been highlighted; Falling

into poverty, the learning crisis, threats to child health and survival and risks to child safety.

235. Public Health Wales has a number of established programmes of work that address some of the health and wellbeing impacts of the pandemic. The most significant of these is the *Whole School Approach to Mental and Emotional Wellbeing* which is supporting the implementation of the Statutory Framework (WG42005). This commenced during the pandemic and has continued to date. There were significant challenges with mental and emotional health and wellbeing among children and young people pre-pandemic and Public Health Wales is working with academic and clinical colleagues to understand the drivers of poor mental health in this group which will include the contribution made by the pandemic. We have also supported work led by the Cabinet Secretary for Education on attendance and behaviour in schools both of which have increased in significance post pandemic.

236. We have also been working with partners across the system to increase the focus on the early years, particularly the first 1000 days. We know that this period is significant in relation to longer term health and wellbeing, and we know that services in this area have struggled to return to pre-pandemic service levels, particularly in relation to face to face engagement and that this is important to build trusted relationships between parents and professionals.

Young carers

237. In response to the need to understand the wider population harms of COVID-19, Public Health Wales Research and Evaluation Division commissioned research from Cardiff University on the impact of the pandemic on unpaid carers in Wales, *Voices of Carers during the COVID-19 Pandemic: Messages for the future of unpaid caring in Wales* **[EXHIBIT GS2/86 INQ000614367].** The report was shared publicly in June 2021. Within the qualitative study reflections from young carers (defined age range 15-25yrs) were collated. There were only 13 responses from this age group, but some of the themes included the impact of caring on education, both school attendance, reduced ability to engage with education at home (when schools operating virtually), possible reduced recognition of young carer's needs in educational contexts during the pandemic, and support for isolation and loneliness. It was noted that *"Many younger participants reported that their schools did not recognise or support them as young carers. Schools,*

colleges and universities all need to be proactive in identifying and supporting young carers, with clear and visible policies in place".

238. The findings of this research were used in a number of ways. It was used to inform further research on education amongst unpaid carers conducted by the Public Health Wales Research and Evaluation Division and Swansea University, such as *Closing the educational engagement gap for young carers* **[EXHIBIT GS2/87** INQ000651481 **.** This research was published in September 2021 and evidenced the negative impact that caring responsibilities have on educational participation in those aged 16-22, and how this has greatest impact on those living in the most deprived areas.

239. The research brought together National Survey for Wales data over three years and found that:

a. One in five young people aged 16 – 22 years in Wales have caring responsibilities.
b. Males and females in this age group are equally likely to be young carers.
c. Overall, the proportion of young people in full time education is lower amongst young carers (45 per cent in carers, compared to 54 per cent in non-carers), and this difference is greater in those living in more deprived areas.

240. A novel finding in this study was new evidence to suggest that this difference is largely in the older age groups (19 to 22 years), where the proportion in full time tertiary education is 10 per cent less amongst carers. The lowest participation is among those with caring responsibilities living in the most deprived areas where only 19 percent remain in full time tertiary education.

241. The findings from Public Health Wales commissioned report *'Voices of Carers during the COVID-19 Pandemic: Messages for the future of unpaid caring in Wales* **[EXHIBIT GS2/86 above***'* were also:

a. discussed by Dr Daniel Burrows and Chris Williams, a social work practice educator and trainer in a Podcast on ExChange (CASCADE) in August 2021.
b. discussed at a Cardiff University organised workshop in March 2022 which brought together unpaid carers and carer groups, policy makers and researchers to discuss recent research findings and identify future research priorities.

c. presented to the Children's Commissioner for Wales (August 2021).

Children and young people's physical and mental health and access to healthcare

The Child Death Review Programme

242. The Child Death Review Programme, (as referred to above in paragraphs 32 and 167 to 175) monitored deaths of children to identify any effects of the COVID-19 pandemic on child deaths. The purpose of the briefing paper was to provide information on the activities of the Child Death Review Programme during the pandemic and a discussion of the findings related to COVID-19 and child deaths. **[EXHIBIT GS2/53 - INQ000651442]** The briefing paper on COVID-19 related deaths identified themes such as anxiety and isolation of children and young people during lockdowns, delayed presentations to healthcare services, and reduced or lack of home visits to vulnerable families. It also included information from the Public Health Wales rapid review of possible suicides in children and young people from June 2020. This briefing paper was circulated within Public Health Wales in February 2021 and information from this paper was included in Public Health Wales' briefing paper to Vaughan Gething the Minister for Health and Social Care, on COVID-19 indirect harms in Children and Young People sent by Tracey Cooper, Chief Executive, on 24 February 2021 **[EXHIBIT GS2/88 - INQ000651483]**. The briefing paper produced by the Child Death Review Programme **[EXHIBIT GS2/53 INQ000651442 as above]** was also circulated to the Child Death Review Programme Advisory group on 3 February 2021.

The Violence Prevention Unit

243. The Violence Prevention Unit also produced resources and reports to support the understanding of the risks of harm to children and young people including those from more marginalised groups.

244. The unit developed the Wales Without Violence Framework, which consulted 1,000 professionals, children and young people and which culminated in *Wales Without Violence: A Shared Framework for Preventing Violence among Children and Young People* **[EXHIBIT GS2/89 - INQ000651485]**. This work developed a guide that could pave the way for a Wales without violence, one that focused on solutions to support professionals and reflected the views, experiences and aspirations of children and young people living in Wales.

245. It also produced an interim report in November 2020 titled *Understanding the Impact of COVID-19 on Violence and ACEs Experienced by Children and Young People in Wales* **[EXHIBIT GS2/90 - INQ000651486].**

The ACE Hub Wales

246. During 2021, the ACE Hub Wales ran its campaign *#Timetobekind*, which urged people to continue to be kind to each other, reach out and make connections to support people struggling during the pandemic.

247. The *#Timetobekind* public awareness campaign promoted the understanding that everyone has a role to play in supporting children, young people and their family experiencing adversity. The campaign recognised that children were not in school and may be experiencing exacerbated harm in the home. The campaign was fully evaluated and concluded that ''*Film can be an effective tool to promote behaviour change for kindness. Films that provoke strong emotional reactions can still be perceived positively and lead to behaviour change. With the COVID-19 pandemic accelerating a move online for many, the findings of the present evaluation are relevant to how public health messaging can adapt and utilise this space to target individuals and promote behaviour change.*". [**EXHIBIT GS2/91 - INQ000651487**

248. Public Health Wales has also published a report on *Children and the Cost-of-Living Crisis in Wales, How children's health and well-being are impacted and areas for action* in September 2023 **[EXHIBIT GS2/92 - INQ000651488].** This highlighted the detrimental impact of the COVID-19 pandemic on children's mental health, school absence and educational attainment, which has exacerbated the cost-of-living crisis, with children living in poverty impacted the most.

PHW involvement in work to assess the impact of the pandemic on the babies born during the pandemic or those children who were pre-school during the pandemic

249. The Congenital Anomaly registration and Information Service (CARIS) team undertook work following the pandemic to investigate the impact (if any) of the COVID-19 pandemic on congenital anomalies [**EXHIBIT GS2/93 - INQ000651489]**. The summary and conclusions of the work were presented to the CARIS annual meeting in November 2024 and noted that there was no evidence of a population-level association between

congenital anomalies and maternal COVID-19 infection in Wales was found. [**EXHIBIT GS2/94 - INQ000651490].** This work was based on triangulating data evidence and includes a number of limitations. Potential associations with specific and rare congenital anomalies cannot be excluded and the work also concluded that National surveillance registries should remain vigilant. This work has since been submitted to a journal for peer review and acceptance for publication.

250. The Staying at Home and social distancing HIA **[EXHIBIT GS2/37 INQ000056307 as above],** stated that *'babies, children and young people have been particularly negatively affected. Many of the impacts are likely to increase health and social inequity in Wales; monitoring is necessary to better understand these impacts for the longer term and inform future decisions.'*

Lessons Learned

251. Public Health Wales has not undertaken any formal specific lesson learnt exercises in relation to the impact of the pandemic or the pandemic response on children and young people. Public Health Wales is part of the multi-agency partnership approach to emergency planning and response (including future pandemic planning) and continues to work with partners across Wales to learn from and plan for future major incident including future pandemic response.

252. We have however reflected on our organisational pandemic response experience and planning process have made improvements to strengthen both our planning and response processes. This includes updating the Public Health Emergency Response Plan. Prior to January 2020, Public Health Wales engaged in regular, system-wide emergency planning activities. While these efforts were primarily designed to address the needs of the general population, they also incorporated recognition of vulnerabilities within the population. This was particularly evident through multi-agency risk assessment and preparedness planning across Wales, which included specific consideration for vulnerable groups—especially in relation to age, mobility and health conditions. The revised Public Health Wales Emergency Response Plan [**EXHIBIT GS2/95 - INQ000651491**] has now further strengthened and formalised this approach by referencing three broad categories of vulnerability, including dependants such as children, reinforcing the importance of inclusive planning through coordinated exercises and inter-agency collaboration.

253. Other reflections include the future importance of:

a. Improved/enhanced surveillance in schools for infectious diseases or risk factors (e.g., vaccination gaps).
b. Better use of school absenteeism data to identify potential patterns of diseases - e.g., respiratory or gastrointestinal.
c. Vaccine delivery models: where appropriate this has already moved from a GP based model to school-based model, e.g., Human Papillomavirus (HPV) vaccination.
d. Continued work to improve the recording of ethnicity data.
e. Continued work to understand and reduce inequalities amongst 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.

Personal Data

Signed: ____ _____

Dated: _____25 July 2025_____