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Clinically Vulnerable Families
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**IN THE PUBLIC INQUIRY INTO THE
UK COVID-19 INQUIRY**

MODULE [8]

**WITNESS STATEMENT OF
LARA WONG
ON BEHALF OF CLINICALLY VULNERABLE FAMILIES ('CVF')**

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I, Lara Wong, on behalf of Clinically Vulnerable Families, will say as follows: -

1. I am writing this statement in response to the UK Covid-19 Inquiry's request, dated 3 April 2025, for evidence under Rule 9 of the Inquiry Rules 2006 in respect of Module 8. I provide this written response on behalf of Clinically Vulnerable Families ('CVF') which I founded and lead with the support of deputy leaders, expert advisors, and dedicated team members. This statement gives a voice to our members and throughout, where appropriate, I have provided quotes, examples and case studies from many of our members to assist the Inquiry in understanding their real life lived experience.
2. In order to prepare this statement, I have drawn on my own experience and knowledge, including from my professional training and understanding, as well as the knowledge and experience of CVF members. CVF is a primarily volunteer group with an online membership base, as set out in paragraph [19]. I am aware of many members' experiences and perspectives because CVF has sought to advocate for members' rights, has provided peer support for members and we routinely discuss the challenges faced both individually and as a group during the Inquiry's defined pandemic period.
3. It is noted that for the purpose of this Rule 9 request, the date range of the pandemic is set as the period between 1 January 2020 and 28 June 2022. Where we refer to the pandemic within this statement we do indeed refer to that prescribed time period. However, we do not agree that the pandemic came to an end on 28 June 2022. As of 2024, the World Health Organisation ('WHO') continues to warn that the Covid-19 pandemic persists. Dr. Maria Van Kerkhove, the WHO's Technical Lead for COVID-19 and Acting Director of WHO's Department of Epidemic and Pandemic Threat Management, has cautioned that *"the world remains in the grip of the COVID-19 pandemic"* [LW.8/01 - INQ000505887], with ongoing virus evolution and continued hospitalisations, as a consequence of continued health risks. For many of our members the pandemic remains a very real and live issue, and in some cases still curtails their fundamental freedoms. We highlight throughout this statement examples of our members' lived experiences, stressing that those experiences have not improved since 28 June 2022 but remain unchanged to this day. This situation will likely continue unless immediate action is taken to address their needs. We therefore respectfully urge the Chair to consider the impact of the pandemic upon Clinically Vulnerable ('CV') people and their families during the defined period, recognising that for many, those challenges persist, as they did at the height of the pandemic.

4. Throughout my statement, I will be using various terms and abbreviations when describing the population that CVF represent and I set out descriptions of those abbreviations below to assist the reader:

Clinically Vulnerable	is used when referring to the whole group, including the original Covid-19 vaccine priority group 4, group 6, and people aged over 65 as defined in the 2020 JCVI vaccination priority list.
clinically extremely vulnerable ('CEV')	Individuals classified as Group 4 under the original Covid-19 vaccine priority list. These individuals were formally advised to shield due to severe clinical risk.
clinically vulnerable ('CV')	Individuals classified as Group 6 under the original Covid-19 vaccine priority list.
CV families / CV households	Households that include at least one member who is either CV or clinically extremely vulnerable. The CV or CEV member may be a child or an adult.

PART A – Clinically Vulnerable Families

(1) History, purpose, aims, reach and membership of CVF

(a) History and purpose

5. CVF is a grassroots organisation founded in August 2020. It was incorporated as a Community Interest Company (a private company limited by guarantee) on 16 October 2024 with me as the Chief Executive Officer. CVF currently represents those who are CV, those who had been identified as CEV (before this terminology was retired), including people who are Severely Immunosuppressed; and those in their households across all four UK nations.
6. When CVF was founded, children were about to return to schools for the first time following their closure towards the start of the pandemic in late March 2020. At that time, parents were told that schools were safe and that all children must be in school. We were repeatedly told that children did not catch or spread Covid-19 infections but despite that, CVF remained concerned due to the risks posed to CV staff and children in schools and

to other CV close contacts living in households with children who were attending school. This was pre-vaccination.

7. Whilst CVF initially concentrated on risks posed by education, it very quickly broadened its focus to other wide-ranging issues such as safety in workplaces and healthcare and access to Covid-19 treatments.
8. CVF's mission is to support, inform and advocate for those in Clinically Vulnerable households as they face an ongoing threat posed by Covid-19. Our vision is that one day we will have sufficient protections to restore the freedoms of society's most vulnerable.
9. CVF has multiple purposes, and these have evolved since its foundation. CVF primarily aims to support, educate, assist, advocate and campaign for Clinically Vulnerable families in the UK due to the risks posed by Covid-19. To further understand the work of the group I have set out how CVF fulfils its functions below:

a. Support

CVF supports its members, in part through an active social media presence that is firmly rooted in our four core principles:

- (1) To be scientific and evidence based;
- (2) To provide peer support and practical assistance (i.e. drafting letters, helping with other correspondence and communications for our members);
- (3) To address the mental health needs of members by offering weekly check-ins with members; and
- (4) To operate exclusively for the CV and their households.

Through communication with our members, CVF are able to identify and address any additional needs that arise from a member's circumstances, such as the need for legal advice and advocacy.

b. Education

Due to my background, along with a number of other expert members, CVF is able to offer a variety of resources to help its members and actively share good quality scientific publications, with possible interpretations, to help assist members to access the information. This includes, but is not limited to, sharing

how to assess individual risk and advice on how to reduce risk of Covid-19 infection, providing information on eligibility for additional vaccines and antiviral treatment (including advice on any processes involved and commonly experienced difficulties), and regular updates on government policy documents relating to CV families.

c. Assist

CVF aims to identify those members with urgent needs and help them by offering peer support. For example, we have helped members access antiviral treatments within the tight timescales of 5 days by providing basic explanations of how to apply, as well as directly making representations to healthcare professionals and members' MPs in some exceptionally challenging cases. We also help draft letters, correspondence and other communications for our members.

CVF has supported members who have faced fines and/or prosecutions, or have been threatened with the above, for Covid-19 related absences in school. CVF also supports those who are at risk of losing their jobs or being made redundant for Covid-19 related reasons. CVF has assisted members in making requests for risk assessments and reasonable adjustments within school and employment settings.

d. Advocate and Campaign

CVF has, and continues to, work collaboratively with various other charities and organisations pursuing shared and unique goals. The key issues we seek to address include, or have included:

- (1) Reasonable adjustments
- (2) Ventilation standards and air quality
- (3) Safety of indoor spaces
- (4) Access to Covid-19 vaccinations and treatment
- (5) Covid-19 Infection Prevention and Control Measures
- (6) Protection of the right to wear a mask
- (7) Maintenance of test, trace and isolate policies
- (8) Maintenance of Covid-19 data collection
- (9) Inequalities faced by CV children and children in CV households in education
- (10) Recognition of Clinically Vulnerability as a protected characteristic under the Equality Act 2010

10. To date, CVF has driven policy change through various methods. CVF has
 - a. Shared members' case studies with the local and national media;
 - b. Developed and maintained strong links with parliamentarians who have asked questions in Parliament on behalf of CVF;
 - c. Taken part in relevant All-Party Parliamentary Groups ('**APPGs**'), for example, the Coronavirus APPG chaired by Layla Moran MP.
 - d. Joined forces with other campaign and educational groups, such as Covid-19 Bereaved Families for Justice, Clean Air Classrooms, Long Covid groups, and Independent SAGE (for example, in relation to 'The Covid-19 Safety Pledge') CVF has brought its unique perspective to these collaborations, a perspective which is not available from any other organisation;
 - e. Made connections, established awareness, and raised CVF's profile through social media platforms, aiming always for a better future for the CV and their families;
 - f. Contributed to the National Institute for Health and Care Excellence ('**NICE**') appraisal for Evusheld and call for evidence: [LW.8/02 - INQ000408806] is demonstrative of the submissions made by CVF to NICE].
 - g. Advocated against recent changes to the UK's Covid-19 vaccination policy proposed by the Joint Committee on Vaccination and Immunisation ('**JCVI**'), which may significantly narrow eligibility for booster doses and risk excluding many individuals who remain Clinically Vulnerable to Covid-19.
11. More information about the group and the work that we do can be found by accessing CVF's website, images of which can be found at [Exhibit LW.8/03 - INQ000408817].

(b) The CV, CEV, and Severely Immunosuppressed population

12. The names of these some of these groups were created by the government during the early pandemic, along with the term '*shielding*'. These terms have continued to be removed and changed by the government over the period of the pandemic to the current day. Although the term CEV has stopped being used by the government, many who were designated CEV continue to describe themselves as such.
13. The newly defined term *Clinically* Vulnerable remains in active use today. It covers all of those who remain at higher clinical risk to Covid-19 and qualify for vaccines based on those risks. The UK Health Security Agency's "Covid-19: Green book, Chapter 14a"

[Exhibit LW/04 - INQ000408795] states that those clinically vulnerable to Covid-19 are (a) children of any age with severe neuro-disability, severe or profound and multiple learning disabilities or immunosuppression (as defined in table 4), (b) adults who have underlying health conditions leading to greater risk of disease or mortality (as defined in table 3), and (c) those of advanced age.

14. It is difficult to calculate how many CV people in the UK qualify for vaccines, however, we do know that:

- a. In March 2022, *The State of Ageing 2022 Summary* by the *Centre for Ageing Better* [Exhibit LW.8/05 - INQ000408850] estimated that 19% of the population were aged 65 and over. Therefore, for those CV due to age (aged 65 and over) the figure is almost 11 million people.
- b. NICE released guidance, published on 14 June 2023 [Exhibit LW.8/06 - INQ000339319], in which it is claimed that the number of severely immunosuppressed people eligible for Evusheld as 1.8 million. Over the period of the pandemic, the various government lists of CV/CEV and Severely Immunosuppressed have changed. Catherine Little, former Second Permanent Secretary to the Treasury, put the figure at 1.7 million [LW.8/07 - INQ000474557_0053, §200], which was repeated in the closing statement made on behalf of the Treasury [LW.8/08 - INQ000648018]. The APPG on Vulnerable Groups to Pandemics has stated that the government's own figures suggest there are 1.2 million people in this category [LW.8/09 - [INQ000417415-0002]. Furthermore, some people may not be aware of their risk or status.
- c. As stated by the BBC News, '*England on track for vaccinating Covid priority groups*' dated 12 February 2021 [Exhibit LW.8/10 - INQ000408872], the total number of persons identified in the top priority groups in 2020/2021, excluding care home workers, health and social care workers, and those aged 64 and under, but including those aged 16-64 with underlying health conditions, totalled approximately 20.5 million.
- d. It is important to note that these figures exclude CV young people under the age of 16.

15. These individuals have always been at highest risk of poorer outcomes from Covid-19 infection, despite vaccination, and continue to be into the fifth year of the pandemic [Exhibit LW.8/11 - INQ000408828, p.60] as noted on 31 December 2023 by Dr. Maria Van Kerkhove [Exhibit LW.8/12 - INQ000408839]. This is especially true for immune suppressed individuals, some of whom may not mount a response, or an effective

response, to Covid-19 vaccination and therefore remain at incredibly high risk from Covid-19.

16. From the final Office of National Statistics ('ONS') dataset, [Exhibit LW.8/13 - INQ000408875] people who have 'underlying conditions' versus 'healthy people' have a 9.2 times increase in death from Covid-19. People who identify as 'activity limited by health a lot, by health conditions' versus 'healthy people' have a 5.4 times increase in developing Long Covid [Exhibit LW.8/14 - INQ000408796].
17. National surveillance confirms that Covid-19 was not universally "mild" for children. ONS death registrations show that fatalities in the under-18s occurred in every wave. An England-wide linkage study published by the National Library of Medicine in July 2023, reported that between February 2020 – January 2022 there had been 33,597 paediatric Covid-related admissions to hospital [LW.8/15 – INQ000648025]. The article goes on to show that UKHSA's data showed that there were 1,631 hospital admissions of under-5's alone in January 2022. Thousands of children experienced serious post-infectious complications, including Paediatric Multisystem Inflammatory Syndrome ('PIMS-TS'), as explained by the Royal College of Paediatrics and Child Health on their website [LW.8/16 – INQ000648026] and Long Covid, both now recognised in national clinical guidance. These data illustrate that preventable severe outcomes for children were both real and foreseeable, warranting specific safeguards for all children, including those who were in higher-risk categories and households, like all of those that CVF represent.

(c) CVF Membership

18. When shielding was paused in April 2021 and never resumed, CVF extended the offer of support to all CV people and those living in CV households, therefore widening its membership and strategy to incorporate the many more concerns and needs of all CV families and households from across the UK.
19. Our support group is limited exclusively to those in CV households. Entry questions are used to determine whether applicants to the group meet the criteria as outlined in "Covid-19: the green book, chapter 14a" [LW.8/04 - INQ000408795] (or those with household members who have qualifying conditions). At present, the combined membership and following of CVF is approximately at 52,446 and is continuing to grow. The group have a significant online presence, through which most of their work is achieved. As at the date

of the drafting of this statement, there are 2,672 members of CVF's private Facebook group, 13,685 followers on Twitter (now known as X), and 1,125 BlueSky followers.

20. While it is not possible to provide exact figures for the numbers of CV children and children living in CV households within CVF's membership, each member or follower in the figures cited above tends to represent a family or household and we can therefore reasonably assume that CVF's reach is at least three times the number of actual members and followers to account for multiple occupancy households.

PART B - Impact of the pandemic

(1) CVF members concerns and experiences during the pandemic in relation to CV children and children in CV families in educational settings.

(a) School attendance and the impact of government guidance about school attendance

(i) Changing government guidance on school attendance

21. Between May and 31 July 2020, the Government issued guidance 'supporting vulnerable children and young people during the coronavirus (Covid-19) outbreak – actions for educational providers and other partners' [LW.8/17 – INQ000648027] in which it was recognised that clinically vulnerable and clinically extremely vulnerable children, and those who lived in CV/CEV households required additional protections. It stated that, *"Attendance is expected, where it is appropriate for them (that is, where there are no shielding concerns for the child or their household, and/or following a risk assessment)."* Even those not formally shielded, as clinically vulnerable or a member of a clinically vulnerable household, were acknowledged in the guidance where it said *"for vulnerable children and young people [...] attendance is expected unless the child/household is shielding or clinically vulnerable."* This guidance was withdrawn on 4 August 2020.
22. This early guidance was welcomed by CV families, as it acknowledged that the risk to life extended beyond the individual child and included the household. It recognised that school attendance should not be universally mandated and had to be balanced against clinically advised risk, including for those living with any Clinically Vulnerable family members.

23. Guidance published on 2 July 2020 [LW.8/18 – INQ000648028], which replaced that withdrawn on 4 August 2020, set out the Government's guidance for the full re-opening of schools. The tone and substance of this new guidance shifted significantly out of CV families favour. Where the earlier guidance recognised clinical risk, this and all subsequent guidance contrasted and dismissed or denied the risks posed to CV families. The guidance increasingly emphasised enforcement of attendance, with little to no formal support for Clinically Vulnerable children or children living in Clinically Vulnerable households. Attendance was mandatory from September 2020, with the threat of fines for unauthorised absences. Schools were told to be clear to 'anxious' families that pupils must be in school. Yet their list included people facing genuine clinical risks putting them at "significant" increased risk of mortality: children, young people and adults who were Clinically Vulnerable.

(ii) Absence recording

24. Government policy throughout much of the pandemic focused on maintaining physical school attendance wherever possible, which failed to account for the increased risks faced by some children and families.
25. In September 2020, pupil attendance was confirmed as '*mandatory*' in 'Guidance Addendum: recording attendance in relation to coronavirus (COVID-19) during the 2020 to 2021 academic year' [LW.8/19 – INQ000648029]. CV families were legally required to ensure their children attended school, with penalties such as fines and prosecution threatened by schools and local authorities for non-compliance, as if the family were school refusers or taking a term-time holiday. This created distress for CV families, who were faced with high case rates and unsafe school environments lacking effective Covid-19 mitigations.
26. Families described a lack of clear options or safe alternatives. Guidance did not permit absence for the purpose of protecting a vulnerable household member unless the child themselves was formally designated as CEV and instructed by a doctor to remain at home outside of shielding periods. Safeguarding life was treated as non-compliance with attendance policies.

(iii) Absence coding and attendance policy failures

27. The extent to which C&YP in CV families were considered in pandemic preparedness must be assessed not only in terms of health protection and educational access, but also through the lens of administrative systems - particularly school attendance policy. CVF believes these systems were fundamentally unfit for the realities of a public health crisis.
28. Children living in CV households were disproportionately affected by prolonged school absences. These absences were not the result of school 'anxiety' - which was the cause that the government commonly attributed them to (see §285 below, 'Anxious' families), but an effort to protect household members at risk of severe illness or death. Yet the government's preparedness planning failed to anticipate that, during a pandemic some children would need to stay home - not because they were unwell, but because they were at risk or posed a transmission risk to their CV contacts.
29. This was a wholly predictable situation. The existence of multigenerational and households which the Government later defined as CV to Covid-19 has long been recognised in public health literature, social care policy, and emergency planning frameworks. According to Office for National Statistics and Aviva data, around 1.28 million homes in the UK have older relatives living in multigenerational households [LW.8/20 – INQ000648030] Also, a report by the Department of Health titled 'Long Term Conditions Compendium of Information, Third Edition' [LW.8/21 – INQ000648031] estimated 15 million people in England live with long-term conditions (many of which make people CV).
30. These households are not rare, and yet their specific risks were largely disregarded in education policy pandemic planning. Public utilities, such as electricity, gas and water suppliers, have prioritised households identified as having vulnerable occupants to specific service disruptions or emergencies since at least the early 2000s.
31. However, no national framework or administrative tools were developed to support or protect these children left vulnerable in a pandemic situation, or to acknowledge the unique circumstances and challenges faced by families at increased medical risk. This failure had serious consequences. CVF's children faced three bad options:
 - a. Attending school in person, risking the health of vulnerable children or adults in the household;

- b. Maintaining a school place but facing frequent short or long-term absences (generally without teaching), with the risk of fines or criminal prosecution for unauthorised absences;
 - c. Deregistering children from schools entirely (something many schools and local authorities actively encouraged) resulting in the loss of their school place and longer-term access to formal education.
- 32. Coercive practices to remove children contributed to rise in the phenomenon of so-called “ghost children”, a term Robert Halfon MP is credited with coining [LW.8/22 – INQ000648032] although CVF rejects this label as highly distasteful, particularly given the context of a pandemic. These children were not lost; they were not dead; they were excluded by design, through policy choices that denied them essential recognition and protection.
- 33. Vulnerable families reject 'ghost children' absence label Government data showed that 1.6 million pupils were persistently absent across the autumn and spring terms of the academic year 2021-22, up 22.5% from pre-covid times where this was around 10%-11%. ‘Persistently absent’ is defined as missing 10% or more of lessons [LW.8/23 – INQ000648033].
- 34. Further analysis from Arbor (a cloud-based Management Information System (MIS) used by UK schools to manage and analyse data on attendance, behaviour, assessment, and communication) based on 1,500 secondary schools, found that the proportion of pupils missing more than half of their lessons had more than doubled - from 1.68% in 2019 to 3.73% in 2022. In addition, elective home education rose by an estimated 34% during 2020–21, according to the Association of Directors of Children’s Services (ADCS) [LW.8/23A – INQ000560894]. A University of Exeter study of nearly 300 parents found that a lack of support for children missing school led to 7% of those children no longer being on the school roll [LW.8/23B – INQ000650826].
- 35. These data illustrate the scale of systemic exclusion experienced by many families - particularly those in CV households - who were locked out of formal education, especially during periods of ongoing high transmissions risks in schools. See §279 - §284 for further on this, including CVF’s survey data.

(iv) Inappropriate Absence Codes

36. The administrative vacuum created was not merely a technical oversight, but a serious structural failure to consider and include CV households in pandemic travel planning. The lack of a dedicated absence code meant that these children were not only unsupported but rendered invisible in official data. This obscured the scale of need, prevented responsive policymaking, and undermined the ability to support or safeguard children in CV families in future waves or emergencies.
37. With no national framework for recognising CV-related absences or withdrawals, schools were left to make decisions on whether to authorise such absences/withdrawals on a case-by-case basis. Some families found that certain children's absences were authorised but others were not, even where clinical risks were comparable. CVF also found that frequently there was different support offered to different CV families within the same school.
38. Schools lacked the medical expertise to assess individual medical risks in the face of a novel virus. Instead, families were left navigating inconsistent policies within a confusing and unsupported system. This was particularly problematic for families where it was not the child at risk, but a third-party household member. Some headteachers asked for private medical details of family members to be shared before considering whether or not to act to support children on the school roll. Critically, when schools interpreted the government guidance strictly and stated that they simply could not recognise certain risks as valid, children's absences were marked as unauthorised – triggering fines letters carrying legal threats of prosecution, and sometimes inappropriate referrals were made to overstretched children's services.
39. CVF believes that the absence of appropriate coding had real-world consequences. Without a formal mechanism for recognising CV household risk, schools lacked the administrative tools, and were not allocated the funding or resources to appropriately support these children. When local authorities escalated enforcement action, families were effectively punished for being CV and trying to follow medical advice to stay safe. This was not an unforeseeable outcome, as risks related to household transmission were acknowledged in earlier shielding and school guidance. The direct result of failing to integrate the needs of C&YP in CV households into pandemic planning led to not only a forced choice between education and risk to life, but also exposure to legal jeopardy. Families trying to retain their child's school place and access education while formally or informally shielding due to clinical risks faced serious consequences. Many were

threatened with criminalisation under attendance laws (with potential impacts on employment and future careers) and some were referred to social services.

40. The vast majority of families would not have qualified for legal aid, and many were understandably reluctant to face prosecution. As a result, some felt forced to send their children into school despite the health risks, whilst others withdrew from school rolls entirely. CV families paid unfair fines, and a very small proportion took their cases to court in order to defend their decisions.

(v) Code X

41. Code X in England, outside of pandemic measures, is used for non-compulsory school age pupils who are not required to attend school. Where the pupil is absent when timetabled to attend school other absence codes must be used. The code is classified for statistical purposes as “not a possible attendance”.
42. During the peak of the pandemic, Code X was repurposed to mean ‘not attending due to Covid-19 circumstances’ and so absences were excluded from official attendance statistics. This significantly skewed school attendance data, as many children were marked with Code X. Of those, some were not ill but learning from home and otherwise well. The code was to be used when a pupil could not attend school due to reasons directly related to Covid-19, including:
 - a. Self-isolating due to symptoms (awaiting test results);
 - b. Self-isolating due to close contact with a confirmed case;
 - c. Quarantine after travel to a country not on the exemption list;
 - d. Advice from health professionals or clinicians not to attend;
 - e. National or local lockdowns where schools were only open to key worker and vulnerable children;
 - f. Shielding, when formally advised (e.g. CEV children with shielding letters during lockdowns)
 - g. Closure of bubble / class / school for public health reasons.
43. Some of CVF’s families found that Code X was used for longer-term absences, but its application was inconsistent and failed to reflect the unique circumstances faced by CV families. While both Code X and the more general Code I (illness) were used for sickness absences, some of which may have not tested but were also Covid-related. Code X was

often also used for children suffering from longer-term post-viral symptoms. However, there was no clear provision for children absent due to household-level clinical vulnerability, meaning children were left without a relevant or protective remote attendance code.

(vi) Code T

44. There was precedent for recognising the specific needs of a defined group. The "T" code allows for authorised absence from school for children of Traveller families who are required to travel for work. There is an implicit acknowledgement of the legitimacy of alternative arrangement based on family circumstances, without penalising the child or triggering safeguarding processes. The existence of the T code demonstrates that the DfE can, and does, make administrative adjustments to protect the educational rights of children in specific contexts - even in the absence of a threat to life or health.

(vii) Code O

45. In March 2021, DfE guidance was revised to state that children kept home due to 'parental anxiety' about Covid-19 should be marked as an 'unauthorised' absence (Code O). This left CV families, who may have been previously supported in protecting their vulnerable members, at risk of fines and coercion, further isolating them.

(viii) September – Guidance for Full Opening of Schools

46. Further to §21 – 23 above, attendance became mandatory once again from September 2020. The guidance required schools to tell families that pupils legally "must" be in school, including those facing significant clinical risk [LW.8/18 – INQ000648028]. The only formal recognition of risk was limited to those following clinical advice or isolating due to public health advice. For CV families, only on a small number of CEV children who had received shielding letters (and were not removed from the updated list) could receive remote education support and only during periods of (government-determined) formal 'shielding'.
47. CV children were told they should attend school unless advised otherwise by a clinician. There was no mention of how such advice might be sought or recognised, nor any for discretion where families were trying to balance competing risks. In practice, families did try to contact their GPs or consultants for support, but they were often reluctant to provide individual advice that contradicted national guidance. This created significant conflict and

confusion. While a few doctors did offer supportive letters, most did not - and even when such advice was given, it was frequently challenged by schools, some of which demanded repeated updates, and in some cases, independently contacted GPs for further information without parental consent, despite no change in the child's risk or vaccination status.

48. Moreover, the 'reassurances' schools were instructed to offer included explanations about risk mitigation measures like handwashing and cleaning, which were not supported by strong scientific evidence, as presented to the inquiry in Module 3 by expert Prof. Clive Beggs. Covid-19 was recognised as an airborne virus in April 2020 [LW.8/24 – INQ000648034] but initial control measures focused on fomites (transfer of infection via inanimate objects) in schools. Significantly, early schools guidance did not reference airborne transmission, ventilation, or the use of PPE (FFP2 / FFP3) masks. As a result, schools were unable to offer meaningful risk reduction strategies that might have made attendance more viable or safer for children in CV households.
49. In the absence of any meaningful risk assessments or clear protections for vulnerable households, 'reassurances' from schools functioned less as support and more as pressure. There was no recognition of the difficulty for households where a child could not isolate from a shielding parent or sibling. Families were told simply to send children in - regardless of medical advice, household risk, or available mitigations.
50. The decision to remove the earlier recognition of CV household risk from guidance in July 2020 - and to never reinstate it - represents a fundamental failure to uphold the rights and safety of this group [LW.8/18 – INQ000648028]. It undermines any suggestion that children in CV households were not considered as a relevant or distinct cohort as they had been clearly acknowledged in June as requiring protection. Their subsequent exclusion, therefore, cannot be viewed as an oversight but must be recognised as an incredibly harmful policy decision.
51. By removing the existing flexibility during rising transmission and prior to any vaccinations or prophylactic treatments, the government knowingly imposed conditions which forced CV families to choose between a child's education and a household member's health or life. The outcomes were obvious: exclusion, coercion, trauma, and lost lives - all of which were avoidable had the policy continued to recognise CV household risk. It is clear that decisions were actively made to exclude C&YP in CV households from pandemic planning.

(ix) Legal consequences of attendance guidance

52. Under the Education Act 1996, parents are guilty of a criminal offence if their child fails to regularly attend school and can be fined up to £1,000 (sections 444(1) and (8)). They commit a more serious offence if they knowingly fail to cause their child to attend school regularly (section 444(1A)). If found guilty of the latter, parents are liable to a fine up to £2,500, up to 3 months' imprisonment, or both (section 444(8A)). While sentences of imprisonment for the section 444(1A) may be rare in practice, CVF notes that the applicable sentencing guidelines require a high-level community order to be imposed in the most serious cases. Parents convicted of either section 444 offence can also be given a parenting order for up to 12 months which may require attendance at parenting programmes, or any other requirement the court considers desirable in preventing a further offence. The resulting criminal record has long-term implications for parents' employment, housing, travel, and DBS checks.
53. In CVF's experience, families who kept their children at home for legitimate medical reasons (such as shielding a high-risk parent), or for short-term absences due to high Covid-19 case rates, were threatened with fines or being criminalised unless the school or local authority accepted the absence as authorised. In many CVF members' experiences, the absence was not authorised and in one case a clinically vulnerable father was fined for keeping his daughter at home after coronavirus cases were confirmed at her school [LW.8/25 – INQ000648035] CVF members consistently reported that school attendance guidance was applied rigidly, with little consideration of individual risk or even specific clinical advice.

Case Study A – Court Action for Historic Non-Attendance

The parents of clinically extremely vulnerable twin boys kept their children out of school during the emergency phase of the pandemic due to serious health concerns. Both boys have an incredibly rare chromosome disorder known to cause multiple complex health conditions, including epilepsy, hydrocephalus, and asthma. The condition can also impact immune function. Based on medical advice, the boys were formally identified as CEV, and the family received shielding letters from the Government. They chose to homeschool until it was considered safer for the boys to return.

In April 2022, following full vaccination, the twins returned to school. Despite this, in December 2022 - eight months after their return - the family received notice they were being taken to court by their local authority for historic non-attendance.

The case was withdrawn the evening before the scheduled court date, following legal support and intervention from their MP. Throughout, the parents had maintained regular contact with the schools, proposed reasonable safety measures (initially accepted, later withdrawn), and provided consistent home education. The boys were both disabled and attending special schools, and their parents had taken every step possible to protect and reintegrate them safely into education.

(x) Practical consequences of attendance guidance

54. For CV families, prosecution letters often meant forced deregistration. To avoid prosecution, many parents were advised (or pressured) to remove their child from the school roll. This led to loss of school places, including specialist or competitive places that were extremely difficult to access again at a later date. Some children were removed from school rolls without adequate alternative provision.
55. Parents faced overwhelming stress, not just regarding lives and health, but of legal action - often receiving letters threatening fines or court hearings. Those unable to support or afford alternative options, experienced prolonged educational disadvantage or emotional stress due to potential exposure in high-risk settings. Some children internalised guilt for "causing" legal problems.

Case Study B – Prosecution for Non-Attendance

A clinically extremely vulnerable mother, a clinically vulnerable father and their three children faced heightened Covid-19 risks. Two of the children were vulnerable due to additional medical needs: one has an airway disorder, another needs immunosuppressant medication.

When national restrictions were lifted the two eldest children did not return to school because of the danger an infection could pose to the whole household. The parents supplied the schools with doctors' letters confirming the family's medical status, yet were told by one headteacher, "I am not a doctor," and offered no alternative teaching, remote provision or GCSE preparation for their eldest child.

The local authority initiated a prosecution for non-attendance. On the first day of the hearing the local authority failed to appear and had not informed the parents. The case was dismissed. Despite this, the family were warned they could face further prosecutions if attendance did not resume, so they felt compelled to withdraw both children and educate them at home.

The eldest child prepared for GCSEs without professional teaching or exam access and was ultimately unable to sit any papers.

(xi) Elective Home Education (EHE)

56. From 2020, many CV families turned to EHE as a last resort. There is no statutory requirement for parents to inform their local authority of their reasons for choosing to electively home educate, and no requirement for local authorities to formally record or report on this. However, the Association of Directors of Children's Services ('ADCS') attempted to gather such information as set out in their '*Elective Home Education Survey 2021*' published in November 2021 [LW.8/23A – INQ000560894].

57. While health-related reasons were not always recorded in detail, the ADCS data showed "health concerns relating to Covid-19" as the most frequently cited reason, with 90% of local authorities placing it in their top three. There was a rise in "health/emotional health" reasons from 54% in 2020 to 73% in 2021 which coincided with the removal of shielding and key mitigations in schools. In the ADCS '*Elective Home Education Survey 2020*' published in November 2020, Local Authorities reported that:

"Parents are anxious about the health and safety of their children at school and opting to home educate to avoid challenge over non-attendance. Parents routinely state that their children would be in school if it were not for Covid-19 and that they plan for their children to return 'when it's all over.'" [LW.8/25A – INQ000643146].

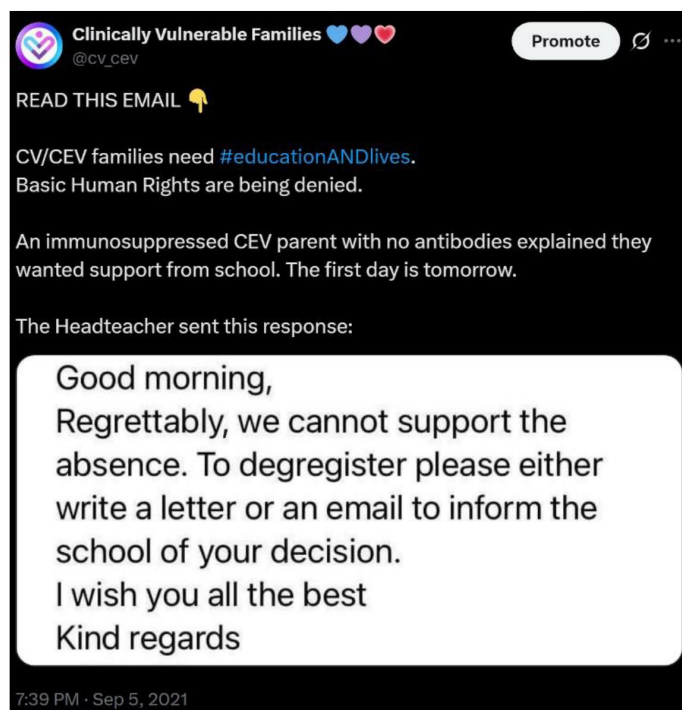
58. Confirming that these were temporary decisions driven by health risk, not philosophical choices. Entire families were often withdrawn to protect vulnerable household members, particularly in disadvantaged or ethnic minority households, which were more likely to be multigenerational and include Clinically Vulnerable people.

59. "We have seen an increase across both primary and secondary schools, with more young people who are eligible for free school meals and with previous social care involvement at some time in their life and more recently from BAME communities. Since September we are seeing more family groups becoming EHE, rather than individuals."

60. The data clearly show that local authorities knew CV families, including otherwise vulnerable children in equality groups were being forced into EHE for safety reasons - yet no action was taken to address the underlying cause, the lack of safe, accessible education.

(xii) Prioritisation of In-Person Attendance

61. The email quoted below in figure 1 represents a common response from headteachers to CV families who sought permission to keep their child at home due to health risks.



[Figure 1]

62. This brief message is revealing. It reflected a systemic failure to engage with families' legitimate health concerns and an abdication of responsibility to offer safe or inclusive alternatives.

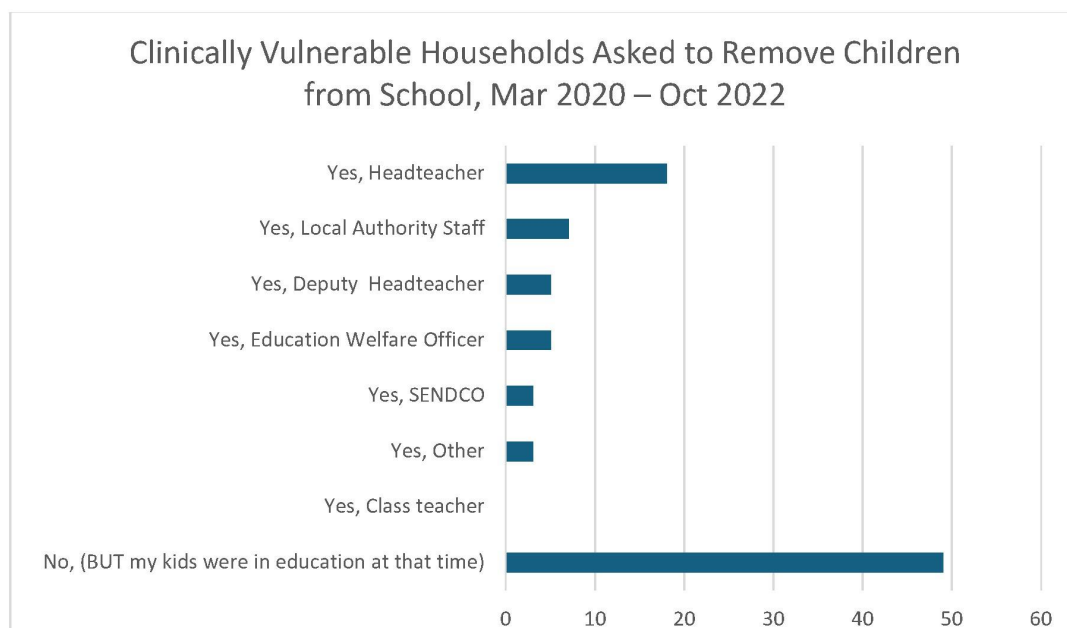
63. Several key issues are embedded in this type of correspondence:

- a. **Pressure to deregister:** Rather than offering flexibility or discussing reasonable adjustments - as required for disabled people under the Equality Act 2010 - the school instructed the parent to remove the child from the roll altogether. CVF

believes that this amounted to a form of coerced off-rolling, leaving families without educational support.

- b. **Lack of empathy or safeguarding:** The letter ignored the fact that the family was navigating extreme health vulnerability. There was no recognition of legal protections for CV families, nor of the need to safeguard those children's rights.
 - c. **Loss of access to school resources and support networks:** Parents (sometimes with serious health conditions) took on the full responsibility of home education despite sometimes lacking means to do so effectively.
 - d. **Emotional toll:** These interactions sent a harmful message to children and parents that their safety needs were not a priority.
64. Whilst the vast majority of schools did not tend to communicate in writing (perhaps because they did not want their responses to be recorded), the outcomes were frequently identical. CVF parents consistently reported:
- a. Phone calls from headteachers or senior staff pressuring them to withdraw their children if they could not attend in person;
 - b. Unannounced home visits ("doorstepping") by school leadership, which placed families under emotional and psychological pressure to deregister; and
 - c. A total absence of written guidance supporting safe reintegration or continued access to learning, once deregistration was enacted.
65. Many parents described experiences which appeared to be coerced off-rolling, under duress and without any recognition of their rights to safety, support, or educational provision. These conversations were often framed as "your choice" - yet their choice was within the context of serious risks: of potentially fatal infections, of legal sanctions, and of loss of access to the education system.
66. This pattern was generally difficult to document, but it was repeatedly and consistently described by many CVF members. CVF are concerned that this systemic failure to make education accessible and safe for children in CV families highlights the urgent need for accountability not only for schools' formal policies, but also for their informal practices.
67. A CVF poll of 198 members carried out in October 2022, as seen in figure 2 below, identified a wide range of staff involved in these discussions since 2020, including Headteachers, Senior Leadership Team ('SLT'), Local authority staff, and SENDCos. CVF polling has consistently found that around half of CV families were asked by schools or

local authorities to consider withdrawing from formal education. No suitable alternative was offered.



[Figure 2]

68. The rigid attendance policy disproportionately harmed families who were already at risk. Further, it reveals a gap between policy rhetoric about “supporting vulnerable children” and the lived reality of exclusion and abandonment of those children most vulnerable to the virus itself.

Case Study C – Hampshire County Council

Hampshire County Council issued internal guidance allowing authorised absences if attendance would “*endanger the life of a [...] household member.*” The guidance resulted from a legal intervention at a fines panel hearing. An immunosuppressed CVF member who had removed her children from school, represented by the Public Interest Law Centre (‘PILC’), was unfairly issued with fines. The guidance was never publicly disseminated and therefore many families in Hampshire would have been unaware of its existence.

The document was titled “*School Communication regarding children with parents who are Clinically Extremely Vulnerable*” but the content itself was applicable to all families with vulnerable members, referencing both the child and household risk.

School Communication regarding children with parents who are Clinically Extremely Vulnerable (CEV)

The Department for Education (DfE) guidance states that attendance is mandatory unless a child is deemed Clinically Extremely Vulnerable (CEV) even if a family member is CEV.

Schools have been working hard to build parental confidence in sending their child to school under these circumstances. However, there have been a few cases which have put the school and/or parents in a very difficult position. In these cases, pupils who were not attending school (as they had a household member who was CEV and it was considered by the family to be too great a risk) were being recorded as having unauthorised absence.

The guidance states that the usual powers of intervention such as warning notices, penalty notices and prosecution remain in place as sanctions that can be accessed. However, following a number of individual cases that have come to our attention, we are amending our advice to headteachers as follows:

- Consideration needs to be given on a case by case basis
- Consideration should be given to any safeguarding concerns in respect of the child
- If a parent provides a consultant level letter, clearly stating that the attendance at school of a child in the household would endanger the life of a parent/sibling/member of that household through the transmission of Covid-19, the absence should be recorded as authorised (code X: not attending in circumstances relating to COVID-19)
- In the above circumstance, remote learning should be made available
- Arrangements should be reviewed on a weekly basis, taking into consideration DfE guidelines which may change.
- Where parents have already removed their child from roll to electively home educate (EHE) due to this reason, schools should contact the parents to explain the change of approach. The school should also inform EHEhampshire@hants.gov.uk if a pupil is re-admitted to the school roll.
- Attendance registers can be retrospectively changed from the start of the autumn term to reflect the amendment to advice given by the LA.
- If Penalty notice warning letters or Penalty Notices have been issued, these need to be withdrawn.
- If schools have any questions or require clarification please contact: attendance_queries@hants.gov.uk

The very existence of this document is significant. It explicitly acknowledges the risk to life posed by schools, the need to support children in vulnerable families by providing remote education, the need to withdraw unfair penalty notices, and the recognition that school places should be reinstated if such families deregistered for safety. Yet, the Department for Education continued to fail to ensure that all at-risk families received these same protections. The fact that such critical guidance was only used locally, kept internal, inconsistently applied, and was reliant on individual headteacher discretion highlights a systemic failure to protect the human rights of CV households. In CVF's view, the update should have been made to national guidance, given its important implications to the safety and rights of CV families.

(b) risks to CV people when a child in the household was attending school

69. Once schools reopened in autumn 2020, government guidance implied attendance was safe for all children - failing to address the fact that CEV children were exposed when shielding was paused (as it was in September 2020), CV children were never shielded, or the fact that healthy children sometimes lived in households with high-risk people.

70. Temporary shielding guidance was only focused on individuals designated as 'clinically extremely vulnerable' and only applied during limited periods determined by whenever the NHS was considered by the government to be under the most significant pressure. However, it failed to identify or address the high-risks posed by children attending compulsory education whilst living in CV households.
71. A major population-based study, 'Smart Thermometer-Based Participatory Surveillance to Discern the Role of Children in Household Viral Transmission During the Covid-19 Pandemic' published in JAMA Network Open in June 2023 (using data collected between October 2019 and October 2022) [LW.8/26 – INQ000648036] found that household transmission from children to adults occurred at a high rate. Among inferred household transmissions involving both adults and children, 70.4% had a paediatric index case. Younger children (0-8 years old) were more likely to be the index cases for an inferred household transmission than older children (9-17 years old). Transmission rates from children were notably higher when schools were in session, supporting a link between school attendance and household spread.
72. The UK government did not acknowledge or address airborne transmission in schools during this time. Masks, or even 'face coverings' were not recommended for either children or staff in primary schools, and not even required for secondary pupils until later, despite growing international recognition of the importance of masking in reducing aerosol spread.
73. The refusal to recognise children as potential vectors of transmission, and education settings as sites of exposure, reflected a dangerously limited model of risk. This failure meant that basic airborne mitigations - such as masking and ventilation - were not implemented. As a result, children in Clinically Vulnerable families in the UK were left unprotected and exposed to unnecessarily high risk, as other nations acted to reduce airborne transmission in schools.
74. In the absence of government guidance to address the specific risks faced by children in CV households, I provided early support to CVF members by publishing a pinned Facebook post [LW.8/27 – INQ000648037] outlining how to make informed decisions around school attendance. The post focused on risk assessments, risk mitigation strategies, decisions surrounding homeschooling, and advice in the case of suspected infection. It was regularly updated as new scientific evidence emerged.

75. The guidance CVF provided to its members aimed to empower families navigating compulsory education requirements while living with health vulnerabilities, and to fill the information void left by official channels.
76. CVF members consistently reported that school attendance created serious and often unmanaged risks for CV people. Children from CV families were expected to attend school alongside their peers even when significant infection risks remained. Families reported that schools rarely, if ever, recognised the additional risks posed by a child potentially bringing Covid-19 home to a vulnerable parent, sibling, or grandparent. One family described the stark situation our families commonly faced:

Quote 1 from CVF Member

"We had anticipated that our daughters would be able to mask in school and that fresh air arrangements would be in place. Instead, in late July 2020, our school wrote to all parents: 'Following the recommendations from Public Health England we are asking students to not use face coverings in school.' We found ourselves in the impossible position of having to choose between our family's health and our daughters being able to attend school. [...] We were told that the government's position was all children back 'with no ifs or buts,' with no flexibility for CV families. Masking was dismissed as 'covid anxiety,' and we were told either to accept the lack of infection control or deregister. We were threatened with prosecution until our GP signed both our children off due to the safety risk. We began homeschooling in October 2020 with the hope of returning once our household had been vaccinated and children were supported to mask safely. Unfortunately, our school did not agree, and both my children were unlawfully off-rolled in spring 2022. Both children were effectively excluded from school for being part of a CVF and had no state educational provision for the academic years 2020/2021 and 2021/2022."

Nicky, 53, parent

77. Shielding families who battled to stay out of school were frequently denied remote education as a reasonable adjustment. This refusal left families isolated and unsupported, despite clear evidence that infection levels remained high:

Quote 2 from CVF Member

"School kept telling us they couldn't authorise absence or provide work. [...] Even when they knew cases in school were high, they were not supportive. We were placed under great pressure, with them agreeing to authorise for a while and then refusing, us providing evidence and repeating this cycle. Which caused huge stress for us as a family during a time when we should have been able to focus on health and support education at home."

Chris, 41, parent

78. Even children who were formally recognised as CEV and required to shield were often denied access to remote learning, due to practical challenges within schools. At the same time, however, remote learning was supposedly being offered to children infected with Covid-19. Many schools were experiencing high staff absence and operational pressures, but there was no national plan in place to ensure continuity of education for shielding pupils.

Quote 3 from CVF Member

"When denied remote learning due to [our CEV child] shielding, this was really frustrating. School said they couldn't do it as they didn't have the staff available."

Dora, 39, parent

79. Families often described being forced into decisions that placed their family's health, finances and children's learning at unacceptable risk:

Quote 4 from CVF Member

"We could not afford to not work or keep the children at home. [...] We understood the value of learning and them seeing their friends. However we as parents were acutely aware that sending them back to school meant their mother was risking her life."

Lenka, 36, parent

80. While many families faced significant pressure to return children to school despite ongoing health risks, a small number reported that individual headteachers demonstrated understanding and flexibility, even when national guidance did not adequately support CV families. In some cases, school leaders made efforts to prioritise the health and safety of vulnerable households, against attendance pressures, in order to protect their school communities.

Quote 5 from CVF Member

"We were lucky to have a very understanding headteacher who allowed our son to stay at home until we were all vaccinated. [...] The government guidance was definitely not helping and we would have been in trouble with the LA if it wasn't for our considerate head of school who was willing to help us knowing we are a CV family."

Maxine, 48, mother

81. Risk mitigation within schools was inadequate and transmission was high. Despite growing understanding of the airborne route, many schools relaxed mask policies and removed infection prevention measures, even when requested by CV families.

Quote 6 from CVF Member

"There was no effective infection control in schools. Children could never distance, and this was of little help for an airborne virus anyway. Bubbles were not effective as if a child with siblings caught the virus it was never just the one bubble affected. Masks were initially worn by adults, but they were of poor quality generally and worn intermittently. There was little ventilation in school, and no mention of CO2 monitors or filtration." Cath, 39, parent

82. Families with children in school found themselves engaged in a cyclical "dangerous dance" - with children in school one day, out again with symptoms the next. Periods where children were identified as "close contacts" and sent home created a strange mix of stress and brief relief before being forced back into unsafe environments. This cycle disrupted education continuity and worsened family stress. They described this pattern as exhausting, emotionally disruptive, and ultimately unsustainable.

Quote 7 from CVF Member

"My secondary-aged children were very cautious and aware of our risks. At any sign of Covid, we would immediately stop everything, pull the siblings out of school - the child with symptoms would isolate in their room with 'room service' and they could all join online lessons. Then we would drive with the windows open to the nearest test centre, waiting anxiously for the results. When the tests were negative there was a brief period of celebration, rapidly followed by the sinking realisation that they all had to return from the safety of our sanctuary back into unsafe school classrooms. As we were not prepared to spread the infection our family was in and out of school on a regular basis. We all found the experience incredibly emotionally wearing."

Ben, 45, parent

83. Government guidance framed school-based risks around the health status of the individual child, rather than considering the risks to their household contacts. This failure to account for household vulnerability - or to guarantee CV families support of shielding, remote education, or effective infection control measures (such as enhanced ventilation and FFP2 minimum masking) - left many families isolated, unsupported, and at an avoidably elevated risk.

(c) Infection prevention and control measures within primary and secondary schools, including face-coverings and ventilation

84. CV families reported that their needs were overlooked in the government's education response to the Covid-19 pandemic. Despite clear scientific evidence about airborne transmission and the heightened risks to CV people, schools were not consistently required - or funded - to implement effective mitigation measures. This key issue caused many CV families to be choose between health and education.

(i) Lack of Targeted Protections

85. While schools implemented some general measures in the name of IPC (e.g. hand hygiene, cleaning, bubbles), they did not meaningfully reduce airborne transmission – which was the primary risk. Suitable mitigations including supplementing ventilation with air filtration, consistent mask use, and remote learning were rarely offered.
86. CVF members, ranging from ventilation experts to school teachers and parent-campaigners, created a rolling set of template letters [LW.8/28 – INQ000648038] to support families to insist on reasonable adjustments when official guidance fell short. The earliest notes (winter 2020-21) politely asked headteachers for an individual Covid-19 risk assessment, continued remote lessons and open-window seating for children in CV families. As airborne transmission became undeniable, later drafts pressed schools to monitor CO₂ and keep levels below 800 ppm, with at least 10 L s⁻¹-person fresh-air flow. When some schools still resisted, CVF created escalated letter templates to local authorities and MPs that invoked health and safety law, called for fines to be suspended until ventilation was fixed, asked for HEPA-filter funding, vaccine access and a legal right to remote education. The purpose of these template letters was to give families a clear, step-by-step pathway to secure the protections that government guidance had failed to guarantee.

(ii) Ventilation

87. From the earliest stages of the Covid-19 pandemic, ventilation was recognised by scientific advisors - SAGE Environmental and Modelling Group ('SAGEEMG')- as a critical component of infection control, particularly in high-occupancy indoor spaces such as schools, as set out in a paper by SAGEEMG, 'Environmental Influence on Transmission' based on evidence available as at 26 April 2020 [LW.8/24 – INQ000648034]. Despite this, the UK government's response to ventilation in educational settings was marked by inconsistency, delay, and underinvestment. Annex A provides a timeline that tracks the evolving approach to ventilation, air filtration, and CO₂ monitoring in schools from March 2020 through to the implementation of the "Living with COVID" policy in April 2022, and beyond.
88. For CVF, the government's handling of ventilation in schools reflected a failure to prioritise the needs of those most at risk. While scientific advice from SAGEEMG consistently emphasised the role of ventilation, air filtration, and CO₂ monitoring in reducing airborne transmission, these tools were never scaled up meaningfully or implemented equitably.
89. Air filters were the only viable mitigation for poorly ventilated spaces but they were provided in extremely limited numbers. CO₂ monitoring was not accompanied by any actions or revised standards and was ultimately quietly dropped under "*Living with COVID-19*" guidance. CVF members who attempted to mitigate risk themselves by offering to supply air filters as a reasonable adjustment often met resistance or rejection from schools due to a lack of understanding, as evidenced by this media story where schools were rejecting offers of air filters and some families said that purifiers were turned down by heads who were prioritising cleaning and open windows in absence of Department for Education guidance [LW.8/29 – INQ000648039]. In some cases, devices were redirected away from the vulnerable children who had supplied them entirely.
90. The withdrawal of all targeted Covid-19 mitigations in April 2022, including ventilation-specific guidance and active CO₂ monitoring, marked a turning point that left families feeling abandoned. For CVF, this was not just a missed opportunity; it represented a sustained failure to protect their rights to equal access to education during a major public health crisis. The continued lack of investment in clean air for schools remains a source of deep concern for those with health conditions living with elevated risk.

(iii) 'Face-coverings'

91. Throughout the peak of the pandemic, government policy on 'face coverings' and masks in schools was inconsistent and reactive, failing to align with scientific understanding of airborne transmission.
92. In June 2020, early government guidance referenced both "face coverings" and "medical masks" [LW.8/30 – INQ000648040] - but the messaging was far from supportive. Instead of encouraging protective use where appropriate, they focused on discouragement:

"Face coverings (or any form of medical mask unless instructed to be used for specific clinical reasons) should not be worn in any circumstance by those who may not be able to handle them as directed (for example, young children, or those with special educational needs or disabilities) as it may inadvertently increase the risk of transmission."

93. Initially, as written by the Department for Education ('DfE') in their blog on 27 July 2020 [LW.8/31 – INQ000648041], the DfE advised against 'face coverings' in schools, even though 'face coverings' were mandatory in all other indoor public spaces at the start of the 2020 school year– creating a confused double standard for families and staff, and a problem for CV families. They advised against the use of face coverings in schools, citing speculative concerns about potential negative impacts including increasing transmission, communication and learning:

"Public Health England does not currently recommend the use of face coverings in schools as pupils and staff are mixing in consistent groups, and because misuse may inadvertently increase the risk of transmission. There may also be negative effects on communication and thus education."

94. They then partially U-turned on 25 August 2020, giving secondary schools the discretion to require face coverings in communal areas. The DfE stated in a blog published on 25 August 2020 [LW.8/32 – INQ000542935]:

"Nationwide, while the government is not recommending face coverings are necessary, schools will have the discretion to require face coverings in communal areas if they believe that is right in their particular circumstances."

95. Guidance entitled “Face coverings in education”, issued on 26 August 2020 [LW.8/33 – INQ000648043], expressed unfounded concerns about the use of face coverings in classrooms, claiming:
- “Face coverings can have a negative impact on learning and teaching and so their use in the classroom should be avoided.”*
96. This early framing, without any scientific basis, influenced school leaders and teachers - embedding a resistance to masks that has persisted well beyond 2020. CVF members found that a negative view seemed to permeate school policy.
97. During England's second national lockdown, which started on 5 November 2020, the UK government updated its guidance [LW.8/34 – INQ000648044] to mandate that face coverings be worn in communal areas of all secondary schools and further education colleges across the country. The updated guidance specified that:
- “Face coverings should be worn by students and staff in secondary schools and further education colleges in communal spaces, outside of classrooms, where social distancing cannot be maintained.”*
98. CVF members were both confused and concerned by the government's decision not to require PPE masks (or indeed non-PPE ‘face coverings’) in classrooms - the very settings where children and young people (‘C&YP’) spent the most of their time in densely populated, enclosed spaces. Government advised secondary school pupils to wear masks in corridors and communal spaces, when local risks were high and not recommended in classrooms “where protective measures already mean the risks are lower, and where they can inhibit learning” as set out in an update by the DfE in August 2020 [LW.8/32 – INQ000542935]. This was not only inconsistent but also ignored the risks to C&YP in CV families. Bizarrely, contact tracing in schools was focused on classroom contacts, recognising those risks, yet non- classroom areas like lunch halls - where masking and distancing also could not be observed - were excluded from tracing.
99. It was not until March 2021 that masks were temporarily recommended in secondary school classrooms. The measure lasted just two months before being dropped in May, despite rising concerns about new variants.
100. However, the March 2021 guidance also introduced more nuance [LW.8/35 – INQ000648045]. On page 6, schools were reminded of their legal duty to make reasonable adjustments under the Equality Act 2010, which should have supported pupils needing to

wear face coverings as a protective measure – including those in CV households who may have been covered under disability. Yet, this was followed by:

“No pupil should be denied education on the grounds that they are not wearing a face covering.”

101. This guaranteed the right to education for any child or young person who did not wish to wear a mask, regardless of their reason, unrelated to their need for reasonable adjustment, and did not require any evidence. It was an absolute right. However, no equivalent assurance was in place for those who needed to wear one.
102. This guidance created a contradiction when compared to government policy for other public indoor settings, where adults and children over the age of 11 were legally required to wear face coverings unless medically exempt - and could be refused access to a service, or directed to leave a service. Police were empowered to instruct those responsible for children aged 11 or older to ensure that they followed the regulations as set out in the Health Protection (Coronavirus, Wearing of Face Coverings on Public Transport) (England) Regulations 2020 Volume 804: debated on Wednesday 8 July 2020 [LW.8/36 – INQ000648046]
103. In schools, the opposite applied: a healthy child could not be excluded for refusing to wear a mask, but a child in a CV household could be for choosing to wear one, despite their need for reasonable adjustments.
104. On 2 January 2022, at the height of the Omicron wave, the Education Secretary Nadhim Zahawi, temporarily re-introduced masks in secondary classrooms to keep schools open but simultaneously launched a survey asking heads for examples where face coverings had “harmed learning or wellbeing”. Masking was dropped again from 27 January, and schools that continued voluntary masking were warned they might face DfE intervention as evidenced in this media article where Nadhim Zahawi is reported to have said that schools should not defy orders to drop face masks for children in classrooms [LW.8/37 – INQ000648047].
105. As Mr Zahawi had sought evidence of harms to justify permanent removal, CVF asked members for their evidence of the benefits of masks. 150 members replied describing masks as an enabling tool that safeguarded health, attendance and mental health:

- a. Well-fitted (KN95 / FFP2/3) masks helped pupils avoid infections, absences, and teaching staff shortages. Many families reported 100% annual attendance since masking, compared to their classmates who were frequently absent due to sickness.
 - b. Children in CV families were able to return to school safely. For high-risk families a child's mask at school is the first, and often only, line of defence against airborne infections.
 - c. Feeling safer let children focus on lessons. Several said they learned better when everyone is masked, because they are not worried about infection risk.
 - d. Universal masking stopped children from being bullied or pressured to remove masks.
 - e. Masks were viewed as a lesson in citizenship, empathy and "doing your bit".
 - f. CVF members, including parents of autistic pupils, those with speech or communication needs, reported stable or improved academic progress while masked.
106. Primary school pupils were never included in mask guidance, and many schools discouraged voluntary mask use - even including those children aged 11, who were otherwise required to wear face coverings in public indoor settings. This left CV families without any opportunity for meaningful protection. Many children, young people, and adults were denied the right to wear masks, or stigmatised for doing so, while others were forced to deregister or accept unsafe conditions.
107. Policy gaps resulted increased risk for CV families, and undermined their confidence in the school environment as a safe and inclusive space. To this day, many CV families (including teachers) report continued resistance to voluntary masking in schools, raising serious concerns about the right to protect yourself whilst attending compulsory education.

(iv) Testing and Isolation Guidance

108. The following timeline outlines the changes in testing and isolation guidance for C&YP:
- **March 2020:** Initially, all individuals who tested positive for Covid-19 were required to self-isolate for 14 days, this was in line with early understanding of the virus's incubation period, as confirmed in a blog by the UK Health Security Agency dated 20 February 2020 [LW.8/37A – INQ000650828].

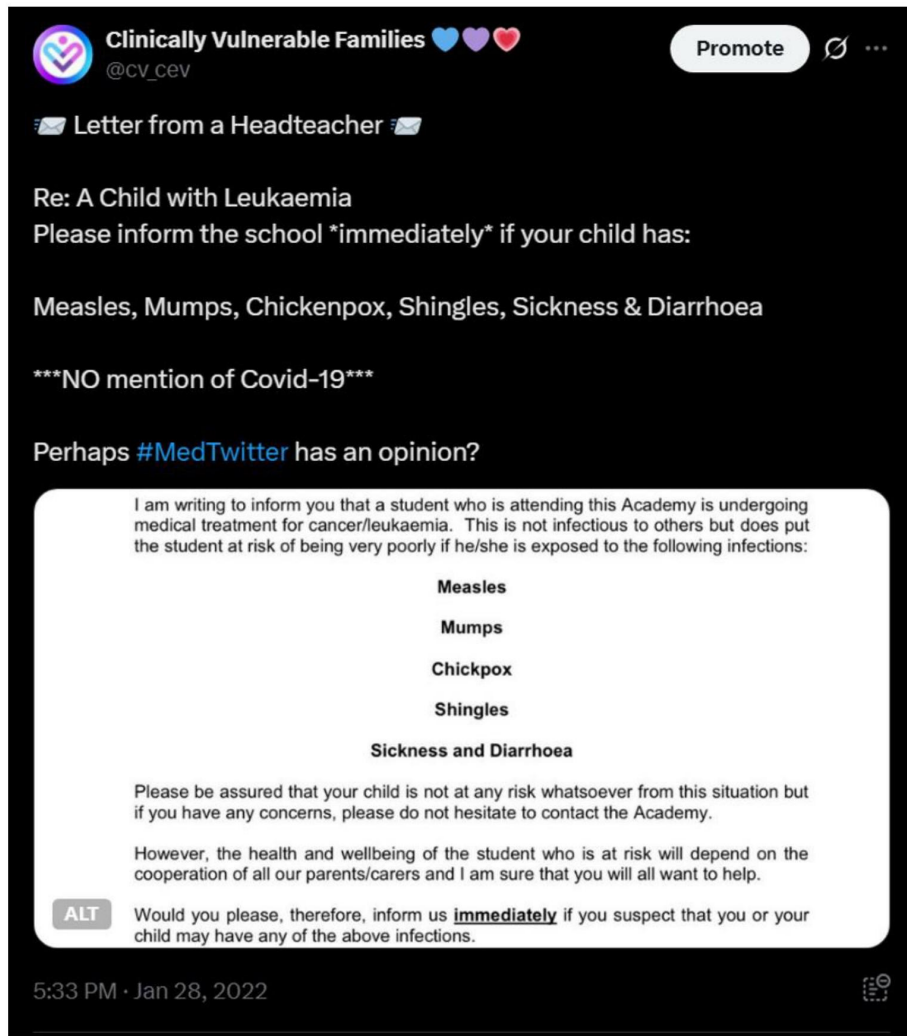
- **14 December 2020:** The isolation period was reduced to 10 days for those who tested positive, reflecting updated scientific insights into the infectious period as set out in an announcement by the Department of Health and Social Care [LW.8/38 – INQ000648048].
- **16 August 2021:** Children were exempted from having to self-isolate if they were a 'close contact', despite the vast majority of children not being vaccinated as set out in The Health Protection (Coronavirus Regulations) (Self-Isolation) (England) (Amendment) Regulations 2021 [LW.8/39 – INQ000648049].
- **30 November 2021:** The exemption was temporarily suspended due to concerns about the Omicron variant. During this period, all close contacts of suspected or confirmed Omicron cases, including children, were required to self-isolate for 10 days, as confirmed in a press release by the Government published on 28 November 2021 [LW.8/37B – INQ000650829].
- **December 2021:** The exemption was reinstated. Self-isolation could be reduced to 7 days, if they had tested negative using lateral flow tests consecutively on days 6 and 7, as reported by the BBC [LW.8/40 – INQ000648050].
- **Updated 15 February 2022:** Guidance for households with possible or confirmed coronavirus infection permitted an end to self isolation after 5 full days, following two consecutive negative lateral flow test results taken 24 hours apart and if the person was fever free [LW.8/41 – INQ000089748].
- **April 2022:** Testing of symptomatic children was not recommended, even if they were living with someone who had tested positive. They should only test on the recommendation of a health professional as set out in the Government's guidance on people with symptoms of a respiratory infection including COVID-19 [LW.8/42 – INQ000648052]. If the child or young person had been recommended to take a test, they were advised to isolate for only 3 days as the guidance made clear:

"If a child or young person has a positive COVID-19 test result they should try to stay at home and avoid contact with other people for 3 days after the day they took the test, if they can. After 3 days, if they feel well and do not have a high temperature, the risk

of passing the infection on to others is much lower. This is because C&YP tend to be infectious to other people for less time than adults.”

However, a 2023 study in ‘Clinical Infectious Diseases’ [LW.8/43 – INQ000648053] found that 75% of children were non-infectious by 7 days, with 10% remained infectious at day 10 - challenging UK guidance that advised just 3 days of isolation for children. The authors concluded *“These findings support the consideration for infection prevention and control interventions for up to 10 days.”*

109. CVF were alarmed by the steady reduction in isolation periods for children – eventually down to just 3 days, and with restrictions on testing - despite limited vaccination in children and the lack of scientific evidence to support the changes. By April 2022, even symptomatic children were most commonly not tested, and schools enforced returns after three days, calling parents and even sending out school minibuses to collect children, despite evidence suggesting that the majority of those children would still be testing positive.
110. Without even the opportunity to test, evidence-based isolation periods, or other mitigations in place, CV families were exposed to unnecessary risk. The government’s approach prioritised school attendance of the unwell few over the health and safety of the many, leaving our vulnerable children and households exposed unreasonably.
111. Schools routinely issue letters alerting parents to head lice – a mostly harmless condition – encouraging parents to treat their children. Yet, even when children were symptomatic for Covid-19 they were not allowed to test, and the few who tested positive were expected to return after just 3 days. For CVF, there was a stark inconsistency in how schools addressed low-risk vs. high-risk health threats.
112. This disconnect extended to how individual risk was treated. In this example from 2022 (following “Living with COVID-19”), a CVF member shared a letter, shown at figure 3 below, asking parents to immediately report if their child had measles, mumps, chickenpox, shingles, or sickness and diarrhoea - in order to protect a pupil undergoing cancer treatment for leukaemia. Covid-19 was notably absent from the list, despite its high transmissibility, high prevalence, and known risk to immunocompromised people.



[Figure 3]

113. This sent a troubling message to parents: that they were not expected to test for Covid-19 or inform the school of infections *even when another child's life could be at risk*. It implied that Covid-19 was no longer considered a threat, despite evidence to the contrary.

(v) Other Measures

114. CVF members supported the suspension of high-risk group activities such as assemblies, choir, and indoor PE, which were shown to increase airborne transmission. However, many of these resumed prematurely without appropriate mitigations. When official protections were withdrawn, families were left to take matters into their own hands - often having to implement their own precautions or negotiate with schools for reasonable adjustments.

Quote 8 from CVF Member

"Increased precautions at home - masks if someone was unwell, regular testing, ventilation, showers when returning home after school. Masks at school."

Ainsley, 39, parent

115. However, not all schools were supportive or willing to accommodate their requests.

Quote 9 from CVF Member

"The school refused our reasonable adjustment requests of ventilation and permission to wear a mask. The headteacher suggested we return our child immediately or home educate."

Rhian, 38, parent

Case Study D – Denied Education for Wearing a Mask and a School's Reluctance to Accommodate

In the spring of 2021, a CVF child in Year 6 chose to wear a protective medical mask at school because they understood the risks of bringing Covid home to their clinically extremely vulnerable parent - someone they had previously seen hospitalised and placed on a ventilator during a prior infection. Despite this, the child was repeatedly targeted by staff and asked to demask.

During an important progress test, following their return, four different adults removed the child from the class to ask them to take off their mask. The child eventually complied under the pressure. They returned home visibly distressed and cried. When the family raised safeguarding concerns, the headteacher responded with a threat: if the child wore a mask again, they would be excluded from school. No individual risk assessment was offered. The head insisted that they were following guidance from the DfE and HSE.

CVF formally contacted the DfE to raise concerns about this incident and the wider pattern of schools denying children from high-risk households the right to mask. This was not an isolated case - although denial of in-person education was not common. Many children were not allowed to mask, particularly in primary school settings, even if the child was over 11 (the age of compulsory masking elsewhere).

Government guidance was interpreted or implemented in ways that actively discouraged or punished mask use, despite scientific consensus on its value. Children in CV households were not only unsupported they were actively told off and obstructed from taking basic steps to protect their families.

116. The shift to online parent consultations and staff meetings was widely supported by CVF members, who also discovered that their appointments were more efficient. However, some schools withdrew these measures, even as an inclusive option for CV or disabled households.
117. Early contact tracing and isolation protocols provided some reassurance to CVF families. However, once these systems were dismantled in mid-2021, CV households were no longer informed of exposure risks - undermining their ability to take precautionary steps.

Quote 10 from CVF Member

"School not allowed to tell parents when COVID cases occurred, even if they knew a child had it whilst sitting next to my daughter - making it impossible to make informed choices to stay safe as a CEV parent."

Dawn, 45, parent

118. While CVF's families appreciated the introduction of lateral flow testing and PCR access, they were dismayed by the abrupt end to testing, during high case rates. They were concerned that younger children and primary pupils were largely excluded from routine testing programs, even when non-invasive saliva testing was proven effective.
119. The decision to allow close contacts, including household members, to attend school without testing or isolation left vulnerable families feeling exposed and unprotected.

(d) infection prevention and control measures for public examinations (such as GCSEs and 'A' levels)

120. Many members of CVF expressed serious concerns about the lack of effective infection prevention and control ('IPC') measures during public examinations (such as GCSEs and A Levels). For CV students and those living in CV households, the arrangements for exams often failed to consider their heightened risk of severe illness or transmission at home.

(xiii) Cancelled exams and algorithm controversy

121. For CV families the cancellation of GCSE and A-level exams brought relief. While all students faced challenges from the algorithm issues, students in CV families were equally impacted by the limitations to the algorithm versus Teacher Assessed Grades ('TAGs').

(xiv) 2021 - Cancelled exams and TAGs

122. Exams were cancelled for a second year, and grades were based on teacher assessments, often relying on mock exams or in-class assessments. This system significantly disadvantaged students from CV families, many of whom had missed large parts of their education due to shielding, unable to safely attend school or college - including during key assessments. Those who had taught themselves from home often lacked any formal evidence of their learning and were penalised by the assessment process.
123. The Joint Council for Qualifications guidance on the determination of grades for A/AS Levels and GCSEs for Summer 2021 [LW.8/44 – INQ000507075] meant that even genuinely independent work carried out at home would be viewed as inadmissible. Evidence from private tutors, parents, or other external educational providers was not accepted by schools and colleges to support their grading decisions.

"Robust mechanisms should be in place to ensure that Teachers are confident that work used as evidence is the students' own and that no inappropriate levels of support have been given to students to complete it, either within the centre or with external tutors"

124. As a result, many students in CV families were unable to fairly demonstrate their abilities, leading to poorer outcomes despite their extraordinary personal efforts.

(xv) 2022 - Return to Exams

125. Examinations resumed with modifications, including advance information on topics and reduced content. Some of CVF's C&YP were still unable to attend exams in packed exam rooms and the abrupt absence of Covid-19 mitigations under the "Living with COVID-19" policy, resulting in missed opportunities to attain qualifications. Others had to battle for the right to sit their exams and felt significant pressure to stay safe while seated in close contact with peers - including those attending despite known infections.

(xvi) Access arrangements or reasonable adjustments

126. Many CV families were concerned that schools did not offer individual risk assessments for pupils in CV families who were sitting exams. Despite Equality Act and Public Sector Equality Duty obligations for those who were disabled, there was no clear pathway to request appropriate reasonable adjustments, such as mask wearing, smaller rooms, filtered air, or alternative assessment off site. Requests for seating away from others perhaps near an open door or window, the use of HEPA filters, or masks were often denied or met with resistance. Most adjustments must be planned and approved in advance, but schools can put in place temporary, last-minute measures if something unexpected occurs, provided they can justify it.

Quote 11 from CVF Member

"My exams were taken in small stuffy exam rooms, due to my access arrangements. I found it incredibly stressful as schools were pressuring us to attend sick and most families didn't want to risk a Covid test. I knew I was at increasing risk as I witnessed the ripples of sickness slowly spread across the exam room, and throughout my year group, during the progressive weeks of exams. My parents asked for me sit at the back of a room next to an open window – although the window frequently wasn't opened. It made me massively more stressed than I should have been."

Mason, 21, CEV young person

Quote 12 from CVF Member

"No infection control. A magic red lanyard was supposed to miraculously protect the children from covid."

Rumit, 45, parent

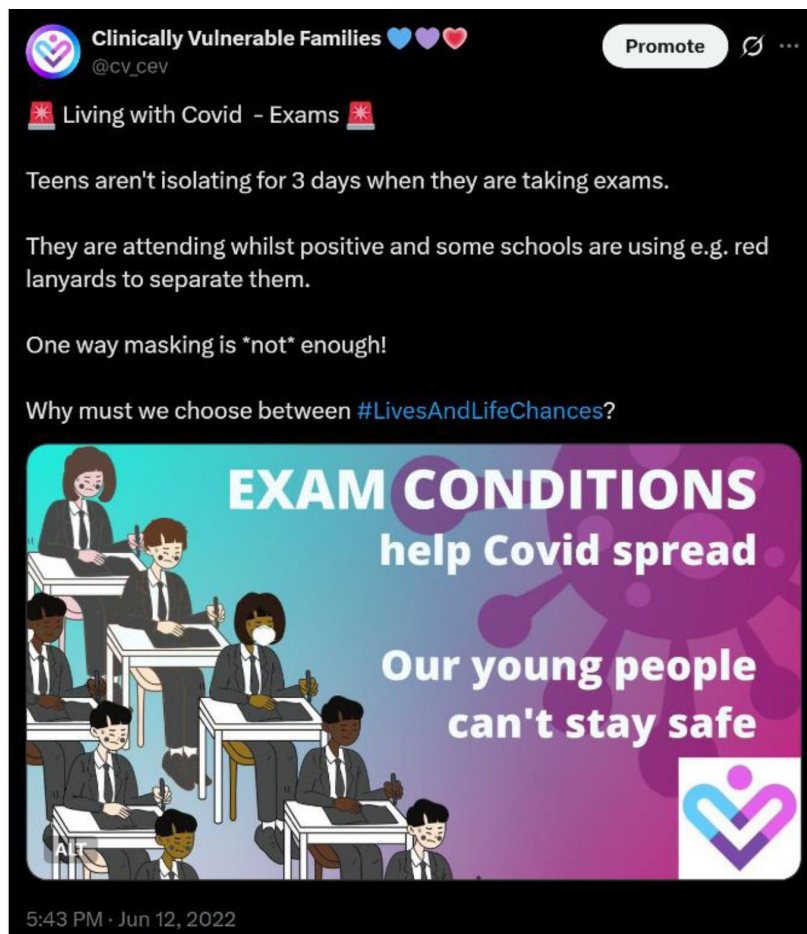
127. Those with more suitable arrangements may have had better outcomes:

Quote 13 from CVF Member

"Small assessments taken for GCSEs in bubbles in classrooms. Windows open so as good as could be. I think child did better due to smaller assessments and less pressure in exam halls."

Anne-Marie, parent

128. Figure 4 demonstrates the concern about lack of appropriate measures.



[Figure 4]

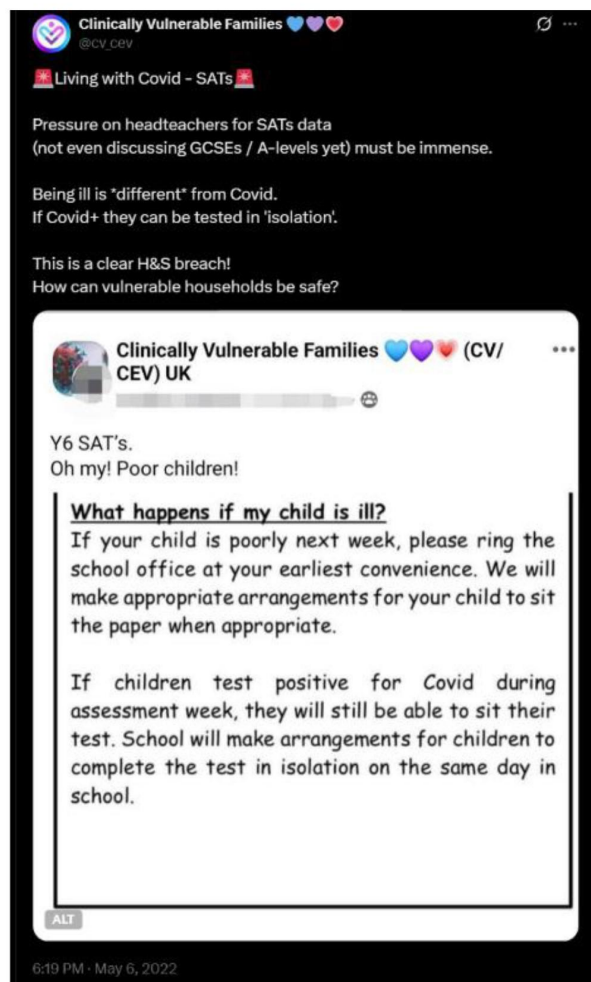
Quote 14 from CVF Member

"Children were still to sit in large groups in the school halls to take exams in 2022. No doors/windows open for ventilation due to sound disturbances. Lack of clean air. "

Trisha, 38, parent

(xvii) Pressure to Attend Exams While Sick

129. By 2022, even primary schools began pressuring Covid-positive children to attend in order to complete their Year 6 SATs. Exams which are unlikely to have any major impact on the child's academic outcomes (as shown in figure 5). Parents were told that if their child tested positive for Covid-19 during assessment week, they would still be expected to take the tests in school, in isolation.



[Figure 5]

130. This practice was widespread and not only ignored public health concerns but prioritised the inclusion of Covid-positive children over the safety of others. By insisting that infectious pupils attend school, the system pressured CV families, who were left without safe options or support. By including those with infections they were excluding those at greatest risk.

(xviii) Self-Taught GCSEs

Case Study E – ‘I had to teach myself GCSE’s while shielding at home to protect my clinically vulnerable mother’

The experience of Lana, a CVF member who was studying for her GCSEs at the time, highlights wider structural failures that affected many children unable to safely take GCSE exams.

While shielding at home to protect her severely immunosuppressed mother, Lana was denied access to remote learning or any alternative provision. Her mother received threats of fines and prosecution when she could not safely attend in person and an attempt was made to remove her from the school roll shortly before her GCSE exams.

Only after her mother paid a fine to prevent deregistration, the school offered a handful of tutoring sessions just weeks before her exams. Lana had taught herself multiple GCSE subjects in isolation and later described feeling “massively let down” by the system. Her exam outcomes were not a true reflection of her abilities, and her learning needs had been systematically ignored.

Her case is illustrative of the barriers faced by other students in CV families, many of whom were excluded from formal learning and denied appropriate adjustments. Without safe access to in-person teaching or robust remote alternatives, students like Lana were placed in an impossible position: risk the lives of their loved ones or sacrifice their own education outcomes. This story gained national attention in the media [LW.8/45 – INQ000648055].

(xix) Lack of Remote Exams

131. Unlike teaching, where remote options were sometimes available, there were generally no valid alternatives for students taking national exams. Some students in CV families had to isolate from their own families during exam periods to minimise risk. Others were forced to choose between risking their health or missing out entirely, and there were also some ultimately received no qualifications at all.

(xx) Impact on Educational Outcomes

132. Some children from CV families withdrew from schools temporarily and had to rejoin different schools or classes, which meant changing to different subjects or exam boards (and therefore content), disrupting not only their learning but also impacting on their future careers and opportunities.

Quote 15 from CVF Member

"[Our child] didn't obtain the grades expected in all subjects. [They also] didn't sit exams for all subjects studied."

Mel, 41, parent

Quote 16 from CVF Member

"The eldest child had to start new exams, new career pathways - they were on a fast track to Interpol and university, that dream has gone, it is not even a possibility anymore."

Jess, 45, parent

133. Those who continued learning from home missed out on essential practical elements of the curriculum, such as required practical work in science, or engineering coursework. In some cases, this meant they were unable to complete coursework or prepare adequately for exams, resulting in withdrawals from certain subjects altogether.

Quote 17 from CVF Member

"Our youngest is about 2 years behind academically now and it is a continual struggle to catch up that learning."

Ravi, 48, CEV parent

134. For C&YP in CV families, the handling of public examinations revealed a systemic failure to deliver inclusive, risk assessed education policy. Despite earlier adaptations in the education system, exam arrangements in 2022 largely reverted to pre-pandemic norms - without any evidence that they had accounted for ongoing needs due to clinical vulnerability of some students and their families. The absence of robust infection prevention and control measures, the lack of remote or flexible assessment options, and the failure to offer consistent reasonable adjustments effectively excluded this group from participating in what should have been an equitable process.
135. Their exclusion was not simply logistical but structural. Students were placed in the impossible position of choosing between protecting health and progressing on their education journey. Some were forced to withdraw from subjects entirely; others missed qualifications, altered their career paths, or have experienced long-term educational disadvantage. Students like Lana were frequently left to self-educate under threat of deregistration, denied even the most basic support.

(e) Availability and quality of remote education in primary and secondary schools across the UK

136. While the DfE promoted the importance of continuity of learning during school closures and subsequent reopening's, those in CV families faced a different reality. Many families were left without adequate educational support when schools failed to provide or maintain remote learning. The refusal or reluctance to accommodate these C&YP often stemmed from rigid adherence to policies that seemingly lacked appropriate equalities impact assessments to meet their needs. Policies failed to take into account the distinct requirements of CV families, resulting in highly inconsistent approaches on the ground. In many cases, institutional priorities – such as minimising staff workload or avoiding setting a precedent - took precedence over legal or ethical obligations to support high-risk households, leaving their needs systematically overlooked or dismissed.
137. There was no planning in place to provide remote education access for children who were absent due to CV household risk, even though the infrastructure had rapidly evolved. Schools were instructed to provide remote education to children who were isolating due to Covid-19 symptoms or a positive test, but not for CEV children outside of formal shielding, or those informally shielding to protect CV children or household contacts. This created a striking and incredibly harmful inequality.
138. In CVF's experience, where remote education was offered to CV families, it depended almost entirely on the discretion of individual headteachers, a small proportion of whom used their own judgement against the guidance. However, over time, as government messaging intensified the focus on attendance, even previously supportive school leaders felt unable to continue accommodating CV families.
139. CVF accepts that remote provision, where it existed, was not equal in quality to in-person teaching. However, for many children in CV households, it was the only viable option compatible with protecting life. Whilst national lockdowns were widely bemoaned by MPs and Children's Commissioners, it is important to acknowledge the brief equity they created for children in CV families. However, many CVF parents reported that the only time their children were on a "level playing field" was during the two national lockdowns that impacted schools, when schools were encouraged or required to provide remote learning to all pupils regardless of their household circumstances. Learning suddenly became safe, more accessible, and more

consistent. Standards for online teaching were generally higher and it allowed families to keep children on school rolls highlighting how poorly served these children were educationally at all other times.

140. Outside of lockdowns, online or remote provision was frequently problematic. Parents often had to chase schools or teachers for work, remind them to turn on cameras, or chase up learning materials. Older learners reported frustration at not being shown the board or not being included in class discussions. The quality of online lessons during lockdowns was considerably higher. Effort and resources went into delivering inclusive whole-class online teaching. Children learning remotely due to household vulnerability outside those periods were often overlooked or given low quality (sometimes inappropriate) learning resources.
141. Accessibility for remote students was not seen as a priority. Despite the growing learning gap this created, inclusion for these students appeared to be an afterthought rather than a consideration within planning. During periods of remote and in-person teaching and learning, those accessing remotely often appeared to be second class learners as they struggled to contribute to lessons or communicate with peers and staff. Inadequate access to learning materials, lack of interaction, and technological difficulties and limitations compounded disadvantage for children in CV families learning from home - who were not only out of sight, but effectively out of mind.
142. Schools routinely track progress for certain pupils, such as those on Free School Meals ('FSM') or Pupil Premium ('PP'), but there was no requirement to monitor or support children absent for reasons related to clinical vulnerability. This absence of targeted inclusion further reinforced and compounded existing inequalities faced by CVF's children. Their education was treated as an afterthought - not because their needs were less, but because their circumstances did not fit the general model of a standard attendance-focused education.
143. The UK government had demonstrated its ability to implement remote education rapidly during national lockdowns, using it as a tool to reduce transmission and protect the NHS from being overwhelmed. However, this same risk-based approach was not extended to protect CV people outside of lockdown periods. While healthy adults were encouraged to work from home, children - particularly those in CV households - had no option, even during the second national lockdown when schools remained fully open.

144. The government clearly recognised the protective role of remote work and education in reducing transmission, whether for infected/quarantined children, or during lockdowns when partial school closures were used to suppress transmission while Covid-19 infections were rapidly rising. It is clear that remote education was only deployed to safeguard healthcare capacity, but not to directly protect vulnerable lives.
145. The DfE stated in its non-statutory guidance on providing remote education [LW.8/46 – INQ000621532]: *“Pupils absent from school and receiving remote education still need to be marked as absent in the register”*. This meant that, whilst schools were expected to provide teaching and children were actively learning, neither the pupil nor the school received credit in attendance figures – which is also a key performance indicator for headteachers. This approach effectively penalised both children and schools, it also failed to capture important data on engagement, and it seemed to discourage schools from offering remote learning. Beyond the added workload for class teachers, the lack of recognition created a structural disincentive to support both isolating children and children in CV families.
146. Without remote education available to CV families, schools, local authorities, and national guidance failed to provide for the needs of their children. The result was a patchwork of interpretations and unjust consequences for families who were simply trying to keep their CV loved ones safe.

Quote 18 from CVF Member

“We were told outright that remote provision would not be provided as it would “open the flood gates” to other vulnerable families. It felt like we were being punished for needing to protect our health.”

Will, 35, parent

147. In some cases, schools openly resisted providing remote education, due to workload concerns, and dismissed requests from CV families as unreasonable. CVF members felt this was discriminatory as schools were placing their needs over child welfare and equal access to education – especially when Covid-19 positive children were being supported.

Quote 19 from CVF Member

"The school refused to support our shielding child because they said remote provision was too much extra work. We were left on our own and made to feel like a burden."

Briony, 46, parent

(i) Inconsistent Remote Learning Provision

148. While a minority of schools provided comprehensive effective remote learning from the outset, the majority of families reported inadequate or non-existent support. Some children were offered structured online platforms such as Google Classroom or the National Oak Academy (which in itself was variable in quality). Many others received only worksheets or irrelevant or inappropriate content.

Quote 20 from CVF Member

"My child, who was only a shiny new year 7 at the time, was sent higher paper GCSE science revision work to complete. If I wasn't scientifically literate myself, I may have missed out on this fact as it was totally inappropriate. We regularly had to prompt teachers, or year heads to remind them that our children were sat in online waiting rooms and frequently not admitted into certain lessons. My children were very patient, but they often felt excluded and forgotten. On other occasions, they were considered in lesson planning and felt included. On one memorable occasion, classmates were given an iPad so that they could complete collaborative learning tasks together. My child, at home, was providing research and contributions which were then printed out and included in the group work. Communication with their classmate like this was rare – but it made them feel a little less isolated."

Sean, 48, father

(ii) Lack of Technological and Educational resources

149. Many families lacked access to appropriate technology and were not provided with laptops or tools to support remote learning. Parents were often forced to purchase materials and take on teaching responsibilities without guidance, creating additional financial and emotional strain.

(iii) Impact on Children with Special Educational Needs and Disabilities (SEND)

150. Children with SEND were particularly disadvantaged. In numerous cases, families reported that no suitable remote learning was offered, despite prior arrangements or EHCPs.

Quote 21 from CVF Member

"The school were very resistant to provide remote learning, they said the local authority had advised against it, in case it encouraged us not to come back to school! They sent home printouts for my child to complete, but the work was inadequate - things like learning to count in Russian or life skills with Mr Bean, which was incredibly insulting for children at a SEN school. [...] They continued to receive thousands of pounds from my child's EHCP while bullying us to return. I believe this funding should be returned to the local authority — or used to support families like mine who had to fund home education ourselves."

Catherine, 40, mother of CEV child

151. Virtual lessons were often inaccessible to children with severe learning disabilities, and families received little or no alternative support.

Quote 22 from CVF Member

"Schools did the best they could but it was rarely appropriate and government seemed entirely ignorant of how provision is delivered in schools and how a lack of 1:1 for SEND children would mean they could not access learning. Online learning was not appropriate as they had custom lessons in school with a full time 1:1, so it was totally unsuitable, so we felt we had to essentially home school them. As nothing school provided from worksheets in the wrong size font for a sight impaired child to resources was not suitable."

May, 41, parent

(iv) Deterioration in Remote Provision over time

152. Even when remote learning was initially provided, families found that support tended to diminish over time. Families found that teacher interaction, feedback, and suitable lesson planning become sparse or ended altogether, leaving children increasingly academically isolated.

Quote 23 from CVF Member

"Initially we were supported... but over time, the support stopped and we were left to teach our child alone."

Vio, 45, parent

(v) Differences by Educational Stage

153. **Primary Schools:** Younger children in primary education were more likely to receive generic worksheets or minimal online support. Parents had to assume near-total responsibility for learning delivery. Some parents reported that their children missed early foundational milestones - such as cognitive and learning skills, speech and language development, social and emotional readiness, physical and sensory integration, and basic school readiness - and some families said they had to delay school starts due to health risks.
154. **Secondary Schools:** Secondary pupils received highly variable provision. A minority accessed structured remote classes, but many others were denied remote learning entirely. Some families ultimately deregistered due to pressure and lack of support, with a few paying privately to continue GCSE studies.
155. **Sixth Form College:** Unlike school-based sixth forms, many sixth form colleges did not follow the government mandates on remote education. This allowed them greater autonomy and flexibility to adjust learning provision according to students' needs. This resulted in more consistent access to remote learning. However, the quality of provision still varied significantly between institutions including challenges with communication and accessibility.
156. **Independent Schools:** Some CVF members had children in independent schools. These schools generally had more flexibility to make decisions to provide online learning. Families found that although the quality of the provision was not necessarily any better, schools were often more willing to support children in CV families.
157. **Specialist Independent Online Schools:** A small number of CVF members who withdrew C&YP from state schools began to attend private online schools. Generally, these schools - already expert in this mode of provision - were better equipped to support pupils' social and learning needs.

158. The experiences of CVF members clearly demonstrate that remote education provision for CV children and those in CV households was inconsistent, often inadequate, and shaped more by institutional discretion than inclusive policy. Despite rapid infrastructure development during the start of the pandemic, remote education was not meaningfully extended to families shielding for health reasons, leaving many children without access to learning for long periods. Where provision did exist, it was typically inferior in quality, poorly adapted to children with additional needs, and inconsistently supported across education stages and sectors.
159. While a small number of schools - particularly some independent and specialist online institutions - offered more suitable and compassionate responses, these were exceptions. The system overall failed to account for the realities faced by high-risk families. The result was that children in CV households were not only educationally disadvantaged but often made to feel invisible.
160. Without meaningful policy commitments to equity and inclusion, these children were left behind. In any future public health emergency children in CV families need clear provisions in place to ensure their rights to education are protected.

(f) National Tutoring Programme and other “catch-up” measures for children in across the UK

161. When the National Tutoring Programme (‘NTP’) was launched in 2021, the government stated in a blog by the DfE [LW.8/47 – INQ000648057], that it was intended to support pupils *“most affected by disruption to their education”*.
162. The experiences of CVF members reveal a disconnect between this objective and reality. Children who missed the most in-person education due to shielding (whether formal or informal), or due to increased absences because of their heightened sensitivity to isolation for symptoms or risks, were not prioritised in this programme. In the vast majority of cases, CVF discovered that these families were not offered NTP support at all.
163. This contradiction meant the very children the NTP claimed to prioritise were frequently left without support, and rather than catching them up it deepened the educational disadvantage for CV households.

(i) Guidance on implementation

164. According to the DfE 2021 guidance on “School-led tutoring: conditions of grant” [LW.8/48 – INQ000648058]:

“The school-led tutoring grant is to support disadvantaged pupils in catch-up learning and schools will select the pupils in need of support. This will focus on providing tuition to pupils eligible for pupil premium but also includes pupils with other types of disadvantage or additional needs. This includes special educational needs and disability (SEND), children who have a social worker, previously looked-after children, young carers and other vulnerable pupils. However, if a school or academy trust feels that a pupil who does not fall into these categories would benefit from catch-up tutoring, the funding can be used to provide this.”

165. Notably absent from the list were shielded CV children or those living in shielding CV households - despite CV families often facing the longest and most frequent absences from school.
166. The guidance's wording placed the onus on schools to “feel” a child merited support - leaving too much to individual discretion and leading to inconsistent and often inequitable implementation. While this guidance allowed for some local discretion, it clearly prioritised support for Pupil Premium recipients and statutory ‘vulnerable’ groups – a group of C&YP with genuine needs, but also largely the same cohort who had been targeted for in-person education throughout all national lockdowns.
167. By 2022, the guidance for the NTP made it clear that all pupils in years 1 to 11 (aged 5-16) in state maintained schools were eligible, again with the specific aim to support those most affected by pandemic disruption. Importantly, earlier constraints – such as the requirement for 65% of the participants to be on PP – were lifted. This should have allowed more freedom for schools to target any pupil affected by Covid-19 related lost learning.
168. CVF questioned its membership in May 2022 on whether they were offered support via the National Tutoring Programme. The results were deeply concerning:
- a. Of the 98 families who responded to our survey (from the wider community of around 2,000 families at that time), only 5 reported receiving support via the NTP.
 - b. This represents a support rate of just 5.1% among survey respondents, a community whose children were often among those with the longest and most

frequent absences from school –either due to additional periods of shielding, or increased Covid-related disruptions due to lower thresholds for testing and isolation.

- c. In the academic year 2021-2022, the National Tutoring Programme for the 2021/22 Academic Year published statistics [LW.8/49 – INQ000648059] that suggested 2.2 million courses were delivered via the NTP, reaching 1.79 million pupils. There were approximately 8.4 million pupils in state-funded schools in England during that year - meaning that approximately 21% of all pupils in state-funded pupils in England received tutoring through the National Tutoring Programme in that year. This suggests that CVF were severely underrepresented within the NTP provision.
- d. Importantly CVF includes a significant, and frequently ignored, group of families who withdrew their children from school and were offered no teaching provision at all.

169. Parents of children in CVF who did receive NTP support felt that it was limited in impact and poorly tailored to their child's needs.

Quote 24 from CVF Member

"Limited [benefit]. It was OK. My child found it a bit boring. He did do it though."

Louisa, 58, mother

Quote 25 from CVF Member

"Not that effective."

Ellie, 42, parent/carer

170. Only two families reported receiving support beyond the NTP and usefulness was variable:

Quote 26 from CVF Member

"Broader class catch up and higher ratio of Teaching Assistants to children than normal were helpful."

Katie, 46, mother

Quote 27 from CVF Member

"We were just emailed work to complete and didn't receive any support for it.."

Isla, 40, parent

171. Some CVF members, desperate to prevent their children from falling further behind, paid privately for tutoring despite some facing financial strain:

Quote 28 from CVF Member

“No [tutoring] at all!! I hired an online tutor who was fabulous for two middle children.”

Lisa, 45, parent

172. A systemic design failure meant that NTP or catch-up support, like much support in schools, was used to address long-standing educational disadvantage - but failed to recognise or respond to the specific disparities caused by government decisions earlier on in the pandemic.

(g) Impact on CV young people attending further or higher education

173. While much attention has been paid to the disruption in Primary and Secondary education during the early phases of the pandemic, the experiences of CV young people, and those in CV households, in further and higher education (FE/HE) were equally profound, and often more invisible. FE and HE institutions were granted significant autonomy in how they interpreted public health guidance compared to schools, with no consistent national strategy for supporting CV students or addressing risk to those they lived with.
174. As a result, CV young people were frequently left to navigate a landscape of inaccessible in-person learning, inadequate remote alternatives, and a lack of recognition for the risks they faced. Their needs were often sidelined, falling between the cracks of health and education policy.
175. Students reported being denied remote learning, even when medically advised to avoid in-person contact. Where remote access was offered, it was sometimes substandard or quickly withdrawn - undermining inclusion. Some were told they must attend placements or practical assessments. The lack of meaningful adjustments or guidance for these students forced many to defer, repeat academic years, or drop out altogether.
176. Equally damaging were the social and emotional consequences of exclusion. CV students were shut out of student life - unable to join societies, attend events, or form friendships in environments deemed too risky. Even in courses centred on healthcare, students reported that their peers and staff failed to understand or account for clinical risk.

177. One CV student summed up their experience of university life as “*lonely*”. For high-risk students, the university experience differed starkly from that of their peers. While others were building friendships and settling into student life, these students were left navigating isolation and exclusion. Socialising in a new environment proved especially difficult. Initial efforts to engage in online events during freshers' week in 2021 were quickly abandoned as universities returned to in-person-only activities:

Quote 29 from CVF Member

“There wasn't a single event I felt safe to participate in... I basically admitted to myself that the chances of me making any real friends on this course were minimal. I couldn't join a single society or go to a single social. And after refusing a few cursory offers of brunch, people just stopped asking me.”

Olivia, 20, young person

178. The academic and emotional toll was heavy. One family explained:

Quote 30 from CVF Member

“They were doing a uni course that required learning sounds and it all went online, they had to repeat their first year... Unis should have shut when they stopped teaching any classes in person.”

Lilly, 41, parent

179. Where support was offered, it was inconsistent or insufficient:

Quote 31 from CVF Member

“She had very little support from [College], she mostly self-learned, there was a distinct lack of communication and she was left guessing what she had to do most of the time.”

Abi, parent

180. Universities have a legal duty to provide reasonable adjustments for disabled students. However, CV students frequently reported that their requests were dismissed, even when the adjustments were simple and health related.

Quote 32 from CVF Member

“I was studying medicine ... but never felt supported by the faculty with regards my CV status. When mask mandates started to be removed and those educating us seemed happy about it, I was called “unprofessional” for asking if mitigations would remain and

suggesting we would ever be put at risk by doctors. I was also called "over-anxious" about my risk, despite being registered CV. It left me feeling terrified to ask the faculty for any kind of accommodations and I felt (and still feel) completely alone in my quest to protect my health

Asha, 22, young person

181. One student described the stress of sitting in-person exams with no protections in place:

Quote 33 from CVF Member

"My university had lifted all mask mandates... I was in a room of 30+ people, many with Covid symptoms... I asked if I could take an air purifier but was told it would be too loud. I was in fight or flight mode the whole time — it made it hard to concentrate."

Amara, 21, young person

182. Students sometimes were left paying for services they could not use, with limited academic benefit:

Quote 34 from CVF Member

"University closed. Hold returned home whilst still paying University fees and for accommodation. Limited online learning. Not very good."

Asma, 59, carer

183. However, for others when online teaching was more widely adopted, it could also act as a powerful equaliser for CV students:

Quote 35 from CVF Member

"My university used more online teaching, although started to scale this back quickly from 2021. For the brief period it was common, I actually felt safe and equal to my peers."

Hanna, 21, young person

184. Students from CV families were often unable to access a safe, inclusive, or supportive learning environment in FE and HE. Their accounts reflect a system that rapidly defaulted to in-person provision without safeguards, and that failed to uphold principles of equal access and reasonable adjustment, particularly during a public health crisis.

PART C - CVF members' concerns and experiences during the pandemic in relation to healthcare in so far as it relates to C&YP.

(a) Access to healthcare

185. CVF believe that ensuring continuity of care for CV children was not sufficiently addressed. Routine and essential services were disrupted and, importantly, environments were generally unsafe for CV families. CVF is not aware of any specific measures to target CV children and ensure protective measures for high-risk families in paediatric healthcare settings, beyond standard masking rules, which did not apply to children under 11. Families had to self-advocate for measures such as safe spaces (isolated from symptomatic patients, sometimes waiting outside or in cars), remote appointments, the opening of windows, or the use of personal air filters. The impact of these gaps has been significant and, in some cases, long-lasting.

(i) Routine Appointments

186. Many of CVF's families reported significant disruption to both routine and specialist healthcare appointments for their children during the timeframe. This included GP visits, routine monitoring, diagnostic investigations, and specialist care such as paediatrics, neurology, cardiology, or immunology. Appointments were often cancelled outright, indefinitely postponed, or moved to remote formats that were inappropriate for some health conditions - especially where physical examination or in-person procedures were required.

Quote 36 from CVF Member

"There were no in-person GP appointments and NHS actively refused to help: the emergency GP surgery outright refused to see the patient when in the hazardous acute stage of Covid."

Clare, parent

187. However, remote appointments did suit some CV families:

Quote 37 from CVF Member

"We were fortunate [...] consultant care actually improved as much of it switched to phone and video appointments [...] we weren't constantly travelling 4+ hours to appointments."

Georgia, 41, parent

188. The disruption particularly affected children with chronic or complex medical needs, many of whom require frequent follow-up to manage their conditions. The loss of these touchpoints created clinical risk and exacerbated health conditions, leading to a deterioration in some children's overall wellbeing. One member explained about the risks of disrupted continuity of care:

Quote 38 from CVF Member

"[My child's] spinal surgery cancelled multiple times... lack of physio support led to worsening conditions."

Nina, 45, parent

189. Families also described the emotional impact of this uncertainty, struggling to make decisions without medical input and feeling abandoned by services they had long relied on. As another member put it:

Quote 39 from CVF Member

"Delays in outpatient appointments, it felt like we were forgotten about."

Cassie, 36, parent

190. The withdrawal or delay of specialist care disproportionately harmed children with established vulnerabilities. As explained in an article by NuffieldTrust, *'These disadvantages are affecting children who already have a greater level of need, and so are exacerbating inequalities'* [LW.8/50 – INQ000648060]. In many cases, parents described feeling forced to either self-manage complex conditions or seek private care, despite the financial strain this imposed.

(ii) Emergency and Inpatient Care

191. While pandemic guidance urged continuation of urgent and emergency services, many of CVF's families encountered significant challenges when seeking care in acute situations. Children requiring hospital treatment - including A&E, inpatient admission, or critical care were often caught in systems unprepared for the complex risks and needs of CV households. Some parents felt the normal standard of care at A&E decreased:

Quote 40 from CVF Member

"[My child] was denied a bed due to so many viruses already on the wards and was sent home the same state he arrived [...] absolutely no care, not even fluids. [with] a potentially fatal condition."

Mia, 45, parent

192. Restrictions on parental presence created additional emotional strain. Many hospitals enforced "one parent only" rules, forcing families into difficult situations:

Quote 41 from CVF Member

"My youngest [...] was in hospital shortly after the 1st lockdown started [...] I couldn't go home at all as they wouldn't have allowed back in. [...] It was hard for my [child] and my husband and eldest [...] who couldn't visit us and had to fend for themselves at home."

Anonymous parent

193. Even when emergency services were technically available, families often weighed the risk of hospital exposure against the urgency of the situation — a choice no parent should have to make. These decisions were made even harder by the visible absence of mitigations in healthcare settings, particularly from mid-2021 onwards when protections were widely withdrawn.

Quote 42 from CVF Member

"We also attended paediatric A&E twice [...], at a time where there were few or no mitigations. This was extremely stressful."

Gabriella, 38, parent

(iii) SEND Care

194. For families of children with SEND, or those requiring specialist medical care, the pandemic exacerbated long-standing gaps in access - and introduced new barriers that many found devastating. CVF members reported that referrals were delayed, assessments halted, and therapy services suspended, often for extended periods. Children awaiting diagnoses for conditions like autism, ADHD, or sensory processing disorder faced waits stretching beyond the inquiry timeframe. Others already under the care of multi-disciplinary teams (including paediatricians, neurologists, speech and

language therapists, and occupational therapists) saw those services pause without clear plans for resumption.

195. This disruption had compounding effects. Without diagnosis, many children could not access educational support or appropriate healthcare interventions. For others, previously stable conditions regressed due to the sudden withdrawal of therapies, particularly those relying on regular input such as physiotherapy or speech and language therapy. One carer explained:

Quote 43 from CVF Member

"Community Support Team for medically complex children completely stopped. No support at all during the pandemic."

Susan, 58, grandparent

196. Families described feeling as though children with SEND were deprioritised, especially where their needs were invisible or considered non-urgent. The consequence for some was a deterioration in physical function, behaviour, or communication, with longer-term developmental risks that continue to emerge.
197. CVF also heard from families who had to resort to private assessments and therapy, absorbing financial costs simply to maintain a child's baseline progress. This further entrenched inequalities, as families without such resources saw their children fall further behind.

(iv) Delayed Diagnoses

198. One of the most serious consequences of healthcare disruption for CVF members was the widespread delay in diagnosis for children with previously undiagnosed health issues. Parents reported long delays in accessing paediatric assessments, specialist referrals, scans, or developmental evaluations. In many cases, families were left in limbo for months or even years without a clear understanding of their child's needs, or the ability to access appropriate care and support.

Quote 44 from CVF Member

"We waited 3 years to speak to a paediatrician about concerns after continuous badgering for an appointment..."

Josie, parent

199. These delays had cascading effects. Without timely diagnosis, many children:
- Were not identified as CEV or CV and potentially protected or shielded;
 - Missed urgent windows for early intervention or treatment;
 - Were unable to access Education, Health and Care Plans (EHCPs) or other formal support;
 - Stayed in inappropriate schools without reasonable adjustments;
 - Experienced worsening symptoms;
 - Health needs were not addressed.
200. In some cases, even when families managed to secure referrals, appointments were cancelled or indefinitely postponed due to NHS backlogs or redeployment of staff during. Families were distressed and frustrated at being left to manage complex symptoms at home without guidance or support.
201. There was also increased inequality: families who could afford private assessments did so out of desperation, while others were forced to wait. The effects of these delays are ongoing. Some children may still have no diagnosis and no access to targeted support, years after first raising concerns. For others, the late start to therapy or care has meant additional trauma, school exclusion, or avoidable deterioration in health—outcomes that may have been prevented with timely intervention. In short, delayed diagnosis was not simply a matter of inconvenience for CVF families; it was a failure of timely care that deepened vulnerability, widened disparities, and left many children without recognition or response from the systems meant to protect them.

(v) Mental Health Impacts of Healthcare Disruption

202. For many of CVF's C&YP, the disruption to healthcare services had profound mental health consequences, not only due to the absence of support, but also because of the loss of safety and trust in the systems that were meant to protect their children.
203. Parents reported that their children experienced:
- Increased stress due to delayed medical care, missed diagnoses, and worsening physical symptoms
 - Suffering from being unable to attend their regular therapy appointments
 - Sleep problems, behaviour changes, and regression, especially in children with SEND or complex health conditions

Quote 45 from CVF Member

“Mental health was the main issue. My son developed anxiety and phobias that we had to address using a private psychologist.”

Natalie, 48, mother

204. For children who were already receiving mental health support before the pandemic, many saw their appointments cancelled or moved online, often without consideration for their individual needs.
205. For some children in CV families, remote appointments were exactly what they needed, but for others they were not accessible at all, effectively severing them from their only source of mental health care. Long NHS waiting lists for mental health services seemed to become entirely inaccessible. Parents were told to wait, or they had to find private alternatives, or in some cases, the threshold for support seemed to have changed and their child no longer qualified - despite demonstrable issues.
206. At the same time, the pressures on carers and young carers increased dramatically. With no access to respite, reduced external support, and full responsibility for managing medical and emotional needs at home, many families described feeling burnt out, isolated, and emotionally depleted. This, in turn, affected children, who were deeply aware of their families' vulnerability and stress. Coordinated care was needed for families managing complex mental and physical health issues alone. The lack of available support, coupled with heightened risks from Covid-19, made it impossible for some families to seek help.
207. CVF members' responses show a clear pattern for C&YP in CV families, the disruption to health services was a catalyst for increased emotional harm. C&YP were left to cope without professional support, while parents felt powerless to help.

(vi) Unsafe Environments and Barriers

208. For many of CVF's families, concerns about the safety of healthcare settings became a major deterrent to accessing care. As infection control measures were rolled back, particularly after the lifting of mask mandates and other protections, parents described feeling forced to choose between risking exposure to Covid-19 and seeking essential medical attention.

209. CVF members found that clinics and hospitals no longer felt safe for their CV children, or for CV adults accompanying them. In some cases, families were explicitly told that no additional adjustments could be made to accommodate their risks.

Quote 46 from CVF Member

"We also attended paediatric A&E twice because of school-acquired infections, at a time where there were few or no mitigations. This was extremely stressful."

Mia, 38, parent

Quote 47 from CVF Member

"By the time our son was due surgery in summer 2021, most protections were dropped and the risks involved in attending healthcare increased exponentially."

Emily, 38, mother

210. These concerns were particularly acute for immunocompromised children, who struggled with common infections. Some parents acted independently to try to protect CEV children who could not mask:

Quote 48 from CVF Member

"I remember taking her for a scan with her under the buggy rain cover to try and keep her air space free from Covid aerosols."

Wanda, 40, parent

211. In addition to safety concerns, families faced significant logistical and other barriers to care. With restrictions on who could accompany a child, many parents were forced to attend appointments alone with their child, sometimes when the child was undergoing distressing procedures or receiving complex diagnoses. In other cases, transport options were limited due to shielding, and families were worried about taking public transport or relying on other support networks.
212. The combination of environmental risk and systemic challenges meant that some families avoided healthcare entirely. As a result, necessary treatments were delayed, and preventable deterioration occurred. Meanwhile, the psychological toll of navigating care alone, in settings that were not seen as safe, added additional pressures. These were not isolated incidents for CV families: they were routine experiences of being unseen and unsupported in a healthcare system that simply did not meet their needs.

(b) Ability to visit and/or contact CV family members who were hospitalised during and/or as a result of Covid-19

213. CVF members faced significant emotional hardship as a result of hospital visitation restrictions. For C&YP in these households, the inability to visit hospitalised loved ones – whether siblings, parents, or grandparents – was another distressing aspect of the peak pandemic experience.

Quote 49 from CVF Member

“I attended A&E as a CEV person and I wasn’t allowed to take my [two] children with me, as the rule was one person only. So childcare became an issue[...] and we were shielding from everyone else...”

Emma, 45, mother

214. In many cases, families were forced to navigate acute medical crises in isolation. When a parent or family member was hospitalised, children were often left at home with minimal information, unable to visit, and with limited or no communication. This created a deep sense of fear and helplessness, particularly for children who had been shielding for months to protect these very relatives. One parent described how her own repeated hospital admissions affected her child:

Quote 50 from CVF Member

“I went into hospital several times during [the] timeframe. We could only FaceTime. My son said after he always thought I wasn’t coming out – he ended up with severe mental health issues – suicidal thoughts linked to this – still struggles whenever I get unwell now.”

Pat, 50, parent

215. Another parent shared the experience of trying to maintain some form of connection during her husband’s hospitalisation, despite the entire family isolating with Covid-19 infections:

Quote 51 from CVF Member

“My husband being taken by ambulance to hospital during the night was a shock. We were unable to visit – as we all had COVID – but I used to drive to the hospital every day and park near my husband’s window – and we would wave while talking on the phone. This was supplemented by FaceTiming. Our child was terrified that my husband

would die, and lots of reassurance was needed. This period had a long-term impact.”
Fiona, 59, kinship carer

216. Others faced the trauma of being denied visits even in end-of-life situations, or having children kept away from hospitalised grandparents and carers who had played central roles in their lives:

Quote 52 from CVF Member

“My child couldn’t visit a family member who was CEV and hospitalised during this time. We eventually saw him once before he died.”

Maggie, 54, parent

Quote 53 from CVF Member

“[M]y children were unable to visit their granny who was in hospital due to risk of them bringing COVID home. Their granny had it twice while in hospital.”

Morgan, 43, parent

217. These experiences reflect a wider pattern within CVF’s evidence: a system that did not account for the emotional needs of children when applying strict, risk-based rules to hospital visitation. While infection control was necessary, the absence of flexibility, compassionate exceptions, or alternatives meant that many children were left feeling confused, frightened, and profoundly isolated at some of the most vulnerable moments of their lives. For some, these experiences have had lasting mental health consequences - including anxiety, unresolved grief, and trauma.

PART D - Overview of CVF members’ concerns and experiences regarding the impact of the shielding programme across the UK on C&YP who were required to shield or who shared a household with a person who was shielding.

218. The following focuses specifically on the experiences of C&YP who were formally identified as CEV, or who lived in CEV households. It sets out the impacts of the shielding programme on this group, based on the concerns and experiences reported by CVF members.

(a) Education

219. Families understood that schools could never eliminate every risk, but many pleaded for better ventilation and infection control measures, so that C&YP in CV families would not be forced to miss out or face greater health risks. Basic mitigations would have reduced the need for visible, individual actions like masking - and with it, reduced the risk from bullying, harassment, and physical harm.
220. In July 2021, I asked CVF members to share the impacts on their children over the school year 2020-2021. The responses revealed a wide range of experiences, both deeply challenging and some unexpectedly positive. These impacts could be broadly grouped into several key categories, reflecting emotional, educational, social, physical, and systemic issues. A detailed overview of those experiences, capturing the experiences of children in CV families navigating the pandemic with extra layers of risk and responsibility is exhibited at [LW.8/51 - INQ000648061].
221. For children in CV families, that first pandemic year was not just about school closures or lockdowns, but about living with significantly heightened fear, continued isolation, and significant sacrifices.
222. The range of negative impacts experienced was extensive: from loss of education and missed medical care to emotional distress, social exclusion, and broad systemic failings. But within the challenges, families also shared powerful positives: deepened family bonds, flourishing in alternative learning environments, and a stronger sense of connection, resilience, and purpose.
223. Children in CV families experienced a very different reality during the pandemic, characterised by limited support, a lack of understanding, and little recognition of the sacrifices they made. Despite facing significant challenges, some developed resilience, adaptability, and determination.

(b) Physical and mental health and well-being

224. Shielding had a mixed impact on the physical and mental health of C&YP. While reducing exposure to Covid-19 provided essential protection and assurance for CV households, prolonged isolation also had significant negative effects on mental health. For many

families, there was no good or safe choice available - no balance could easily be found which avoided longer-term emotional and developmental harms.

225. Families reported significant disruption to essential healthcare services, leading to missed medical appointments, delays in diagnoses, and stalled progress in managing complex health needs:

Quote 54 from CVF Member

"Access to healthcare was reduced and it felt like we missed out on medical appointments at critical stages in their development. If not for the pandemic we would have expected more frequent contact with medical teams and more frequent appointments."

Chloe, 36, parent

Quote 55 from CVF Member

"Delayed MRI scans and appointments confirming diagnosis for multiple conditions which in turn delayed application for financial support"

Maya, 43, parent of CEV child

Quote 56 from CVF Member

"Community Support Team for medically complex children completely stopped. No physio, OT or SALT input for many months, sessions at home had been weekly so again all these areas which had been improving, became stagnant. Community Nursing input had to continue at least weekly due to complex needs also some hospital admissions were necessary and readily accessed, although no direct access to ward, only via A&E which carried more risk and stress for the child. MRI's, ultrasound scans, x-rays and clinical reviews all postponed unless a life/death issue."

Jackie, 58, grandparent

226. Shielding also had serious emotional consequences. In many cases, schools failed to recognise or accommodate the risks faced by CV families:

Quote 57 from CVF Member

"[Our] schools [...] actually offered [me] grief counselling for when [my CEV] children died from covid, as they refused to consider their needs."

Vicky, 45, parent

227. Shielding children carried immense burdens. They experienced exclusion through the most restrictive form of isolation faced by C&YP. They had to try to continue their education without teachers, classmates, or suitable learning resources. At the same time, they internalised a profound fear - that their actions could result in their own severe illness or death, or the loss of a loved one. Further detail is provided in Section 7 below. For some, the cumulative emotional strain led to crisis:

Quote 58 from CVF Member

"Our eldest son really struggled with his mental health... left home one day and left his phone on his bed after texting me to say he'd had enough."

Maddie, CV parent of CEV child

228. Families often reported feeling discriminated against while trying to manage conflicting risks and maintain a sense of normality.

Quote 59 from CVF Member

"Worsened our son's autism, increased his anxiety, particularly as he could not understand why the headmaster excluded him from his online leavers concert."

Aaliyah, 50, CEV and CV parent with CV child

229. The experiences of CVF members highlight that shielding policies, while necessary to reduce immediate Covid-19 risk, had profound and lasting impacts on both the mental and physical health of C&YP.
230. Interrupted healthcare, prolonged isolation, exclusion from learning and friends at school, plus the constant burden of managing infection risk placed significant stress on already vulnerable families. CVF considers that these impacts were largely unaddressed during the pandemic response and these C&YP's needs must be fully recognised and supported.

(c) Social and emotional development;

(i) Access to and Use of the Internet, Social Media and Online Resources

231. Reliable home internet became the single most important gateway to education for children in CV families during shielding. Where families already had broadband and suitable devices, pupils were able to follow live lessons, submit work online and access healthcare or SEND services that switched to video calls. In households that lacked a

connection or shared unsuitable devices, the loss of classroom access translated directly into significant impacts in terms of lost learning time and progress.

- 232. Online spaces were vital for maintaining friendships. Multiplayer games, messaging apps and video calls gave isolated children a way to “hang out” with their friends after lessons and preserved friendship bonds during months of separation. Use of virtual classrooms, shared documents and presentation software also accelerated digital skills and confidence for many pupils.
- 233. Extended, often unsupervised screen time did, however, expose new vulnerabilities. A CVF member has reported an incident in which their young child, who returned to school once shielding ended, was subjected to a sexual attack from another pupil who had accessed inappropriate material online. Without close oversight, online content can result in real-world harms.
- 234. Families therefore stress the need for guaranteed access to suitable devices and data, robust age-appropriate content filters, and training that equips parents and staff to spot warning signs early and intervene before harm occurs.

(d) Family Life

- 235. Children identified as CEV, and children living in households with CEV family members, faced significant disruption to their family lives. Shielding advice meant that many families isolated for prolonged periods, resulting in severe social isolation, breakdown of normal routines, and a profound loss of normal childhood experiences.
- 236. Shielding significantly restricted children's ability to see extended family, friends, and participate in community activities. Families described feeling abandoned, trapped, and unsupported as restrictions eased for the general population, but shielding families continued to self-isolate due to ongoing clinical risks:

Quote 60 from CVF Member

"Our whole family didn't leave our bubble for over 2 years except for the CEV child's stay and surgery in GOSH. It changed our entire lives, However I don't view all of the impacts of us shielding as negative we made the most of our enforced family time. However the lack of support was incredibly stressful."

Naomi, 41, CV parent of CEV child

237. Children who normally relied on extended family members for emotional support, childcare, or cultural and religious community connections were cut off from these networks:

Quote 61 from CVF Member

"The period of shielding meant that our children were no longer cared for by family members after school as would have been the norm previously. They regularly saw their grandparents and extended family via online systems or through a window. We continued to keep contact and celebrate special occasions, for example, in as normal a way as was possible at the time."

Madhu, 42, parent of CEV child

238. The strain of shielding deeply affected family dynamics. Parents described the burden of enforcing isolation, managing heightened anxiety, and what often felt like sole responsibility for their children's safety.

Quote 62 from CVF Member

"The biggest impact was our decision for me to move out of the family home when schools were reopened [...] whilst my son was in the final year of A levels and there was much uncertainty about how they would be assessed. We were also unable to visit universities to make decisions on which ones to apply to. It was stressful for him and a worry for us especially given his pre-existing anxiety issues. It was a difficult decision to move away, but we felt it was better overall for his mental health to know I would be in less danger of contracting Covid."

Kimberley, 58, CEV parent

239. Shielding also disrupted children's development of independence and normal social skills, with families reporting long-term effects on children's confidence and mental health:

Quote 63 from CVF Member

"Anxiety. Both developed mental health issues which continue to be supported. I had to take ill-health retirement from work. Dad ended up on antidepressants."

Zoe, 50, CEV parent

Quote 64 from CVF Member

"Parents felt guilty that our children missed out on clubs such as swimming and extra-curricular activities they would usually have done as we were being more careful. Our children lost over 2 years of their childhood doing things and going places as we had to be more careful."

Dani, 36, CEV parent

240. Overall, CVF members reported that shielding, while necessary to protect life, came at a profound cost to family life. The combination of prolonged isolation, disrupted development, and emotional strain left lasting scars on C&YP. Many shielding families felt forgotten as wider society moved on, facing the burden of protection without recognition or support.

(e) C&YP as carers for family members or guardians who are CV

241. CVF members reported that many C&YP in shielding households took on informal caregiving roles to protect CV family members. These responsibilities were often significant, emotionally burdensome, and carried out without formal recognition or external support.
242. Families reported that children felt a heavy personal responsibility for protecting vulnerable family members from infection:

Quote 65 from CVF Member

"They felt responsible for my health and well-being when they hadn't beforehand."

Jennifer, 45

Quote 66 from CVF Member

"Pressure to keep CEV parent safe, not able to access education, not able to meet with friends, needing to follow strict hygiene whilst totally shielding at home."

Priya, 50

Quote 67 from CVF Member

"Pressure to keep me safe. They felt enormous pressure to 'not bring Covid home it will kill Mum.' The guilt when they did was overwhelming and heartbreaking. Their caring responsibilities then increased considerably as I became more unwell and

disabled and had to take ill health retirement from work – we had to sell our house and move and [it] massively impacted our family."

Nani, 50

243. Young people had to adapt their behaviour in ways far beyond normal childhood expectations:

Quote 68 from CVF Member

"Both my kids went out of their way to keep me (CEV) safe, with masking and hand gel and asking to sit somewhere else in the class if someone was ill or not to play with kids that sounded ill."

Sarah, 45

244. The burden of responsibility carried psychological consequences for many of these, frequently unrecognised, young carers:

Quote 69 from CVF Member

"The young children in our home had to bear the burden of protecting their mother. Although they were happy to do so, I feel this was a huge responsibility for young people to have to do to be in this situation. They were singled out for masking, having to be extra cautious. I'm sure this is something that has affected them and remains with them."

Rachael, 38

245. Some children took on active roles in infection prevention at home, often with little external support:

Quote 70 from CVF Member

"Our child felt responsible for keeping me safe. He used to ensure that his hands were always clean and he might sometimes help my husband with disinfecting shopping."

Inge, 59, kinship carer

246. Older siblings also adjusted their life plans to support their CV families:

Quote 71 from CVF Member

"[...] my eldest son delayed starting University to assist with his youngest sister during the latter stages of lockdown/ Covid impacts until she was fully vaccinated."

Mathilda, 43, parent of CEV child

247. The experiences reported by CVF members demonstrate that living in a CV family often placed a significant and often invisible burden on C&YP in CV households. Many took on caregiving roles far beyond what would normally be expected at their age, managing responsibilities that impacted their education, social development, and emotional wellbeing.
248. These C&YP were frequently unrecognised as young carers; were largely unsupported by formal systems; and were not recognised in government planning or pandemic response measures. Their contribution to protecting vulnerable family members during the pandemic remains unacknowledged, despite the considerable sacrifices they made and the long-term impacts many will continue to face.

(f) Safeguarding vulnerable C&YP

249. CEV children were often not recognised as at high-risk by wider society, due to widespread media commentary framing 'children' as a low-risk homogenous group. As a result, high-risk children – whose doctors had explicitly identified them as requiring shielding due to their medical vulnerability – were frequently left unsupported by education and safeguarding systems.
250. This created immense challenges for parents, who were willing to take extraordinary steps to protect their child's life, but who found themselves in conflict with education staff. School leaders and local authority staff, lacking medical knowledge about an individual child's health risks, often refused to accommodate shielded children outside of formal shielding periods. This was particularly devastating for families at a time when they did not want to contact overstretched healthcare professionals to provide additional advocacy and put them into conflict with education workers.

Quote 72 from CVF Member

"School raised concerns and suggested [that our CEV shielded child] could be a victim of FII [Fabricated or Induced Illness] in relation to reasons for shielding."

Áine, 39, parent

251. Another CVF parent described their experience:

Quote 72 from CVF Member

"My main instinct as a loving parent is to protect my child, who is also CEV, so that need is even stronger for me, because they live with a life-threatening health condition.

The SEN school my child attended tried to disable my ability to protect my child through constant bullying, threats and harassment. [...] It was so intense that it stopped me sleeping and made me physically ill, because my body was constantly rigid with fear. I sent my child back to school in September 2020 on the understanding that they knew how to control this virus and they would keep them safe. Within just a few weeks they had made my child very ill (the only place we went was school)! I will never know whether the infection was Covid or another virus, because there was no universal testing available [...].

I will never forgive myself for trusting people whose primary concern was to tick an attendance box rather than the safety and future health of my CEV child. [...] I kept my child at home after that, but was loathed to de-register, as I still believed the UK Education System was best for my child and we had fought for years to gain a place at a SEN school.

The bullying went to another level and the head teacher, who knew he didn't have my consent to do this, began contacting my child's medical team. They then started threatening to report me to Children's Services and it was at that point that I was forced to de-register [...]. During that time my health suffered even more [...]. My child has learnt so much since being home educated and is so much happier in themselves, I wish I had de-registered in March 2020 and saved both of our physical and mental health from the trauma of being pressurised and bullied by the state."

Millie, 40, mother

252. This testimony reflects a wider pattern in CVF evidence, where safeguarding mechanisms were weaponised against shielding families, causing serious emotional and health harm. Rather than receiving protection they needed, families following clear medical guidance were sometimes subjected to suspicion because it conflicted with attendance guidance. They faced suspicion, compounding the emotional pressure faced by CEV children, and their families, at that time.

(g) Any other concerns regarding the impact of the programme, its extent and its period of operation

(i) Shielding guidance issued to CEV C&YP

253. The government did issue shielding letters to some children designated as CEV advising them not to attend school to reduce the risk of severe illness. However, these letters were not written with children in mind. For example, the first iteration of the shielding letter sent to CEV people [LW.8/52 – INQ000068544], instructed: *"You, or the person you care for, should not leave your home."* Support appeared to be intended for adults, including workers, but not children in education: *"Patients have been told that the letter they have received can be used as evidence for their employer, to show that they cannot work outside the home."*
254. The suggestion that the shielded person should keep in touch with others using phones, the internet, and social media was not necessarily appropriate or suitable for children, and especially younger children. Advice also included the strict avoidance of shared spaces and minimising time with others which was extremely challenging for children, who need both social interaction and supervision. Telling children (or parents of children) to avoid shared spaces, sleep in separate rooms, eat alone, and minimise contact with others was not only developmentally inappropriate, but also logistically impossible for most families. Such instructions were deeply isolating for children and disruptive to family life.
255. No age-appropriate advice was provided, and the mental health support listed was not suitable for young people: advice to eat or isolate away from caregivers, rely on adult-focused NHS exercise links, or suggestions like reading (when children couldn't access a library), cooking (when families struggled to meet basic food needs), or avoiding alcohol and recreational drugs ignored not only their developmental needs, but failed to consider the emotional needs and realities of C&YP.
256. The guidance did not adequately address the significant mental and new health challenges faced by C&YP, such as the stress from being made to isolate from their peers for prolonged periods, and the anxiety caused by potentially knowing that they were at increased risk of mortality. More targeted mental health support and resources should have been provided to help C&YP cope with their feelings.

257. Suggesting spending time with windows open looking at a nice view is firstly not possible for everyone, but it is also not a suitable activity for most C&YP. Getting out into a garden was good advice for those with access to gardens, but C&YP could not be expected to maintain a 2m distance indoors or outdoors.
258. Overall, while the advice provided might have been useful for some adults, it lacked the specificity, engagement, and consideration of the practical, emotional, and developmental needs required to effectively support C&YP during shielding.

(ii) Removal of Shielding Without Replacement Protections

259. When shielding formally ended for CEV children in August 2021, as set out in a letter sent to by the Department of Health and Social Care [LW.8/53 – INQ000648063], those families were left without alternative protections. This was despite persistently high community transmission rates and the emergence of new variants. CV children aged 12–15 (and those living in immunosuppressed households) had only just become eligible for the Covid-19 vaccination, and vaccines were not yet practically available to most in this cohort. No children under 15 could have been double vaccinated at that time, leaving the vast majority of CV children, including those formerly designated as CEV, exposed and completely unprotected. Those under 12, or not in a qualifying group, had no vaccine offer at this time.
260. Once this protection was withdrawn, even children formerly identified as CEV were pressured to return to school without individual risk assessments, mitigations or remote learning options. Whilst some early guidance acknowledged some discretion, and schools were initially encouraged to support these children through remote learning where necessary [LW.8/17 – INQ000648027], all support was dropped by August 2020. This withdrawal left CV children in a difficult position. Parents were told to follow medical advice, but schools were no longer required to accommodate that advice - creating a vacuum of support and inconsistent outcomes. No national framework existed for how risk assessments might be conducted or how to document or mitigate clinical concerns for children not formally shielded themselves.
261. Parents of CV children lacked confidence in the government's messaging around the safety of returning to school, particularly because the evidence cited to justify the full reopening of schools in Autumn 2020 was based on data collected during partial closures, when attendance was low, bubbles were small, and CV and CEV children were largely absent. As such, the data did not reflect real-world risk once schools returned to full

capacity. Families felt reassurances completely ignored the conditions that had made school attendance in June 2020 safer. Attendance in 2021 felt even less safe, because many of the mitigations present in 2020 were rolled back including the use of 'face coverings', contact-tracing of under 18s, and there was a black-out when it came to sharing information positive cases in classes - even though far more minor health issues, such as head-lice outbreaks, still triggered letters home.

262. Unsurprisingly, many families followed their natural instincts to protect their children's lives. Being told that school attendance was mandatory, with less mitigations in place, and regardless of medical risk was distressing. Children and their families were often left with a profound sense of abandonment by the very systems they felt were meant to safeguard them.

(iii) CV children

263. The shielding policy, while offering limited and temporary support to a narrow group, did not go far enough to protect all CV people. It operated as an arbitrary mechanism, based on administrative decisions rather than a full assessment of individual clinical risk, and provided minimal support even to those it did identify. Expert evidence to the Inquiry from Professor Snooks has previously noted that the distinction between CEV and CV was "*in some ways almost an arbitrary cut-off*" (Module 3 Hearing Transcript, 30th October 2024, Day 23, p.169, line 11) and some families lacked confidence that the risks posed to children, especially those who were medically complex or had rare diseases but did not fall neatly into a listed risk group, had been fully considered.

264. Many CV people – including C&YP – faced the same risks and impacts as those designated CEV, but without any formal recognition, guidance, or protection. In some cases, they experienced greater exposure risks precisely because they fell outside the government's narrow criteria for shielding.

(iv) Other concerns about the shielding programme

265. CVF members identified a number of additional concerns regarding the impact of the shielding programme and its operation. These concerns highlight systemic issues related to digital systems, inconsistent school attendance pressures, the psychological impact of the stop-start nature of shielding policies, the sudden withdrawal of support, and failures of accountability across education and safeguarding structures.

266. Lack of accountability from schools, local authorities, and regulatory bodies left parents with no effective recourse when schools refused to respect medical advice:

Quote 73 from CVF Member

"Lack of accountability with schools and LA to implement medical advice. LGO couldn't review it either as the school was an academy and it was out of Ofsted area. MP felt like school was the best place for the child, despite consultant saying covid would kill the child."

Amanda, 45, CEV parent of CEV child

267. CVF believes that there was systemic neglect and profound emotional and practical harm caused by the shielding programme's failure to recognise and meet the specific needs and risks of some C&YP, as well as its poor implementation and abrupt withdrawal without any transitional support.

PART E - Experiences of C&YP in CV families who lost a primary carer due to Covid-19

268. CVF is acutely aware of the profound and lasting impact that the loss of a primary carer has on C&YP, particularly within households where clinical vulnerability heightened the risks associated with the Covid-19 pandemic.
269. While CVF's membership includes many individuals with lived experience of vulnerability during the pandemic, we acknowledge a significant limitation in our ability to capture detailed personal accounts from C&YP who lost a primary carer due to Covid-19. CVF did sadly lose a small number of adult members who were primary carers to Covid-19, or other causes, during the height of the pandemic. In many instances our members are themselves the CV member of the household. As such, once they pass away, CVF's direct line of communication with the family was often lost or understandably diminished due to the grief and upheaval experienced by surviving family members.
270. Although in some cases we have maintained contact with extended family, they have not, to date, come forward to share detailed experiences regarding the impact on C&YP in their households. Despite the absence of extensive first-hand testimony, CVF strongly advocates for the recognition and support of this highly vulnerable group. C&YP who experienced the loss of a primary carer – especially in CV households –

faced not only bereavement, but also the sudden removal of key emotional, financial, and care-giving support, often in already isolated circumstances due to shielding.

271. CVF believes that tailored support for bereaved children in CV households should have been automatically offered, regardless of whether the carer's death was directly attributed to Covid-19 or other causes. While there are comprehensive guidelines and resources available to support bereaved children in UK schools, the absence of statutory requirements leads to variability in the support provided. Implementation varies across schools and local authorities, leading to inconsistencies in the support provided to bereaved C&YP. Enhanced training for school staff and stronger inter-agency collaboration are essential to ensure consistent and effective support for bereaved children.
272. In CVF's view, the support should have included:
- a. **Proactive outreach** from local authorities or healthcare services to ensure the child's immediate and long-term needs were assessed. The UK Trauma Council's "Traumatic Bereavement Support Plan" [LW.8/54 – INQ000648064] advises schools to maintain contact with the bereaved child's home and actively monitor their wellbeing, facilitating referrals to specialist services when necessary.
 - b. **Access to grief and trauma counselling**, delivered by professionals trained to support C&YP, particularly those dealing with complex household vulnerability. In addition, bereavement training should be incorporated into continuing professional development for teachers.
 - c. **Educational support**, including emotional wellbeing plans and flexibility in school attendance or performance expectations, recognising the disruption caused by bereavement. This is currently recommended but not mandated.
 - d. **Case management**, involving coordination between health, education, and social care services to provide a cohesive and child-focused response.
273. Children who lost parents or primary carers due to Covid-19 was an issue publicly raised by CVF as a concerning growing demographic. While direct cases within CVF data are limited, wider testimony confirms the psychological toll of these experiences.
274. A profound psychological burden was frequently carried by C&YP in CV households. In many cases, children were aware (either at the time or as they grew older) that they

had tested positive for Covid-19 before other household members and may have inadvertently transmitted the virus to a CV family member. CVF members commonly described children expressing intense fear that attending school or having social contact could *"kill their mum"*. Families often spoke of the *"enormous pressure to not bring Covid home"*, and when transmission did occur, *"the guilt was overwhelming and heartbreaking"*. CVF parents shared concerns:

Quote 74 from CVF Member

"He used to worry I would die or that our elderly relatives would die. We used to have to limit TV news for him. On the second occasion we had Covid (March 2022) and my husband was hospitalised [...] with clots in his heart and lungs, our child and I looked after each other at home. It was tough. He was terrified that one or both of his guardians would die – and asked more than once what would happen to him then."

Flo, 57, guardian

Quote 75 from CVF Member

"A sudden awareness of the consequences of contracting illness and passing this on to vulnerable parents and the inherent pressure a child of secondary school age feels when they become aware of this. They obviously were aware of the risk of catching covid at school and bringing it home to family. The thought of being orphaned as a result weighed heavy. And even what would happen if one or both parents became sick. This seemed to be something school and the government had paid little attention to. We and [our] child were provided with no information on what to do if we were incapacitated by Covid."

Ashley, 41, parent

275. This offers a deeply troubling glimpse into the fear these children lived with on a daily basis, and the guilt carried by those who were unfortunate enough to carry a fatal infection to a vulnerable loved one.
276. While CVF's ability to document the full scope of experiences is limited by the nature of our membership and the sensitive circumstances surrounding bereavement, we remain deeply committed to advocating for systemic improvements that ensure no bereaved child in a CV family is left unsupported or unheard.

PART F - The main challenges facing CV C&YP as a result of the pandemic

(a) Education

277. CVF conducted a survey of 350 of its members since schools reopened in 2020 (see §278 - §281 below). This quantitative survey data, alongside family case studies, revealed widespread and disproportionate disruption to the education of CV children or children living in CV households. Our evidence details exceptionally high rates of persistent and severe absence, barriers to access, inadequate educational provision, exam loss, bullying, and the failure to implement safety measures. Our findings show a clear pattern of educational inequity that was as predictable as it was insufficiently addressed by government policy.

(i) Absence rates

278. Figures 7 and 8 below show how CVF's survey data from 2021 – 2022 compares to the national figures [LW.8/55 – INQ000648065] for absences in the same period.

Figure 7 - INQ000588194

Figure 8 - INQ000588195

279. Figures (7) and (8) illustrate the significant disparities in both persistent (defined as missing more than 10% of school days) and severe (defined as missing more than half of school days) school absences during the 2021–22 academic year. The persistence absence rate in CV families (80%) was significantly higher than the national average (22.5%), and other 'vulnerable' groups, such as pupils with EHCPs 36.9%) or those with FSM (37.2%). The contrast is even more striking for severe absences. Children in CV families reported a severe absence rate of 33% which is more than double the figure for Irish Traveller pupils (14%) ,more than four times the rate experienced by Gypsy/Roma pupils (8%), and almost twenty times higher than the national average (of just 1.7%).
280. In CVF's view it is not surprising that children in CV families appear to have experienced the highest levels of both persistent and severe absences. However, as they were not identified in official government datasets they did not benefit from targeted interventions such as inclusive learning strategies during the health emergency.
281. Our survey revealed that 28% of CVF families reported withdrawing from schools and only 9% of CV families said they would not consider withdrawing their children again in the future if infection risks remain high. This, along with the fact that 91% of CVF's families reported higher absence levels than their peers since March 2020, highlights their vulnerability to educational exclusion.

(ii) Consequences of persistent absence

282. The results of CVF's survey found that:

- a. 42% of CVF's families were approached by schools or local authorities and encouraged to deregister their children.
- b. 28% resorted to deregistering.
- c. 8% were referred to safeguarding services.
- d. 4% received prosecution notices.
- e. 4% were issued School Attendance Orders (SAOs).

283. **School Attendance Orders ('SAOs'):** Even at the height of the pandemic, some families with Clinically Vulnerable members were issued SAOs, despite the health risks of in-person attendance. SAOs are intended to ensure children receive an education when there is evidence of neglect or a lack of provision. But in these cases, families were not neglecting education – they were denied access to remote teaching that was offered to Covid infected children whilst shielding. The government failed to provide them with a safe alternative. Using SAOs in this context was inappropriate, placing unfair pressure (directly or indirectly) on families to return to unsafe schools during a public health crisis.

(iii) The impact of designating CV families as “anxious”

284. The term “anxious” was used frequently throughout Department for Education ('DfE') guidance (and government messaging) when referring to CV or CEV people in relation to schools, see for example [LW.8/17 - INQ000648027]. CVF rejects the characterisation of our families as simply “anxious” – a term often used to imply emotional overreaction or unfounded worry – when in reality, concerns were grounded in scientifically proven and quantifiable risks to life. By presenting legitimate clinical risk to school staff as “anxiety” it minimised the seriousness of the situation.

285. This rhetoric was both dismissive and actively harmful. It was used to undermine families' decisions and to defend the refusal of any support. It contributed to hostile school environments and coercive practices.

286. It also skewed how absence and safeguarding data were recorded and subsequently interpreted. The failure to formally recognise CV household risk in attendance coding and official datasets has led to a significant data gap. Our children, especially those kept home to protect vulnerable family members, were statistically invisible. This ‘invisibility’

compounded their existing inequalities, making it harder to assess need, target resources, or advocate for appropriate protections.

(iv) Impact of severe absence or withdrawal from school

287. Across all stages of education, CVF's families reported significant gaps in educational provision and recovery support for C&YP in CV families. Many children missed one to two years of formal education without access to online classes or suitable alternatives, outside of periods of provision to all children. Yet, children in CV families were often excluded from catch-up schemes despite suffering greater than average learning loss. For children in critical exam years the impact was even more acute. In terms of exam disruption, CVF's data revealed:
- a. 46% were unable to sit one or more GCSE or A-level exams (or equivalent).
 - b. 29% had to change subject choice due to high Covid risks.
 - c. 44% received lower-than-expected grades.
 - d. 23% missed out on taking any exams at all.
288. The impact on exams extended beyond missing assessments: students were often forced to abandon core and/or chosen subjects altogether, potentially limiting their future outcomes. The lack of remote or flexible learning option left many without pathways to qualifications, despite significant personal efforts to continue learning independently.
289. In addition to the impact on attainment, the loss of a school place has serious and lasting consequences for a child. Places were hard to restore, particularly in highly sought after settings such as schools with a good reputation, SEND provision, or other specialist support. This often meant that the child was unable access or potentially return to a familiar learning environment - disrupting access to learning support from staff who understood their individual needs, as well as severing links to friends, peer support, and pastoral care.
290. The emotional and social effects of being removed from a school community, often under pressure, are also significant: children experienced anxiety, confusion, and distress. CV families did not actively choose to home educate, and in some cases were among the least equipped to do so due to serious health conditions, but it was the only viable option left available to them.

(b) Physical and mental health and well-being

(i) Physical Health

291. Official data is limited, however available evidence including both CVF member testimony and independent research such as the National Institute for Health and Care Research (NIHR): Policy Research Unit Children and Families Policy Research Unit in Children & Families (PRUCF) report, 'Changes in hospital contacts during the COVID-19 pandemic among vulnerable children and young people'—[LW.8/56 – INQ000648066]) indicates that the pandemic significantly disrupted healthcare access for children, leading to long-term impacts on the physical health of many CV children and children in CV families.
292. Shielding guidance for CEV children, though necessary, also contributed to reductions in healthcare access, as families avoided healthcare settings due to infection risks. Essential treatments, therapies, and interventions were often delayed, disrupted, or cancelled without alternative provisions. These gaps in healthcare access risked exacerbating existing health inequalities and may have lasting impacts on the physical health trajectories of C&YP.

(i) Mental Health and Well-Being

293. Mental health emerged as a significant area of concern for members of CVF. Whilst formal shielding measures were implemented to protect the physical health of vulnerable people, they had particularly profound and often overlooked effects on C&YP. For most C&YP in CV families, informal shielding extended well beyond official shielding periods and generally involved a far more stringent form of social isolation which contributed to anxiety, stress, and other mental health challenges among children living in CV households.
294. The British Psychological Society ('BPS') identified the fact that a significant psychological toll had been experienced by children in shielding families in its 2022 report, '*Meeting the Psychological Needs of Children in Shielding Families*' [LW.8/57 – INQ000648067]. The report identified several key factors affecting mental wellbeing: prolonged isolation, frustration if shielding continues, the fear of transmitting Covid-19 to vulnerable loved ones, and significant social exclusion. Children in vulnerable families were seen as a 'forgotten' group who frequently took on responsibilities to help manage healthcare and protect their families, while navigating extreme disruptions to normal life. This was often without recognition, validation, or access to support services. The report noted:

“Whilst little research has yet been conducted in this group, we know from research into the impact of social isolation and loneliness of children in other pandemics that children can be at increased risk of psychological difficulty from the impacts of quarantine. Studies show that children can still be affected by the impact up to nine years later, with rates of depression linked to feelings of exclusion (Loades et al., 2020)”

295. This document provides strong professional validation of CVF’s concerns. It confirms that shielding-related trauma in children was foreseeable. Despite the well-documented risks, no targeted mental health provision was developed or offered. The experiences of these children remained largely invisible within national policy, and there remains an urgent need for formal recognition and support.
296. The strain on such children was compounded by an already overburdened mental health system. The Child and Adolescent Mental Health Service (**‘CAMHS’**) had been widely known to be under-resourced even before the pandemic; in 2018, a leading psychiatrist described it as “not fit for purpose” [LW.8/58 – INQ000648068]. The pandemic exposed and deepened these systemic gaps, leaving many CV families without safe access to psychological support during a time of acute need.
297. In CVF’s view, government-imposed definitions of vulnerability created an arbitrary divide between those classed as CEV and those who were “only” CV, despite also facing heightened risk of severe illness or death. There was a general failure to acknowledge informal shielding – which was frequently carried out by CV households based on increased clinical risks. This meant that many children in CV families were not considered by organisations like the BPS. The government’s approach therefore not only excluded these families from public health planning but also denied these children clinical recognition.

(c) Access to Healthcare

298. Routine medical appointments, essential for managing chronic conditions, were delayed or cancelled as healthcare systems prioritised Covid-19 cases. CVF members also frequently proactively avoided non-urgent face-to-face care. The disruption to normal appointments posed risks for C&YP with clinical vulnerabilities, which in some cases will have exacerbated their existing health conditions and delayed vital

treatments required to manage their conditions. It also delayed diagnosis and care for CV children and those in CV households.

299. Guidance around masking for children created a troubling conflict of needs for CV families. On the one hand, they were expected to bring their CV or otherwise healthy C&YP into healthcare settings, which were environments recognised as high-risk for Covid-19 transmission. On the other hand, CVF's families were often shocked to find that they were discouraged from presenting with a child in a mask, even when the child themselves was CV, and their mask was a well-fitting KN95 / FFP2 or above. CVF members have reported that occasionally safeguarding referrals were made in response to them presenting with their children in a mask. These same healthcare settings often served young children and those with SEND, who were exempt from restrictions and unmasked. This left vulnerable children in close proximity to others without the option, in some cases, for any basic protective measures.
300. Children's healthcare environments were essential infrastructure, but they were among the least mitigated for airborne transmission, leaving the most vulnerable families caught between the need for care and the need for safety from infection. As a result, some families avoided, or significantly minimised, accessing healthcare. For some children this delayed necessary treatment and had a long-term impact on health.
301. The PRUCF report confirms that CV children faced some of the steepest reductions in access to care between 23rd March and 31st December 2020:

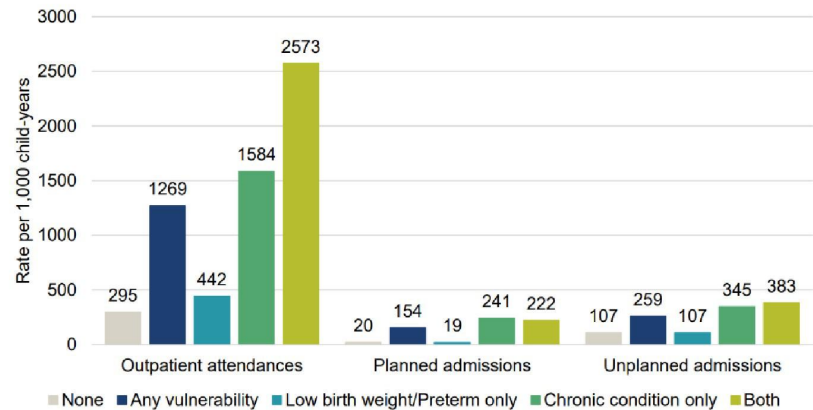
*"The COVID-19 pandemic has highlighted the inequalities in our society and it is likely that the decreases in hospital contacts among children have not been borne equally. **Children who are clinically or socially vulnerable** due to additional needs for healthcare or social or educational support **are likely to have had greater reductions in hospital contacts than their peers.**" (NIHR PRUCF 2021, p9 [LW.8/56 – INQ000648066])*

302. The research found that CV children, who had higher prior healthcare use such as frequent outpatient or inpatient care before the pandemic, experienced greater drops in planned healthcare during 2020. This suggests that the children with the most significant ongoing health needs were most impacted. The report found that these reductions were not simply due to shifts in delivery of care, but a real gap in service provision for children with

established vulnerabilities. It points to systemic failures in pandemic planning for children reliant on continuous medical support and undermines equity in healthcare access:

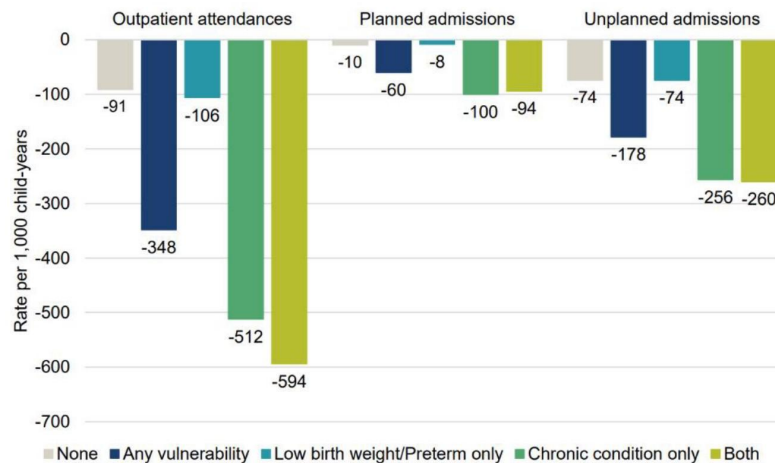
*“A large number of outpatient attendances and hospital admissions were deferred or foregone during the pandemic. Among children age 0 to 4 years there were 511,185 fewer hospital contacts than predicted between 23rd March to 31st December 2020 [as shown in Figure 9 and 10 below]. This deficit comprised 282,820 fewer outpatient attendances, 39,044 fewer planned hospital admissions, and 189,321 fewer unplanned hospital admissions. **These deficits disproportionately affected children who were clinically vulnerable.** The 20% of children with a chronic condition, born preterm or with low birth weight accounted for 48% of the deficit in outpatient attendances, 60% of the deficit in planned hospital admissions, and 37% of the deficit in unplanned hospital admissions.”* P (NIHR PRUCF 2021, pp. 20-21 [LW.8/56 – INQ000648066])

Figure 7: Pre-pandemic average rate of hospital contacts per 1,000 child-years among children aged 0 to 4 years (2015 to 2019), by vulnerability group.



[Figure 9]

Figure 8: Difference in predicted versus observed rates of hospital contacts per 1,000 child-years among children aged 0 to 4 years for the period March 23rd to December 31st 2020, by vulnerability group.



[Figure 10]

303. It is also important to recognise a significant blind spot in the data: children living in CV households were not explicitly captured in these datasets as a distinct risk group as explained in NIHR PRUCF Report dated 4 November 2021 [LW.8/59 – INQ000648069]. As a result, decisions to reduce or delay care by these families, often made to protect a vulnerable household member from exposure to Covid-19, may be misclassified as part of the general decline in healthcare use among otherwise “healthy” children. CVF is concerned that this invisible subgroup likely contributed to the apparent drop in attendance among children not identified as CV, obscuring the true extent of unmet need and behaviours. These children were not only deprived of care, but also lacked recognition in any recovery planning or future planning - widening disparities for families already managing health vulnerabilities.

(d) Social and emotional development

304. National policies promoting the return to school and wider social mixing were framed as supporting emotional development for all children.
305. From CVF’s perspective this approach was not inclusive of CV families, for whom returning to school and increased mixing carried serious health risks. CVF saw no acknowledgement of the fact that prolonged isolation due to risk avoidance created significant barriers to emotional development, and safe alternatives were not provided. No targeted interventions have been offered to address the impacts experienced by these children.

306. CVF have identified profound and unique challenges to the social and emotional development of C&YP who were themselves CV or who lived in CV households during the inquiry timeframe. These challenges were often overlooked by mainstream policy and support structures, yet they had significant and undoubtably long-lasting impacts on the wellbeing of this group.

(i) Emotional strain

307. CVF members reported that CV C&YP and those in CV households often carried an acute and ongoing pressure to avoid Covid-19 infections. The responsibility often caused intense emotional stress and legitimate anxiety for many children who were aware that their actions, such as attending school, could endanger themselves or a family member. CVF members recognised this as an impossible burden to be placed on children, who were expected to maintain normal routines in an environment that felt inherently unsafe to them and their families. Even children in their early primary school years were often acutely aware of the risks, and they were put in a position where they had to navigate adult-level fears and responsibilities during a time in their development that should have been defined by safety, learning, and play.
308. Where a child or young person was not CV, some C&YP felt resentment, guilt, or emotional conflict related to unequal freedoms or increased responsibilities. There is evidence that in the case of disability, siblings can experience significant developmental consequences and may require attention as set out in this article by The British Psychological Society, *Meeting the psychological needs of children in shielding families* | BRE33p | 21.07.2020, Griffiths, O'Connor, Phillips et al [LW.8/57 – INQ000648067] in which is said:

“Siblings of children who have chronic health needs are already at greater risk of psychological distress, and are often seen as a ‘forgotten’ group in terms of their psychological needs. As the focus in the family can often be on the needs of the person who has a health condition, healthy siblings/children can sometimes be overlooked.”

309. Despite the clear psychological toll, CVF members found that no specific counselling or emotional support services were proactively offered to CV C&YP or those in CV households. Many struggled with feelings of guilt, fear, loneliness, and trauma, yet were expected to cope without any professional guidance or understanding and support from their schools or colleges.

(ii) Social isolation

310. Many CV families engaged in informal or extended shielding and reduced social contact well beyond official guidance, particularly before vaccines and antivirals were available. As a result, children in CV households often missed out on in-person schooling, extracurricular activities, or peer interactions. This led to pronounced social isolation. Unlike their classmates, who had returned to social norms after a matter of weeks, many C&YP in CV families remained isolated for much longer periods, delaying social development outside of the home and their ability to form or maintain their previous friendships.
311. For children in the Early Years Foundation Stage ('EYFS') - which, as defined by the government, "sets standards for the learning, development and care of your child from birth to 5 years old" [LW.8/60 – INQ000648070] - CVF found that many young children, who were below the age of compulsory schooling, simply remained at home rather than attending 'Reception' years or pre-school settings. This limited their access to early education and social environments. They missed opportunities for play-based learning and interaction seen as important for emotional intelligence, communication skills, and social integration.
312. In response, some CVF members often sought alternative ways to mitigate these effects, such as enrolling their children in outdoor Forest Schools or forming small, trusted outdoor playgroups with more cautious CV families. Older C&YP were often better able to maintain their social connections via the internet, through gaming, chat groups, and other social media. Virtual spaces provided them with a vital connection, helping to reduce their feelings of isolation and preserve some of their friendships during extended periods of shielding.

(iii) Masking and Discrimination

313. CVF members reported that for children in CV households, the choice - or necessity - to wear masks in educational settings became a significant source of social exclusion, bullying, and discrimination. Further data collected in CVF members' survey found that of C&YP in clinically vulnerable households:
- a. 47% had received negative comments from staff.
 - b. 56% had received negative comments from peers.

- c. 27% had experienced physical bullying (including intentional coughing)
 - d. 29% had suffered verbal bullying.
 - e. 6% had experienced online bullying.
 - f. and 90% of CVF families said they wanted their children to have the option to wear masks in a supportive school environment.
314. When mask-wearing was no longer the norm in schools, these children were frequently isolated, harassed, and even punished for continuing to wear face coverings to protect vulnerable family members. Continued mask use in schools became a visible marker of difference. CVF received numerous accounts of pupils facing challenges for wearing face coverings after broader mandates were lifted.
315. Children were commonly bullied by peers, called names, or sometimes physically intimidated. In some cases, children were physically attacked - including masks being pulled off or deliberately coughed on. Some CVF member shared their following experiences:

Quote 76 from CVF Member

"Our son was widely bullied by children at school for wearing a mask when others were told it was no longer mandatory... Some even tried to remove it from him physically. Some teachers would question him as to why he was wearing a mask or tell him to remove it."

Gemma, parent

Quote 77 from CVF Member

"[My child] suffered bullying and discrimination from their peers and staff as a mask wearer. They were told repeatedly they didn't work / weren't required, questioned as to why they continued to wear one... Physically intimidated and verbally abused. A classroom assistant asked how [they] would react if someone ripped the mask off their face. Another child told [them] that they hoped their sibling died of Covid and on another occasion told [them] that they and their sibling should both kill themselves."

Keegan, parent

[This young person ultimately left school midway through A-levels due to persistent bullying and lack of support]

Quote 78 from CVF Member

"My oldest daughter started secondary school in September 2020. She wore a mask. She had her bag stood on and was picked on daily by kids for wearing a mask. On the coach to competitions, no one would sit next to her and a group of girls would spend the journey repeating 'why are you wearing a nappy on your face' and making nasty comments."

Quinn, 45, parent

Quote 79 from CVF Member

"My eldest child was told they'd prefer he died, then they wouldn't have to wear a mask."

Samira, 43, parent

Quote 80 from CVF Member

"Son in particular was bullied at secondary school by other children and staff. Made to remove mask and caught Covid - brought it home to our CEV family and still has massive guilt to this day about the effects it had."

Davey, 50, parent

Quote 81 from CVF Member

"School called me and requested they didn't wear masks as it was making things difficult for the children with their peers. We gave our children the choice and they wore them and so did some of their close friends in support. When teachers didn't wear masks it was more difficult. They therefore sat close to open windows and unmasked after time due to peer pressure and pressure from school to not mask. Children didn't want to 'get told off'"

Kate, 36, parent

316. Children in CV families frequently faced pressure from teachers and school leaders to remove masks, despite wearing them to protect family members or themselves. CVF has documented multiple instances of explicit coercion, exclusion threats, and undermining of medical precautions, often resulting in serious emotional distress. In one instance that CVF is aware of, a child was removed from a critical school progress assessment to be asked to take off their mask, against parental consent. The repeated pressure from staff led the child to comply, even though they wore the mask to protect a highly CEV single parent. The experience left the child in tears at home and

contributed to long-term anxiety. The school headteacher threatened to exclude the child entirely if they ever wore a mask again in school.

317. This is not an isolated incident. Across the CVF, multiple families reported that school staff:

- a. Repeatedly questioned children's use of masks;
- b. Claimed masks were not necessary or made teaching too difficult;
- c. Refused to provide safe spaces for masked children to eat or drink;
- d. Created classroom dynamics in which mask-wearing students were treated as problematic or disruptive;
- e. Failed to intervene when a child was harassed by their peers.

318. There were frequently mental health and other consequences:

Quote 82 from CVF Member

"As a direct result of our 12-year-old daughter understanding that the school would not let her mask, a large section of her hair fell out. We explained our family situation to both our school and LEA and asked for flexibility and help with basic infection control measures so that our children could return safely to school. We were met with flat refusals at every turn."

Morgan, parent

319. CVF's findings revealed that the bullying of masked pupils / students intersected with broader patterns of exclusion and stigmatisation. Children from CV households were made to feel different, or that they were a problem. Sometimes children were excluded from optional activities like music concerts, or school trips, as they were masking and required adjustments such as ventilation. Schools failed to provide inclusive messaging or enforce anti-bullying policies that recognised mask-related harassment as a safeguarding concern. Some CVF members reported that their children's schools banned mask wearing entirely.

320. For those in CV families, masks (FFP2/3) were an enabler – they allowed C&YP to return to high-risk school environments safely and yet they increasingly found they were challenged for wearing them. Schools began treating the mask as the safeguarding concern even though, not long before, mask-wearing was a requirement for many, and it was the absence of masks that had been recognised to be the risk.

(iv) Long Term Effects

321. Many CV C&YP have emerged from the acute stage of the pandemic with unique social and emotional legacies. While some developed greater empathy, maturity, and resilience, the psychological cost of shielding, social isolation, stigma, and sustained anxiety has also left a lasting impact.
322. For many, this includes heightened anxiety, social withdrawal, trust issues, and fractured friendships - especially among those who were seen as "different" due to masking or continued caution. One parent reported:

Quote 83 from CVF Member

"Our children are well rounded, intelligent, empathetic young people... but the lack of support or understanding does impact them... They have been left more cynical about other people's intentions and behaviours as a result of how they have been treated."

Campbell, 48, parent

323. Another described their children's emotional and developmental regression due to the pandemic's toll:

Quote 84 from CVF Member

"It led to them being behind their peers in development in certain areas... [Our non-CEV child] is now taking a year out before university... to work on the areas that cause them anxiety and stress. They are not confident going out alone, for example."

Kate, 41, parent

324. A young person's mental health was described as suffering from the burden of constant advocacy and vigilance:

Quote 85 from CVF Member

"The major issues for [the child] revolved around the pressures of trying to mitigate the risk of carrying infection home... This is/was a huge responsibility on young shoulders and, with the lack of support from school, had a detrimental impact on their mental health."

Charlie, 42, parent

325. Another family explained that their child, once social, had become withdrawn and lost trust in both peers and adults:

Quote 86 from CVF Member

“Social ostracization – bullying – loss of socialisation – lost education – loss of faith/trust in adults in positions of authority.”

Katherine, 39, parent

326. These responses highlight a consistent theme: children in CV families were frequently overlooked and unsupported by educational and health systems. As a result, many now carry the unacknowledged consequences. Some developed strong emotional intelligence described by one parent as becoming *“emotionally wise beyond their years”* a reflection not of resilience alone, but of the pressure to navigate inconsistent adult behaviour and social exclusion without support. Enforced maturity sits alongside unaddressed trauma and, in some cases, emerging PTSD.

(e) Family life

327. For many CV children, shielding meant a reversal of expected roles. Children took on emotional responsibility for keeping their families safe, worrying about infection risks, and adjusting their own behaviours to protect others. In some households, this included practical caregiving duties normally carried out by adults. This shift placed an unfair emotional and developmental burden on children.
328. Isolation from extended family was another major loss. To reduce risk, many shielding households cut off almost all in-person contact beyond their immediate family. Children missed not only their friends, but the broader emotional support usually provided by grandparents, cousins, and family friends. Normal family events: birthdays, religious holidays, graduations were often missed entirely. Over time, this loss of connection deepened feelings of isolation and exclusion for many children.
329. Financial strain also played a significant role. Parents who had to shield or manage the risks within their household frequently faced loss of income, reduced working hours, or precarious employment conditions. Some families faced severe financial hardship, increasing stress within the household and compounding the challenges children were already facing.

330. Day-to-day life at home also became much harder. With the lack of safe access to schools, respite services, and external support networks, the full weight of childcare, education, and household responsibilities fell onto shielding families. Children with additional needs were particularly affected, but even those without formal diagnoses lost access to normal developmental supports. The lack of respite placed constant pressure on every member of shielding households, often with no outside relief.

(f) C&YP as carers for household members who are CV

331. Many C&YP in CV households took on informal caregiving responsibilities that would not typically be expected at their age. CVF members consistently identified the following main challenges for these young carers. Significantly, many of them were new and not formally recognised:
- a. **Increased emotional and psychological burden:** Children often felt personally responsible for protecting their CV family members from infection. This led to heightened concerns regarding bringing home an infection that caused serious illness or death, causing significant emotional strain.
 - b. **Disruption of normal childhood activities:** Many of these young carers had to withdraw from their normal activities to minimise the risk of bringing infection home. Shielding measures limited their ability to attend school fully, meet friends, or participate in extracurricular activities.
 - c. **Lack of formal recognition and support:** These new young carers were not formally identified by local authorities, schools, or healthcare providers. As a result, they did not receive access to the support services typically offered to young carers, such as respite care, counselling, or educational adjustments.
 - d. **Increased practical responsibilities:** C&YP often took on practical tasks normally carried out by adults, including managing infection prevention and control measures both within the home and in school or college environments. Many supported siblings with education, assisted with household duties, and in some cases, helped with healthcare needs. This was particularly common where single parents or carers were CV and unable to safely receive outside care due to risks.

332. CVF members expressed concerns that the pressures and burdens placed on these young carers may have long-term effects on their mental health, social development, educational attainment, and future opportunities.

(g) Safeguarding C&YP

333. In the context of the Covid-19 pandemic, safeguarding principles took on specific relevance for C&YP in CV families, whose unique risks and needs were often overlooked in standard safeguarding practices. The NSPCC have outlined the key aspects of safeguarding as: protecting children from abuse and maltreatment; preventing harm to their health and development; ensuring they grow up with safe and effective care; providing early support when problems emerge; and taking action to secure the best outcomes for all C&YP.
334. Government policies should have, but did not appear to, account for safeguarding the needs and complexities faced by C&YP in CV families either whilst in school or during any form of shielding (formal / informal). This oversight meant that the specific needs and risks of these C&YP were unrecognised and unaddressed whilst exposing this particularly vulnerable group to avoidable harms.
335. The shortfall in support can be considered using safeguarding headings, as defined by the NSPCC:
- a. **‘Protecting children from abuse and maltreatment’:** Safeguarding typically focuses on protecting children from direct abuse or neglect, but children in CV families faced known risks to their physical and mental health. Many also experienced bullying for wearing masks or taking extra precautions - behaviour that caused emotional harm. Children were also exposed to high infection risks in poorly mitigated high risk classroom environments, resulting in avoidable harm.
 - b. **‘Preventing harm to children's health and development’:** Children in CV families faced both direct health risks from Covid-19 and secondary harms due to efforts to avoid infection. Some families delayed or avoided healthcare appointments for fear of exposure, potentially worsening pre-existing conditions or delaying diagnoses. Others missed significant periods of school - either through shielding, or repeated absences - which disrupted learning and social

development. These combined physical, emotional, and developmental harms were foreseeable but unaddressed.

- c. **‘Providing support to meet children’s needs when problems emerge’:** Children shielding at home required timely access to remote education and emotional support. Those attending in person often did so without adequate protections, and experienced stigma for taking additional precautions. Many received no appropriate early support. The lack of support for these children meant that their emerging needs were frequently unmet, contrary to safeguarding principles.
- d. **‘Ensuring children grow up with safe and effective care’:** Where possible, safeguarding aims to ensure children grow up in safe environments. For children in CV families, this meant minimising exposure to Covid-19. However, the pressure to attend school in person, despite health risks, compromised the safety of their home environment and so safe and effective care was not provided by schools.
- e. **‘Taking action to enable all C&YP to have the best outcomes’:** Achieving the best outcomes for children includes ensuring their physical health, emotional well-being, and educational progress. For children in CV families, this required a nuanced approach that balanced these factors. Standard safeguarding measures often lacked the flexibility to accommodate these complexities, potentially hindering the children's overall development.

336. While the core principles of safeguarding are designed to protect children, their application during the inquiry timeframe did not always align with the new needs of children in CV families. A more adaptable and empathetic approach was necessary to truly safeguard these children in unprecedented circumstances.

(i) Inappropriate Referrals

337. The systemic lack of consideration for CVF children also resulted in some families experiencing inappropriate referrals to Children's Services for safeguarding concerns related to non-attendance. CVF data indicates that 8% of CV families experienced such safeguarding referrals [LW.8/61 - INQ000648071], despite legitimate health concerns. CVF believes that this was an abuse of safeguarding protocols which should have been

there to protected children in these families from such pressures and ensure that decision-making considered the child's and family's health.

338. Schools and Local Authorities were driven by attendance targets when they diverted safeguarding services away from children who urgently needed to be protected from harm. Safeguarding was used as a further means to pressure families, who were acting to protect their families' health, into choosing between retaining school places and safeguarding the lives of CV household members. Fortunately, once a family's situation was clarified, services usually rapidly recognised that these referrals were not caused by neglect or abuse and cases were dropped.

Quote 87 from CVF Member

"The [safeguarding] officer said that it was clear very quickly that this was a malicious referral to them. That there were no safeguarding issues whatsoever and that they had done this purely to try and force me to send my children into school"

Melissa, 43, parent

(ii) Genuine Safeguarding concerns

339. Some children in CV families would have required safeguarding interventions - not because of their CV status, but due to circumstances exacerbated by the pandemic. The unique challenges faced by these families, such as increased isolation, reduced access to support services, and heightened stressors, could elevate the risk of harm to children. For instance, the NSPCC reported, in a publication in June 2020 [LW.8/62 – INQ000073864] that the pandemic increased stressors on caregivers, which in turn heightened the risk of child abuse and neglect. The reduction in normal protective services, such as face-to-face visits from social workers and health professionals, meant that signs of harm could go unnoticed. As children in CV households experienced considerable prolonged and more extreme isolation, increased risk of job losses and financial insecurity, and not just digital exclusion but in-person exclusion from both healthcare and education, there was need for safeguarding frameworks to adapt and address their heightened vulnerabilities.
340. While CV status itself does not necessitate safeguarding interventions, the pandemic-related circumstances surrounding CV families can create environments where some children may be at increased risk. Safeguarding frameworks should be updated to incorporate a more comprehensive understanding of the diverse risks and pressures faced

by all families during public health crises. This includes acknowledging the legitimacy of health-related absences and ensuring that protective measures do not inadvertently penalise families simply trying to protect vulnerable members, effectively forcing them out of the formal education system and its safeguards.

PART G - Government support for CV children or children in CV households during the pandemic

341. CVF is aware of a limited number of government support measures made available during the emergency phase of pandemic to CEV children, and, to a much lesser extent, to CV children and those living in CV/CEV families. These measures have been considered in greater detail in other parts of this statement [cross-reference] but are summarised below.
342. CVF believes that these were largely fragmented, inconsistently applied, and not designed to meet the distinct needs of all CV households, many of whom were excluded from the little support that was available. The scale and design of the support were insufficient to mitigate the disproportionate and significant educational, health, social, and emotional impacts experienced by CV C&YP.

(i) Education

343. **Laptops and Internet Access:** The DfE enabled eligibility for digital support for CEV children and children in CEV households. However, distribution was inconsistent, and many shielding families reported not being contacted or receiving support or devices. CVF considers that the provision of digital access was insufficient, both in scale and implementation, to meet the needs of C&YP in CV families during extended periods of shielding.
344. **Remote Learning Access:** CEV children were, during periods of enforced shielding, recognised as entitled to remote learning. However, shielding CV children or those protecting CV/CEV family members were not guaranteed remote education beyond general national school policies. CVF considers that remote learning support was inadequate, particularly when children were unvaccinated and after other national protective measures were withdrawn.

(ii) Healthcare

345. **Remote Healthcare Services:** Telemedicine was expanded nationally across NHS to enable remote consultations during the height of the pandemic. CVF considers that while telemedicine improved access to some healthcare services, it was insufficient to maintain continuity of routine or specialist care for many CV children.

(iii) Food Security

346. Food insecurity was a significant concern for families with Clinically Vulnerable members. Government help for CEV C&YP - food parcels, priority supermarket-delivery slots and medicine deliveries - was hampered by access barriers and poorly suited contents. Clinically vulnerable (non-CEV) families were left out of formal schemes, so both CV and CEV households struggled to secure essentials.

347. **CEV Food Parcels:** The shielding programme's food-parcel scheme offered a weekly box store cupboard basics to anyone formally listed as CEV, which included C&YP. However, their contents often fell below basic nutrition guidelines and rarely took account of medical or cultural food requirements

348. The offer applied only to the named individual, with nothing extra for shielding C&YP in a CEV household. This urgent, early pandemic, help arrived too late for many households, and families quickly ran out of supplies while trying to access to online deliveries. CVF members said that a one-off payment, would have offered faster, safer and more flexible support.

349. **Priority Supermarket Delivery Access:** CEV people registered through the national shielding programme were eligible for priority online supermarket delivery slots. CVF considers that while this was helpful for shielding households once they were added to the lists, but there were issues faced by larger families or where the CEV person was not themselves the previously registered for online accounts/ It was particularly problematic if the CEV individual was a child and therefore unable to register a supermarket account, which seemingly needed to be linked via government databases for approval purposes.

350. **Free School Meals:** The government's FSM support for children learning from home consisted mainly of school-issued food parcels or vouchers. However, the scheme

generally required families to physically attend to collecting supplies from school, many shielding CV households were effectively excluded. Some CVF members were told they must send children back to school to keep their FSM entitlement. Those who had deregistered in order to shield lost the support altogether.

351. Where FSM parcels did reach homes, they often failed to meet nutritional standards and were ill-suited to medical or cultural dietary needs. Vouchers were patchily distributed and not usable for online supermarket orders, leaving many CV low-income households without access to this essential resource during a time of heightened need.

(iv) Mental Health and Wellbeing

352. National Digital Mental Health Resources: There were some increases in digital mental health provision (e.g. NHS mental health support via online services) and public health messaging around wellbeing. Every Mind Matters “*a campaign run by NHS England, which features the mental health tool My Mind Plan* at the heart of their resources and advice for those facing mental health problems” was expanded to parents supporting children and teenager’s mental health. CVF is concerned that resources were not targeted to CV C&YP or those impacted by shielding. Many CVF families report worsened physical health due to loss of services and distress stemming from prolonged isolation, infection risks, and systemic exclusion. CVF is not aware of any specific mental health support for these C&YP, despite their increased risk.

PART H - Positive Impacts of the pandemic on CV C&YP

353. While the pandemic posed significant challenges for CV C&YP, as well as those living in CV households, families and individuals reported experiencing some positive outcomes as a result of the changes in lifestyle and education that the pandemic brought about. The benefits were often nuanced and personal, but the feedback provided by CVF members includes insights into aspects of pandemic life which may help to inform more compassionate and inclusive policies in the future. Below are some key areas where CVF members identified positive impacts for CV C&YP:

(i) Strengthened Family Bonds and Emotional Connection

354. Lockdowns and stay-at-home orders resulted in many families spending significantly more time together. For shielding families, this often translated into deeper familial bonds, a

sense of security, and consistent emotional support. In survey responses, parents noted that the closeness and increased time at home allowed them to better understand and meet their child's emotional and developmental needs.

Quote 88 from CVF Member

"We are fortunate to be a close family with two parents able to work from home, so we were able to support our children and grow even closer."

Sam, 53, parent

(ii) Improved Mental Health and Emotional Stability

355. Some C&YP, particularly those who previously struggled with overstimulation due to external environments, benefited from the calmer atmosphere of home life. This benefited children in specific cohorts, such as those with autism, anxiety, sensory processing issues, and those who had experienced trauma (sometimes induced by the strain of staying safe in a pandemic) reported that the slower pace of life and the predictability of home routines were described as beneficial. Being away from busy classrooms, noisy corridors, flickering lights, and rigid schedules allowed them to feel more secure and emotionally balanced.

Quote 89 from CVF Member

"Our child was much happier during lockdown than usual. Due to the nature of his medical conditions (ASD, ADHD and early life trauma) he felt more secure at home. Life was slower, more predictable, and he knew that he had both my husband and I all day every day... His behaviour was improved due to the low demand environment and his overall feeling of safety"

Margaret, 57, kinship carer

356. This shift in environment provided a sense of stability and safety that, for some children, was not accessible at that time in education settings.

Quote 90 from CVF Member

"My child was like a different person once away from school, happy, content and able to sleep."

Mel, 40, parent

357. School environments, while designed for the average child are not always adequately accommodating the needs of all children, including those who are neurodivergent or emotionally vulnerable.

(iii) Benefits of Home-Based Learning

358. Though many CV C&YP struggled with remote education due to lack of support or technology, others thrived in the home learning environment. Parents who had the capacity or educational background to support their children were able to tailor learning to their child's pace and interests. This sometimes led to improved academic engagement, increased confidence, and in some cases, better educational outcomes.
359. Some children explored subjects of personal interest, such as digital art, science, or history through online platforms like NASA archives or virtual museum tours - resources they might not have accessed under normal circumstances.

Quote 91 from CVF Member

"Actually my daughter's academic progress accelerated. She was far above her peers when she returned to school."

Jo, 45, parent

Quote 92 from CVF Member

"We are fortunate to live in a village in the countryside which is also less than a mile from the beach. Our child needs regular exercise to regulate as well as to stay fit, and he had twice daily exercise with my husband, walking and/or cycling in our local area and playing on the beach and in our garden. We made our old camper van on the drive into an arts and crafts room for him. His physical and mental health were OK during lockdown. In fact his mental health was improved."

Anne, 60, primary carer

(iv) Increased Resilience, Empathy, and Advocacy

360. A number of young people developed a heightened sense of empathy, responsibility, and resilience. Living in a pandemic, especially with the added layer of protecting a vulnerable family member or managing their own health risks, developed a sense of maturity and a greater awareness of social and health justice issues.

Quote 93 from CVF Member

"Children developed a love for science and data. They also developed resilience. They are happy to stand out from the crowd and accept being different, especially if they are convinced that they are doing the right thing."

Liz, 48, parent

361. Several CVF respondents noted that their children became more vocal in advocating for the rights of vulnerable populations, including their own families.

Quote 94 from CVF Member

"Developing understanding of disability rights and the importance of advocating for yourself and others has been positive for personal development."

Sarah, Primary Carer

(v) Freedom from Negative School Experiences

362. For some C&YP, being out of school provided a reprieve from harmful or stressful experiences such as bullying, racism, or anxiety-inducing classroom environments. Parents noted that their children, who were struggling in school, regained self-esteem and joy during home education.

Quote 95 from CVF Member

"No school = No bullying"

Sharon, 41, parent

Quote 96 from CVF Member

"I hadn't realised how badly attending school affected their behaviour and general wellbeing. Discovering how well home education works for them only came about because we were forced into it, but I wish I had known about the possibility of it much sooner"

Jenny, 40, parent

Quote 97 from CVF Member

"The Lockdown periods were when [child 2] felt safest, they had access to online resources for learning, everyone was in a similar situation and treated equally. [...] It has been well documented that children needed to attend school 'for their mental health' but the huge mental toll of keeping a family member safe from infection, of

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

Alex, 42, parent

363. Systemic issues within school environments disproportionately impacted certain CV or otherwise vulnerable children. Many of the challenges already highlighted - such as bullying, lack of inclusion, and unsafe conditions - meant that some C&YP experienced school as a source of distress rather than support. CV C&YP often felt hugely pressured in unsafe school environments and a sense of relief at home often and this points to the need for reforms in guidance on safety, and education policies.

(vi) Exposure to New Hobbies, Interests, and Digital Learning Tools

364. The shielding and lockdown period provided children with time and space to pursue hobbies and creative interests outside the traditional curriculum. Some children developed digital skills, learned to code, explored online art and music programs, or engaged in virtual communities that were inclusive and accessible to them.

Quote 98 from CVF Member

"Youngest earned art awards and had his art displayed in galleries. Oldest passed online LAMDA acting exams. The biggest positive was for them to recognise their own worth and value intrinsically."

Amy, 45, parent

Quote 99 from CVF Member

"He started a Duke of Edinburgh award which was great and gave him a focus. He started cycling as part of that, and his dad also got a bike to support this. This has turned into a long term hobby"

Michelle, 48, parent

365. Self-directed learning seems to have provided a sense of accomplishment and identity beyond the academic pressures of school and college.

366. These positive experiences highlight the importance of flexibility and inclusivity in public policy. Moving forward, there is a strong case for maintaining elements of remote learning, improving accessibility, and recognising the diversity of children's needs - especially for those who have thrived outside of traditional education. Their lived experiences must inform long-term planning, not just in pandemic preparedness, but they can help to create a more equitable and compassionate environment for *all* children.

Part I - CVF's interactions with Government

367. CVF made extensive efforts to engage with government ministers, departments, and agencies, particularly around the issue of school attendance and safety for children in CV households. Despite repeated contact with officials including the Prime Minister, Secretaries of State for Education, and Ministers for School Standards, CVF was not formally invited to participate in government consultations, Select Committees, or stakeholder roundtables. Policy decisions that directly affected CV children were made without input from families that were most impacted.

(i) Direct Correspondence with Ministers and Departments

368. CVF telephoned and submitted numerous letters and emails to key departments, warning of the risks created by mandatory school attendance, lack of mitigations in classrooms, and the withdrawal of remote learning for children in high-risk households. These communications included:
369. On 6 December 2021, CVF wrote to the Secretary of State for Education asking that remote learning be recognised as "in attendance" for children in CV/CEV households, that families be allowed to choose hybrid or remote schooling until mitigations improved, that fines and safeguarding referrals cease where absence protects life, and requested that the minister meet with them to urgently discuss these issues. CVF received responses from the Secretary of State, as well as the Minister of State for School Standards, and the Ministerial & Public Communications Division and these are exhibited as [LW.8/63 – INQ000648073].
370. CVF submitted evidence to Parliamentary inquiries and government reviews, including:
- a. The Schools Bill Committee [LW.8/64 – INQ000648074]
 - b. The Parliamentary Inquiry into School Attendance [LW.8/65 – INQ000648075]

(ii) Lack of Consultation or Engagement

371. CVF was not invited to any formal education stakeholder meetings, DfE working groups, or public health roundtables regarding vulnerable children. This contrasts with the inclusion of representatives from other sectors (e.g. school leaders, or SEND organisations), and in CVF's view this is symptomatic of a systemic lack of recognition for CV children and children in CV families as a distinct cohort needing specific support.
372. CVF also submitted a Freedom of Information request to the Department of Health and Social Care, regarding the vaccination of children, particularly those in CV/CEV families and subsequently received a response [LW.8/66 – INQ000648076]

(iii) Early Petition for Remote Learning

373. Not long after CVF was formed, I created an official government petition titled "Enable online learning for children who live with those who are vulnerable", calling for safe, remote education options for pupils living with CV family members [LW.8/67 – INQ000648077].
374. The petition highlighted the impossible choice many families were facing between protecting life and accessing education, urging the government to allow authorised remote learning without fear of fines or prosecution, as resources were available for those isolating. It received over 6,000 signatures, but no formal response was issued, as it did not reach the 10,000 threshold required for a government reply. This prevented urgent grassroots concerns from being formally acknowledged - despite the petition raising a direct threat to life and safety for a high-risk group.
375. CVF believes that this reflects a broader systemic failure: there appeared to be no screening in place to identify and prioritise public concerns that involved valid threats to health. In a national emergency, there should be oversight of such petitions and clear pathways for engagement with serious issues, especially those raised by or on behalf of vulnerable populations.

(iv) Layla Moran MP

376. CVF collaborated with MPs including Layla Moran to raise concerns in Parliament and directly with ministers:

- a. 3 February 2021: CVF administrator Sughra Nazir, along with another CVF member, gave testimony to the All-Party Parliamentary Group (APPG) on Coronavirus, describing the distressing treatment she received from the head of pastoral care at her daughters' school. She recounted being told *"that [she] had lived [her] life and [she] should sacrifice [her] life for the sake of [her] girls' education."* The pastoral head went on to tell her, *"Well, you are not understanding the implications in terms of mental health on your girls."* Nazir responded, *"I do understand. I am a social worker of 23 years, and as somebody who experienced parental bereavement at a very young age, I also have an appreciation of the potential impact that might have on my girls."*
- b. Following CVF's involvement in an All-Party Parliamentary Group ('APPG') on Coronavirus, Layla Moran MP raised the issue of unauthorised absence for CV families with then Schools Minister Nick Gibb.
- c. CVF members provided written statements to Layla Moran's office ahead of her scheduled meeting with Schools Minister Nick Gibb.
- d. 11 March 2021: Layla Moran met with Nick Gibb. In a follow-up email to me which she ask to be circulated to CVF contributors, she shared that Gibb had acknowledged *"that it was wrong for schools to forcibly deregister or off roll students that weren't coming to school for CEV/CV relative reasons."* [LW.8/68 – INQ000648078] He asked that families reported cases of off rolling to Ofsted. She also shared that he emphasised headteachers had discretion in such cases and that fines should only be used as a last resort. Layal Moran relayed that Nick Gibb advised that headteachers should consider granting a "leave of absence" for affected pupils, though this was not stated in official DfE guidance at the time. No formal update was issued to schools or local authorities following the meeting.
- e. 2 March 2021: In the page update history for the school attendance guidance, the government website notes: *"2 March 2021 Added a link to the new set of sub-codes and clarified information in the Data collection section."* [LW.8/69 – INQ000648079]
- f. This action resulted in a crackdown on attendance enforcement and fines, leading previously supportive schools to reverse their stance. Absences for

Covid-related risk were no longer accepted; with many schools claiming they had no way to code such absences.

- g. 4 March 2021: CVF members reported that Hampshire LEA ceased support for remote learning, even though many CV adults remained unvaccinated, and many CEV adults had only received a single dose. CV children under 16 also did not have an approved vaccine available to them.
 - h. 26 April 2021: I phoned Nick Gibb's office on behalf of CVF and explained in detail to an administrator risks and issues. I was advised to follow up with an email outlining CVF's concerns around risk, the need for remote learning, mask support, and concerns over deregistration [LW.8/70 – INQ000648080] No reply was received.
 - i. 29 April 2021: The DfE responded to concerns regarding a particular family who was being threatened by quoting Dr Susan Hopkins: *"It is not advisable for primary school children to wear face coverings."* [LW.8/71 – INQ000648081] Guidance was quietly updated days later to permit masks for all children, but no formal notification was given.
 - j. 7 May 2021: A follow up email was sent to Nick Gibb requesting remote learning options, parental choice on masks, and vaccine prioritisation for CEV/CV children [LW.8/72 – INQ000648082]. No response followed.
 - k. Around this time, families who had deregistered received letters from government encouraging them to return children to school [LW.8/73 – INQ000648083]. However, school places were not guaranteed. Many families felt increasingly exposed and were uncertain about the lack of mitigations in schools and the potential for fines and prosecutions following the reapplication process.
377. Ministers sometimes recognised CVF's concerns, but the absence of formal guidance updates meant that CV families remained exposed to enforcement and exclusion. CVF members who had acted on medical advice continued to be penalised by the very systems that should have been designed to protect them.

PART J - How easy was it for CVF to communicate with the Government (whether UK or devolved) in order to raise concerns about the impact the pandemic would have or was having on CV C&YP?

378. CVF found it extremely difficult to communicate effectively with the Government and decision-makers during the emergency phase of the pandemic to raise concerns about the specific needs of C&YP in CV families. Although CVF made persistent efforts to highlight the risks and needs of CV families - particularly children - there was no formal mechanism provided by the Government for our community to feed concerns directly into policy decisions.
379. CVF was not consulted in policy design, risk mitigation strategies, or recovery planning, despite actively trying to engage. Efforts made by CVF included:
- a. Contacting the PM, MPs and departments, including the DfE and DHSC, about the lack of protections for CV children
 - b. Encouraging and supporting members to contact their MPs
 - c. Launching a government petition in December 2020, calling for online education options for CV children
 - d. Submitting concerns and evidence to the All-Party Parliamentary Group (APPG) on Coronavirus, including issues affecting children
 - e. Contacting the Children's Commissioner
 - f. Raising awareness in the media and on social media (tagging MPs)
380. Despite these substantial efforts, CVF received limited to no meaningful responses from Government departments.
381. There were no feedback mechanisms that allowed shielding or CV families to report problems or inform decision-making. When concerns were raised, including via MPs, they were often acknowledged without any substantive change in policies.
382. CVF found that even within emergency measures in education and public health, there was no official recognition of the needs of CV children living in CV households. Shielding advice, school attendance guidance, vaccination policies, and access to Free School Meals were developed without targeted consultation with groups like CVF.
383. Communication with government was extremely challenging. No official feedback structures existed specifically for CV children and families. CVF had to use indirect routes

(petitions, MPs, public campaigning) rather than being recognised as a formal stakeholder group. Even when CVF's issues were raised, policy rarely changed to reflect our concerns.

PART K - The main issues that CVF sought to raise with the Government (whether UK or devolve) during the pandemic

384. CVF repeatedly sought to raise major concerns with the UK and, to a lesser extent via members, devolved governments during the acute stage of the pandemic regarding the specific needs and risks facing CV C&YP, as well as children living in CV and CEV households.
385. Despite our efforts, we found engagement was incredibly challenging and we were never offered any formal meetings with government ministers. We often resorted to raising issues more indirectly via the media and social media.
386. The main issues CVF sought to raise were:
- a. **Lack of safe education options.** CVF raised concerns that shielding families were being forced to send children back to unsafe schools without appropriate mitigations (e.g. ventilation, masking).
 - b. **Remote learning access.** CVF strongly advocated for remote learning options to be formally available to CV and shielding families. We argued that children in CV families were being forced to choose between health and education and that remote learning needed to be counted as formal attendance to avoid penalties. We also emphasised that families shielding due to life-threatening risks should not be coerced into deregistering or homeschooling without support.
 - c. **School attendance pressure and deregistration risks.** CVF warned ministers about the pressure many families faced from schools to either send their children back into unsafe environments or risk fines, safeguarding referrals, or deregistration. We raised concerns that schools were effectively off-rolling shielding children without offering suitable adjustments. The resulting loss of school places risked permanent exclusion from mainstream education, particularly for children in under-provided specialist settings such as SEND schools. CVF also highlighted the broader impacts on children's academic progression, social development, and mental health. We were concerned that

these children were often left outside of the education system entirely, without appropriate safeguarding measures, alternative educational provision, or clear pathways to return to their previous schools - further compounding their issues.

- d. **Mask wearing and infection control in schools.** CVF advocated for the right of children to wear masks voluntarily in school settings. We expressed concern about the withdrawal of mask policies and urged that vulnerable families should retain the choice to maintain protections even after general mask mandates were lifted. CVF raised objections to the withdrawal of school-based protections such as free lateral flow testing, and poor ventilation standards, arguing these changes further endangered CV families.
- e. **Inequalities in education outcomes.** CVF highlighted the lack of consideration for education arrangements for shielding children during critical periods such as GCSEs and A-Levels. We expressed concern that CV C&YP experienced substantial losses of in-person learning without either adequate or any alternative provision or recognition.
- f. **National Tutoring Programme.** CVF also raised concerns that children in CV families were not identified and therefore were left largely unsupported by educational recovery programmes such as the National Tutoring Programme, despite its proposed aim to target those most impacted by the pandemic.
- g. **Healthcare access.** CVF raised the issue of unsafe healthcare environments due to reduced Covid-19 precautions, which placed CV people (including C&YP) at risk when attending appointments.
- h. **Vaccination priority.** CVF asked for CEV and CV children to be prioritised for two doses of Covid-19 vaccine as early as possible. We highlighted that many CEV/CV children and household members were left unprotected by vaccines while return-to-school mandates were enforced.
- i. **Mental health impacts.** CVF warned of the severe mental health impacts caused by attending unsafe schools, prolonged shielding, educational exclusion, healthcare disruption. Children experiencing heightened anxiety, trauma, and in some cases suicidal ideation, exacerbated by the difficulty in accessing mental health services, were not given appropriate support or consideration in policy.

- j. **Recognition of new young carers.** CVF identified the emergence of a new type of young carers - children who took on increased caregiving responsibilities within shielding households. In addition, CVF raised concerns about children who, while attending unsafe school environments, took personal responsibility for trying to protect their families from infection – shouldering a burden of pressure far beyond what would normally be expected. This new category of unrecognised young carers was not considered in government planning or support schemes, despite managing substantial emotional and practical burdens.
- k. **“Covid Orphans”.** CVF also raised concerns about children who lost parents or carers to Covid-19 - referred to as “Covid orphans”. We were concerned that these children were invisible in recovery planning.
- l. **Lack of consultation and exclusion from decision-making.** CVF requested meetings to consult CV families about pandemic policy particularly affecting education. We were either refused meetings or received non-substantive responses.

PART L - Did the Government (whether UK or devolved) take steps to address any of the specific concerns that CVF raised?

387. CVF considers that the Government took limited actions in response to the concerns raised regarding the specific needs of CV children and those living in CV families.

388. Actions of the UK Government included:

a. **Clarification on Mask Wearing in Educational Settings.**

On 6 July 2021, following CVF's advocacy but without any direct confirmation, the DfE issued its STEP 4 transitional guidance (to be implemented from “Freedom Day” on 19 July 2021) and inserted the specific clarification I had requested: *“No pupil or student should be denied education on the grounds of whether they are, or are not, wearing a face covering.”*[LW.8/74 – INQ000075585]

This change was made quietly, without public announcement or direct communication to school leaders or shielding families, but it provided important

protection for children who were CV or living in CV households, enabling them to continue wearing masks in educational settings.

However, this update did not form part of a broader policy to support CV families, and there was no mechanism to monitor or enforce compliance at the school level. Families continued to report incidents of bullying, harassment, and indirect discrimination against masked children, despite the change in wording.

Prior to this update, only the right of children not to wear masks, including when national mandates were in place, had been explicitly protected. Following the withdrawal of Covid-19 school guidance, the right for children to voluntarily wear masks was no longer maintained in policies, meaning that children in CV families left without formal support for masking in schools – once again leading to challenges for those who wished to continue masking for health reasons.

b. Provision of CO₂ Monitors and HEPA Air Filters

In response to concerns about air quality in schools, the DfE announced in August 2021 [LW.8/75 – INQ000648085] that all state-funded education settings in England would receive CO₂ monitors to help staff identify areas with poor ventilation. A total of approximately 300,000 monitors were distributed, with special schools and alternative provision settings prioritised due to their higher numbers of CV pupils.

Subsequently, in January 2022, the government provided 1,000 air cleaning units, again prioritising special schools, followed by an additional 9,000 units for other schools where poor ventilation could not be easily remedied.

While these measures were steps toward addressing air quality concerns, their implementation faced challenges. Reports indicated that some CO₂ monitors were not used effectively, with instances of devices remaining unused or even being resold online.

Additionally, the limited number of air cleaning units fell short of meeting the needs of all schools, leading some to purchase their own units independently.

389. Actions of the Welsh Government included:

a. **Provision of CO₂ Monitors and Foggers**

In August 2021, the Welsh Government allocated £3.3 million to provide 1,800 ozone disinfecting machines to schools, colleges, and universities [LW.8/76 – INQ000648086]. These machines were designed to disinfect classrooms after a confirmed Covid-19 case by converting oxygen into ozone, a gas known for its disinfectant properties.

However, as ozone is a toxic substance, its use raised serious safety concerns. Critics, including CVF, medical professionals and other campaigners, questioned the efficacy and safety of introducing ozone into educational settings, especially when safer alternatives like improved ventilation and HEPA filters were available.

b. **HEPA filters**

In January 2022, the Welsh Government's Technical Advisory Group ('TAG') released guidance [LW.8/77 – INQ000066374] emphasising the role of air filters in improving indoor air quality, particularly in poorly ventilated spaces. The TAG report highlighted that HEPA filters are effective in removing viral particles from the air and recommended their use to supplement existing ventilation strategies.

While the exact scale of HEPA filter deployment across Welsh schools hasn't been publicly detailed, the government allocated £3.31 million to improve ventilation in schools, colleges, and universities [LW.8/78 – INQ000648088].

390. Actions of the Scottish Government included:

a. **Provision of CO₂ Monitors, Air filters and Trimming Classroom Doors**

Scotland proposed trimming the bottoms off 2,000 classroom doors to improve airflow, as part of a £4.3 million ventilation strategy launched in early 2022. This also included investment in mechanical fans and air filters [LW.8/79 – INQ000648089].

The door-trimming policy was met with public and expert concern over fire safety and effectiveness, prompting authorities to abandon it before it was ever put into practice. Scotland's mitigation strategies were undermined by inconsistent implementation. Parents reported classrooms relying on one open window for ventilation, and families received little communication about air quality monitoring.

391. Actions of the Northern Irish Government included:

a. **Provision of CO₂ Monitors**

In Northern Ireland, 13,506 CO₂ monitors were distributed to schools from October 2021 onward [LW.8/80 – INQ000648090].

b. **HEPA filters**

In January 2022, the Education Authority ('EA') in Northern Ireland ordered an initial supply of 100 HEPA air filtration units. These units were scheduled for delivery starting the week of January 10, 2022, with 85 units expected in the first batch. The deployment prioritised areas where improving natural ventilation was not feasible or would require significant time to address – similar to the English approach [LW.8/81 – INQ000648091].

392. CVF is not aware of any substantive government measures directly addressing the other major concerns raised.

393. CVF believes the government's actions to be wholly insufficient. While the late clarification on mask-wearing and the provision of CO₂ monitors and air filters were positive steps, they were limited in scope and did not comprehensively address the challenges faced by CV families.

394. CVF experienced significant barriers to engagement with the government and saw little evidence that the specific needs of CV families were meaningfully incorporated into pandemic decision-making or recovery planning.

PART M - Collaboration or joint work undertaken by CVF during the pandemic insofar as it relates to C&YP.

(a) Government departments or agencies in the four nations of the UK

395. CVF actively sought engagement with UK government departments to raise concerns about the impact of the pandemic on children in CV families. While formal collaboration was limited, several communications are recorded:

(a) Department for Education ('DfE'). Between 7 January and 3 February 2022 the DfE sent four letters (from the Minister of State for School Standards, the Ministerial & Public Communications Division and the Secretary of State) responding to CVF's

concerns [LW.8/63 – INQ000648073]. The letters reaffirmed the Government's priority of face-to-face schooling, stating that remote education would be provided only for pupils already absent on public-health grounds. The Education Secretary cited the July 2021 end of shielding, describing it as "no longer the best way to keep people safe", and offered no alternative protections. The Education Secretary declined a meeting due to "diary pressures" and did not amend national guidance. CVF therefore considers that the correspondence merely reiterated existing policy and left children in CV households without meaningful protection.

- (i) In addition, CVF submitted written evidence to the Schools Bill Committee and the Parliamentary Attendance Inquiry [LW.8/64 – INQ000648074 and LW.8/65 - INQ000648075], highlighting the discriminatory impact of in-person attendance mandates, impacts on learning, and pressure to deregister.

(b) Department of Health and Social Care. CVF submitted an FOI to DHSC seeking clarity on vaccination access for CV children and those in CV households, and their prioritisation in vaccine rollout [LW.8/66 – INQ000648076].

(c) Other public bodies and NHS

396. CVF members, including those who were working for the NHS, engaged with the NHS to address healthcare access issues for CV children. CVF provided template advocacy letters to raise concerns about the safety of healthcare settings, especially after the withdrawal of universal masking policies. Responses were frequently along the lines of "*We are following the guidance*".

(i) NICE

397. CVF was formally recognised as a stakeholder in consultations run by NICE (the National Institute for Health and Care Excellence) on Covid-19 treatments. CVF participated in NICE consultation processes [LW.8/02 – INQ000408806] on:

- (a) Evusheld (a long-acting monoclonal antibody treatment for pre-exposure prophylaxis against Covid-19)
- (b) Covid-19 antivirals (e.g. Paxlovid)

398. CVF contributed views, evidence, and concerns regarding equitable access to treatments for severely immunosuppressed children and adult in severely immunosuppressed households living with children. This stakeholder engagement was

part of CVF's broader aim to ensure that clinical guidance considered the risks to CV groups, including C&YP.

(ii) Children's Commissioner

399. CVF repeatedly attempted to engage with the Office of the Children's Commissioner for England to raise urgent concerns regarding children in CV families. We sent direct emails to the Children's Commissioner's office requesting meetings, follow-up emails restating the urgency of the issues and offering case studies and evidence, and made direct contact via social media to raise awareness [LW.8/82 – INQ000648092]. Despite these efforts, CVF did not secure a meeting with the Commissioner. The office acknowledged receipt but cited high volumes of requests and competing priorities. CVF's concerns particularly regarding off-rolling, loss of education access, and the risk to life remained unaddressed by the Children's Commissioner during the critical periods.

(iii) Schools and Educational Establishments

400. CVF engaged with schools, other educational settings, and local authorities in support of children in CV households. The group played an active role in representing the concerns of affected families and supporting individuals navigating systemic barriers. These included direct support to families facing unlawful school attendance enforcement, threats of fines, or safeguarding referrals where children could not safely attend school.
401. As part of its support for CV families, CVF developed and distributed a range of template letters and resources to assist parents in communicating with schools and local authorities. These included model letters addressing school attendance during periods of household risk, requests for remote learning, and concerns about Covid-19 mitigations [LW.8/28 – INQ000648038].
402. CVF also issued specific letters timed to major changes in government policy, such as school reopening in January and March 2021. These tools enabled families to advocate more effectively for reasonable adjustments and protections, particularly in the absence of formal recognition or guidance from education authorities. They formed a key part of CVF's strategy to empower families in navigating systems in public bodies during the height of the pandemic [LW.8/29 – INQ000648039].

(d) Other advocacy groups.

403. CVF undertook some collaborative work with other advocacy groups in relation to C&YP. This included:

(i) Public Interest Law Centre (PILC)

404. CVF liaised with PILC regarding school attendance policies and legal challenges related to protecting CV families, especially around the right to remote education and shielding support. In November-December 2020 CVF shared PILC's pre-action protocol letter challenging DfE attendance guidance [LW.8/83 – INQ000648093]. Although the DfE rejected their claim, PILC's action (and follow-up briefing note for parents and schools) identified the human rights and equality implications of denying remote education or shielding support to CV families. Some members used PILC's legal letters to push back against fines and avoid deregistration, but because the DfE did not change its attendance guidance, those successes were isolated exceptions and most CV families were left exposed by this policy failure.

(ii) Good Law Project (GLP)

405. CVF contributed directly and indirectly to work, campaigns and media articles initiated by the GLP concerning school deregistration pressures, unsafe school environments, and failures to protect CV families [LW.8/84 – INQ000648094]. In September-October 2021, the GLP produced an open letter to the Education Secretary and a formal pre-action protocol that challenged DfE attendance guidance for children in CV households. They highlighted coerced off-rolling, unsafe school environments and equality and human rights concerns. The GLP demanded that guidance be updated to reflect schools' legal power to authorise absences for CV households in 'exceptional circumstances' and to provide remote learning. However, the DfE did not update its guidance, and parents continued to face pressure from schools and local education authorities.

- a. **All-Party Parliamentary Groups:** CVF members contributed evidence to the APPG on Coronavirus and the APPG on Special Educational Needs and Disabilities, helping to highlight the issues facing CV households.
- b. **Social Media Campaigning and Informal Alliances:** CVF used platforms like X (formerly Twitter) to amplify our work, including public advocacy on children's

rights to safe education and healthcare . Some posts reflect collaboration with broader movements pressing for clean air in schools and Covid-safe policies. We occasionally collaborated with groups such as Long Covid Kids, Parents United, Shield Us, Safe Ed For All, The Vulnerable and Shielding Network, and One Voice towards common goals [LW.8/85 – INQ000648095].

406. When CVF was first established in 2020, our founding members initially reached out to significant number of large established charities and organisations representing a wide range of health conditions affecting our members. We sought their support in raising our urgent concerns, including the serious risks CV families faced in schools, healthcare settings, and wider society. Despite escalating our issues to senior and board levels in some organisations, these concerns were not picked up or championed. As a result, CVF often found ourselves leading efforts independently.

PART N - Does CVF consider communications with the Government could be improved in the event of a future pandemic or other civil emergency?

407. CVF considers that communications with the Government could and must be significantly improved in the event of any future pandemic or civil emergency.
408. Engagement with government departments was extremely challenging. Requests for meetings with ministers or officials to discuss the specific needs of CV children and CV families were largely ignored or refused. When responses were received, they were often generic, non-substantive, and failed to meaningfully address the concerns raised.
409. As a result, CV families were left without clear guidance, appropriate policy responses, or inclusion in critical decision-making processes - despite facing disproportionately high risks and burdens. CVF recommends the following improvements:
- a. **Formal consultation**
CVF and other organisations representing CV groups should be formally consulted in the development of pandemic policy, particularly on issues relating to education, healthcare access, and family support.
 - b. **Designated minister and other officials**
The Government should appoint a designated Minister responsible for CV groups, alongside dedicated civil servants tasked with operational engagement

and policy development on a departmental level. This would ensure that the needs of CV children, young people, and families are formally represented at both strategic and operational levels of government decision-making during pandemic and emergency responses.

c. **Transparent feedback**

Where concerns are raised by representative groups, there should be a clear and transparent process for acknowledging, considering, and responding to these concerns, including publishing reasons where requests are rejected.

d. **Specific communication channels**

Government communications should include specific messaging and guidance tailored to the needs of shielding families and CV households, recognising that their circumstances differ from the general population

e. **Inclusion in recovery planning**

Recovery frameworks should explicitly include consultation with organisations representing vulnerable groups, ensuring that lessons learned are embedded into future resilience planning. CVF believes that meaningful, early engagement with the CV community would not only improve policy outcomes but would also foster trust, reduce confusion, and prevent the disproportionate harms experienced during the Covid-19 pandemic from being repeated.

Part O - Lessons learned and what could have been done better to protect CV CYP

410. CVF believes that the following policy changes and measures are needed in order to better protect CV children and children in CV households, both now and in the event of a future pandemic.

(i) Governance and Accountability

a. **Formal consultation processes**

Formal mechanisms should exist to engage representative groups of CV populations for emergency preparedness preparations and response phases to ensure policies reflect their specific and emerging needs

b. **Appointment of dedicated government officials**

A designated minister and civil servants specifically responsible for CV groups would enhance decision-making during pandemics and emergencies.

c. **Transparency and accountability**

Clear processes should exist for acknowledging and addressing concerns from affected and high-risk communities, with transparency regarding decision making and those involved.

d. **Emergency planning for at-risk children**

Emergency and contingency planning at national and local levels must include specific protocols to protect and include children in CV households. These plans should be co-developed with affected families and integrated into broader civil contingency systems.

e. **Petition system failed to protect vulnerable groups**

Petitions that raise urgent, evidence-based concerns - such as the need for remote learning to protect vulnerable households - received no government response if they failed to meet arbitrary signature thresholds. This meant that valid threats to life and health were not reviewed or acted upon, simply because they came from smaller or marginalised groups.

This failure in process must be addressed. In future emergencies, petitions that raise public health risks or safety concerns - especially those affecting high-risk groups – must be subject to independent oversight and early screening. Mechanisms need to be put in place to escalate and review any serious issues, even where formal thresholds are not met.

f. **Food security and practical support**

Support for shielding households must include food, hygiene, and medication delivery for whole households. Systems should have been designed for dignity, cultural inclusion, and accessibility, beyond reliance on volunteers.

g. **Data collection and public reporting**

In Module 2 of the UK Covid-19 Inquiry, (then Equalities Minister, Kemi Badenoch MP, confirmed that disability was not examined in her remit during the emergency phase, except where it directly overlapped with clinical risk. She stated:

“Where I did look into disability was where disability interacts much more on the health side [...]. But disability generally, across the board, no, that would not have been within my remit.” [LW.8/86 – 23 November 2023, p.38, para 149. Line 4 – 11 – INQ000587289].

CV status - including among children - was neither publicly tracked nor recognised as an independent axis of inequality, leaving a large, high-risk group effectively invisible in the data that drove pandemic response. National data systems must be reformed to publish information on attendance, exclusion, educational outcomes, mental health referrals, and service access for CV children and in those in CV households. Without this data, policy-makers cannot assess the scale of harm, evaluate impact, or target support effectively. Transparent reporting and public accountability are essential to ensure C&YP in CV families are no longer left behind in emergencies or overlooked in equality planning.

h. Legal and human rights protections

Pandemic preparedness must include clear legal guidelines to prevent human rights abuses and discrimination against particularly vulnerable groups, such as CV families in educational settings.

i. Recognising CV status as a distinct inequality

The experience of being CV, or living within a CV household - particularly for C&YP - must be recognised as a distinct form of inequality.

CV families faced unique and profound barriers that went beyond immediate health risks, including vulnerability to educational exclusion, social isolation, and reduced access to vital services. Unlike other groups, during pandemics and other emergencies C&YP in CV families are persistently disadvantaged due to systemic failures in planning, lack of appropriate health guidance, inadequate educational guidance and support, and the absence of protective legislation specifically designed for their needs. Their vulnerability extends beyond pandemics and emergencies, with health conditions placing CV C&YP at greater risk of long-term educational disruption, systemic discrimination, and reduced life opportunities.

To effectively address this form of inequality, targeted policy reforms and legislative protections are essential. By formally recognising CV status as a specific, legally defined category of inequality, governments and institutions can ensure dedicated support structures are in place, significantly improving educational continuity, equitable healthcare access, and social participation for CV C&YP.

(ii) Educational Access and Inclusion

a. Remote learning as standard

Availability of high-quality remote education must be in place for C&YP CV households to avoid educational exclusion. This should apply outside of pandemics for all children as a reasonable adjustment based on health needs. A centrally funded, permanently staffed national online school would give every child - CV or not - a safety-net curriculum accessible during periods of health or mental health issues, relocation, or during future crises. CVF believe that initial teacher training and ongoing CPD should include training in digital pedagogy, so that online teaching becomes part of mainstream professional skills practice rather than a last-minute workaround.

b. Clear and inclusive attendance policies

National attendance codes must explicitly recognise medically justified absences related to underlying health conditions, by distinguishing them clearly from other absences and removing the risk of discriminatory penalties. Ensuring accurate data collection for this disadvantaged group would also enable targeted catch-up provision.

During local epidemics or international pandemics, attendance codes must also recognise the needs of C&YP who remain at home to reduce transmission risks. In these circumstances, remote education must be provided and recorded as attending an approved educational activity, rather than marked absent.

c. Exam catch-up

Currently, if young people miss formal exams due to a pandemic, long-term health, or other unforeseen circumstances that keeps them out of education at a critical time, they face significant barriers to catching up academically.

Those who miss GCSEs (for example) often discover limited options available in sixth-form settings. The existing provision generally offers a minimal selection of Foundation level courses (maximum grade of 5, with 9 the maximum on a Higher paper) targeted at students retaking core subjects (English and Mathematics). For academically gifted students, this lack of academic pathways can severely stunt their learning and future opportunities.

State online schools should be available to them offering remote learning and exams, with flexible learning to allow gaps or for a slower pace as an adjustment for those with acute or chronic health needs. Rolling intakes would support students who missed learning and formal examinations. Such a system would enable these young people to maintain academic continuity and reach their full potential.

Establishing a national online school would significantly expand the range of available course options to this group.

d. Equitable distribution of devices

Robust plans were needed to ensure equitable digital access, including provision of laptops and reliable internet, particularly for CV families who face increased barriers to learning.

e. Avoiding systemic exclusion

There must be policies and/or legislation which explicitly prevent schools from or exerting pressure on families to attend in unsafe conditions or coercively off-rolling children, particularly those vulnerable groups such as CV families. There must be oversight and accountability.

(iii) Risk Mitigation

a. Child-specific shielding guidance

If shielding instructions are to be sent in future pandemics or emergencies, there should be explicitly child-focused versions which are practical and achievable, considering the needs and realities of C&YP.

b. **Consistent and transparent health communication**

Government communications must directly address and clearly articulate, in an age-appropriate manner, risks specific to CV C&YP, avoiding ambiguous or contradictory messaging without treating them as a homogenous group.

c. **Risk assessments**

National and local frameworks for risk assessments should include detailed protocols for CV households enabling more suitable support rather than generalised, often inadequate, broad guidelines. High-risk activities in educational settings, such as assemblies, choirs, and indoor sports, should have had clear guidelines and be subject to stricter risk assessments monitoring and mitigations.

d. **Airborne mitigations**

New ventilation standards should be set recognising the risks of airborne infections. CO₂ monitoring and sufficient ventilation to enable reading below 800ppm and supplemented with air filtration if this standard cannot be met. Educational settings must take action to reduce infection risks, particularly where outbreaks occur. Enhanced ventilation has been linked to improved academic outcomes and long-term health outcomes. This would not just help prevent the spread of Covid-19 but all airborne pathogens, which would have the additional benefit of ensuring that fewer children miss days of school during a given year.

e. **Protective measures**

In any pandemic, measures such as mask-wearing, effective contact tracing, testing programs, isolation periods, and other infection control strategies should not be prematurely dismantled without clear epidemiological justification.

Just as masks were widely used in schools when community transmission was high, the continued use of masks by C&YP or staff who remain at elevated risk must be respected as a reasonable health adjustment.

Any pupil or staff member who needs - and / or chooses - to wear a mask should be fully supported, and any harassment related to mask-wearing must be clearly addressed through anti-bullying procedures. Individual choice and mutual respect is required to depoliticise mask-wearing as a valid protective health measure, particularly when no other measures are in place.

f. **Education settings must not be exceptions to health guidance.**

Schools and education settings were often treated as exempt from broader public health standard (e.g. such as mask use, contact tracing, and restrictions on large indoor gatherings). This exceptionalism undermined protections for C&YP in CV families, who were placed at disproportionate risk compared to their peers and in other public spaces or adult workplaces.

The message that “Schools are Covid safe” was often used to justify exemptions, despite clear evidence of high levels of in-school transmission. This approach not only increased risk but also fuelled stigma and confusion, isolating CV families further. It exposed a failure to treat schools as part of the wider public health system, and to treat CV children and those in CV households as equally deserving of protection

g. **Recognition of household-level risk**

Acknowledging and addressing household transmission risks is essential. Families should NEVER have to choose between a risk to life and a child or young person’s education.

(iv) Targeted Social Support

a. **Mental health support**

Mental health provisions must be integrated within pandemic response plans, recognising the psychological impact isolation and shielding imposes on C&YP.

b. **Young Carers – new roles**

The pandemic gave rise to a new group of young carers - C&YP in CV households who took on different and significant caregiving responsibilities. These included practical tasks (e.g. helping with infection control, supporting siblings, caring for unwell relatives) and emotional strain, such as advocating for safety in schools and coping with the fear of transmitting Covid-19 to vulnerable family members.

Unlike those already recognised as young carers before the pandemic, these children were not identified by local authorities, schools, or support services. They were excluded from entitlements such as counselling - even when

performing similar or greater levels of care due to the lack of paid carers (as a consequence of the increased risk). Existing systems failed to adapt, leaving these children unsupported.

Even those who were already flagged as young carers found that their additional and changing needs were not fully considered. Policy must recognise both pre-existing and this new group of young carers, and address this gap by expanding eligibility criteria, training school staff to identify caregiving in CV households, and ensuring flexible, targeted support for this group including access to mental health services, support for learning and catch-up, and formal recognition in safeguarding frameworks.

c. Addressing Inequality

Pandemic responses must recognise CV status - including for C&YP and those in CV households - as a form of structural inequality.

CV families face systemic disadvantage due to health-related risks that restrict their access to education, services, and safe public participation. These challenges are further compounded by intersecting factors such as poverty, racial disparities, disability, and unequal healthcare access.

Without explicitly acknowledging CV status within equality frameworks, policy responses risk overlooking one of the most persistently excluded groups during this public health emergency. Future strategies must be designed with CV children and families as a priority group for targeted protections and inclusive planning.

PART P - Please set out any other information CVF considers relevant to Module 8's outline of scope.

(i) Preparedness and planning for a pandemic

- a. The Covid-19 pandemic had a profound and wide-ranging impact on C&YP, particularly those in CV households. These families, already living with chronic illness, issues posed by older age, or compromised immunity, were placed under extraordinary pressure. Despite the foreseeable risks posed by an airborne pandemic to these households, there is little evidence that CV children

or children in CV families were meaningfully included in the UK government's pandemic preparedness planning. CVF believes that their absence was not an oversight, but a critical omission with foreseeable consequences.

- b. Pre-Covid preparedness documents, specifically the 2011 Influenza Pandemic Preparedness Strategy and the 2017 National Risk Register [LW.8/85A – INQ000022708], did not identify children living in Clinically Vulnerable households as a group needing protection. They provided no pathway for whole-household protection (beyond antiviral prophylaxis), no mechanism to secure food and medicine support, and no consideration for airborne mitigations in schools. CVF considers these omissions critical: when Covid-19 arrived, there was simply no plan to keep these children both safe and learning, a gap that resulted in many of the harms documented elsewhere in this statement.

(ii) Continuing invisibility of CV children and CV families

- a. In 2021, the Children's Commissioner for England conducted "The Big Ask". It was the largest ever survey of children in England, aimed at understanding their priorities mid-pandemic.
- b. CVF encouraged its members to participate, recognising the importance of representing CV families in national conversations. However, the survey design lacked the ability to identify or analyse responses from CV/CEV children or those in CV families, including those shielding to protect vulnerable relatives. No questions were included to determine household vulnerability, and as a result, the unique experiences of these children - including prolonged absences from education, exclusion from peer activities, and their heightened concerns due to ongoing health risks - were not accurately reflected in the findings.
- c. This omission meant that this major national evidence-gathering exercise overlooked one of the cohorts most affected by pandemic policies. CVF is concerned that this contributed to an ongoing invisibility of CV families in government and public discourse. Any future engagement exercises should ensure that clinical vulnerability, including household-level risk, is captured as a core demographic category.

Statement of Truth

I, Lara Wong, for and on behalf of CVF, 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.

Signed

Personal Data

Lara Wong, Chief Executive Officer of Clinically Vulnerable Families

Dated

21/07/2025