Friday, 6 October 2023

(10.00 am)

MR KEATING: Good morning, my Lady.

LADY HALLETT: Good morning, Mr Keating.

MR KEATING: Could I call Professor Taylor-Robinson, please.

PROFESSOR DAVID TAYLOR-ROBINSON (affirmed)

Questions from COUNSEL TO THE INQUIRY

MR KEATING: Thank you. Do sit down.

Could you give the Tribunal your full name, please. Thank you.

A. Professor David Carlton Taylor-Robinson.

Q. Professor, thank you so much for attending today and assisting the Inquiry.

Just a few preliminary matters. Firstly, keep your voice up. It's important that the stenographer, who is just to my left, hears what you say. If a question is unclear, please do say and I'll just rephrase it.

You've produced a report to assist the Inquiry, a child inequalities report, dated 21 September of this year, and that's at INQ000280060. And we see that there. And at the bottom of that page you have signed a declaration setting out your compliance with your duty as an expert.

A. Yes.

Q. Is that correct?

A. That's correct.

Q. We see at the top your professional background and expertise, and perhaps you'll forgive me for just dealing with it briefly. You are a professor of public health and policy at the University of Liverpool, you also are a professor of child health at the Copenhagen University?

A. Yes, yeah.

Q. And you're an honorary consultant in public health at Alder Hey Children's Hospital?

A. Yeah.

Q. You have done significant work in the field of research into child inequalities and their impacts during the pandemic?

A. That's correct.

Q. If we could just turn to page 2 of your report, we see the contents. It's an extensive report, which we're very grateful for, nine areas you consider in relation to child health inequalities, focusing on the period leading up to the pandemic in 2020, and they range from poverty, mental health, and educational attainment.

I'm not going to cover them all. We have your written evidence. But I want to draw out some of those in the hearing today.

If we turn over to page 3, please, you pose

the question, "Why are health inequalities impacting children important?" We see at the top of that page. Perhaps can I invite you to provide an answer to that question by way of overview.

A. Yes. Yes, thank you. I mean, I work in Liverpool in child public health, in a city that's at the sharp end of health inequalities, and if you take the life expectancy of a child born in Kensington round the corner from where I work, Kensington here, there is a gap of ten years in terms of life expectancy, 20 years in terms of healthy life expectancy for children.

Those are social inequalities in health, and we can say a number of things about those differences. They're profoundly unfair, there's nothing natural about them, they're a consequence of how we organise society, and we can do something about them. We can do something about them through the organised efforts of society.

And inequalities that affect children are particularly important, because we know that early childhood inequalities track through and layer on top of one another over the course of children's lives to generate inequalities in adult health. So lots of the problems we face in society around pressures on systems, health services, et cetera, have their origins in inequalities in children's health. So that's the life

course perspective on health. If we want to address inequalities in adult health, we need to address early gaps in health affecting children.

Q. That's something that runs through your report, that there is that linkage between childhood inequality which follows it through into adulthood?

A. Absolutely, if you don't get things right in childhood, it's very problematic in adulthood. But inequalities affecting children are a moral imperative in of themselves. It's unfair that children across different parts of the country have a different risk of dying in childhood, of developing asthma, of having poor educational outcomes, et cetera, as outlined in the report.

Q. You mentioned the role of socio-economic circumstances in child health. Again, just a short overview about the relevance of socio-economic circumstances and how that impacts child health?

A. I guess my expertise is in the impact of socio-economic conditions on children's health, and we measure those in a number of ways. We often look at family income, we look at parental education or occupation, so it's about the circumstances of families into which children are born, and then you can look at how those kids grow and develop on the basis of those circumstances.

I guess central to the narrative is the influence of child poverty and the importance of material conditions in early life in structuring what happens over the rest of children's lives as they grow.

Q. Let's move on to child poverty, which is a substantial part of your report, and we see it at page 5. You describe this at paragraph 7:

"Child poverty is a disaster for child health."

Why is that?

A. Well, I mean, as a child public health doctor, it's baffling to me that we let an exposure as toxic as child poverty wash over almost -- well, a third of the kids in this country. We know from a huge body of scientific evidence that child poverty structures children's exposure to all sorts of things that are harmful to their health. So child poverty, kids growing up in poverty, they're exposed to adverse material conditions early on in life, so poor housing, et cetera, which affects health. They're exposed to psychosocial risks, so they're more likely to grow up in an environment where there's stress, there's toxic stress, there's exposure to violence. They're more likely to be exposed to behaviours such as smoking, et cetera, in pregnancy, which affect health. And it's the layering and clustering of all those exposures with poverty that

makes poverty such a toxic exposure for children's subsequent health.

Q. Well, let's look at some of the figures which you have set out in your report. If you look at figure 1 at the bottom of that page and you have set out elsewhere on that document that in 2019/20, on the eve of the pandemic, 4.3 million or 31% of all children in the UK were living in relative poverty.

And in terms of the terminology, there's different measures as to poverty, we've got relative poverty, absolute poverty, relative poverty after housing costs. We perhaps don't need to overcomplicate it, but if we see the top line of the graph, the green line, which is the most deprived group, we see that high in each of these three graphs; is that correct?

A. Yeah, that's correct.

Q. That's charting from 2015 to 2020, so in the five years leading up to the pandemic?

A. Yeah.

Q. And you say this, that by any measure children in the most deprived areas of England were moving into poverty by the time of the pandemic; is that correct?

A. That's correct.

Q. If you look at paragraph 8, please, you say this:

"Rising relative poverty rates, and high absolute

child poverty rates, contributed to worsening child health and wellbeing in the lead-up to the pandemic."

What was the effect of that, those rising relative poverty rates?

A. Well, you know, as I've described, poverty is a major determinant of children's health, and over the period of the pandemic we saw deteriorating socio-economic conditions for children in terms of poverty, food poverty, material circumstances, and we also started to see increasing inequalities in a number of aspects of health, as we outline in the report: infant mortality, we saw an increase in children dying in the first year of life, particularly in disadvantaged areas; rising inequalities in child obesity; rising inequalities in children entering the care system. All of which have been linked to rising levels of poverty.

Q. We'll touch upon those briefly in your evidence this morning. At the bottom of paragraph 8 you say that this rise in child poverty increased children's vulnerability to the negative health impacts of the pandemic and decreased their resilience to financial shocks. Is that right?

A. That's correct.

Q. In terms of differences amongst the four nations, you set that out at figure 2 on page 6, and there is

a difference between the different nations. We see Wales at the top, there's an increase in child poverty as of 2020. But stepping back at the moment we see all these zig-zag lines. At the beginning of the new millennium there was higher child poverty, isn't that correct, across the board?

A. That's right, yeah.

Q. Then we see a decrease, significant decrease in child poverty over the next five to eight years, and then around 2010 there was -- that progress stalled, and then we see more recently in certain countries, certain nations, an increase in child poverty; is that correct?

A. That's correct.

Q. With Wales and England at the front, and lower levels but still, is it fair to say, significant levels, 25, just below 25% in Scotland and Northern Ireland?

A. Yeah.

Q. Within England, you mention at paragraph 11 that the rises in child poverty largely occurred in the northern regions and West Midlands, is that the position?

A. Yes, indeed.

Q. And London still had a particularly high poverty largely due to housing costs?

A. Yeah, that's correct.

Q. So a concentration in urban London, but also northern regions and the West Midlands?
A. Absolutely.
Q. You describe other dimensions of poverty, food poverty being one feature which has increased significantly prior to the pandemic.
If we turn to paragraph 13, you use a phrase, more households with children were more "food insecure" than those without children, and an increase in the number of children supported by food banks, an increase of 49% between 2018/19 and 2019/20?
A. Yeah.
Q. And digital poverty, perhaps relevant to many families who had children during the pandemic. Prior to the pandemic you touch upon this as a dimension of poverty at paragraph 17 and you cite survey data in early 2020 that there was between 1.1 and 1.8 million children in the UK who had no home access to a computer or a tablet.
A. That's correct.
Q. The access to the internet and access to education for many was via mobile phone; is that correct?
A. That's correct. Again, we outline the data there. The important thing is that there were social differences in access to a computer -- there were inequalities in terms of kids that had access to

computers and access to the internet. So more disadvantaged children, as you would imagine, had less access to online learning during the pandemic.
Q. You use the phrase that there was a digital divide; is that correct?
A. That's correct.
Q. At paragraph 25 you talk about -- when framing and examining poverty and the different measures of poverty, you speak of in-work poverty that had risen over that period of time. What did you mean by that, in-work poverty?
A. So over 70%, seven in ten children who were in poverty were in families where somebody was working. So it's not the issue that this is completely a story about employment and unemployment. Part of the problem is that families in work still found that they were, their children were living in poverty prior to the pandemic.
Q. And a significant proportion of those were actually working who were in poverty?
A. Absolutely.
Q. The family structures which were impacted the most of this in-work poverty were?
A. So large families and lone families and families from non-white ethnicities were more likely to experience child poverty.

Q. In examining poverty, you talk about the other axes of inequality, and you probably have seen and heard the evidence of Professor Nazroo yesterday, who provided a report and dealt with ethnicity and the inequalities in relation to that. Perhaps we could very briefly just touch upon this, because you've addressed this in your report on page 9 at figure 3.
In terms of ethnicity, how does that impact child health inequality?
A. Well, our report -- ethnicity and poverty intersect to influence health outcomes in complicated ways, as we outline in the report. But the report outlines a general picture whereby, as you see in the plot here, minority ethnic groups are much, much more likely to -- kids are much more likely to be in poverty, almost twice as likely to be in poverty. The plot also shows the regional differences across the country. And we see that being in a minority ethnic group and being in poverty generally speaking is particularly harmful for children's health across the data that we present in the report.
Q. Throughout every region, significant difference?
A. Yeah. I guess it's smallest in Northern Ireland, but it's still significantly different.
Q. You would consider a 5% difference still to be --

A. Yeah, absolutely.
Q. Disability is another area of inequality which you've touched upon, and we see that at paragraph 21, and it says there that just prior to the pandemic 37% of children living in a household where someone was disabled were living in poverty, and the difference is those -- this is compared to 25% for children in households where there is no disabilities, so again that's another feature which feeds into the inequality you spoke about?
A. Yeah, absolutely, that's the layering of disadvantage. So disabled children or adults are more likely to live in poverty, and that increases vulnerability to the consequences of being disabled or being in ill health.
Q. If we turn to paragraph 26, please, and drawing those threads together in relation to child poverty, which is really at the heart of your report, you say this: that child poverty was increasing in the lead-up to the pandemic, particularly for children of lone parents and families with multiple children and families with someone with a disability and some ethnic minority households, and the effect of that was widening socio-economic and ethnic inequalities in child health and wellbeing. And you describe how that structures an increased vulnerability to the effects of the

pandemic.
A. That's correct.
Q. I want to turn to child and adolescent mental health, and that's found at your report at page 22, paragraph 58.
What was the position in relation to child mental health prior to the pandemic, in the lead-up to the pandemic?
A. The best data we have is from the NHS Digital survey in England, which clearly showed that mental health problems, children with a likely diagnosis of a mental health problem were rising incrementally. So the prevalence of mental health disorders in 5 to 15-year olds had risen from 9.7 in 1999 to 10.1 in 2004 to 11.2 in 2017. And then the next data wave of that survey was in 2020, just at the start of the pandemic. It's not included in this report, but what we see is a dramatic rise in the levels of mental health problems and in the social inequalities in mental health problems affecting children.
Q. So this dramatic rise, you mentioned that, as a health problem, this is one of the leading areas of childhood disability globally and nationally?
A. Yeah. I guess obesity and mental health problems have been described as the modern epidemics of childhood, and

they're of particular concern for the reasons I've outlined, because they affect children and there are inequalities in those outcomes, but they also predict outcomes in later life. So the majority of mental health problems present, you know, before the age of 20, and they tend to track forward into adulthood if they're not picked up and treated. And if you have a childhood mental health problem, you're much more likely to develop a persistent mental health problem as an adult, and that leads to comorbidity, impacts on productivity, education, et cetera, over the life course.
So poor mental health in children is a critical societal concern.
Q. You've touched upon how socio-economic factors impact this, and how certain groups of children are more impacted than others; is that fair?
A. Yeah. You know, there are social gradients whereby disadvantaged kids are most likely to have poor health, but it's particularly the case for mental health problems. So mental health problems in children appear particularly sensitive to social conditions and the impact of poverty, and, you know, the graph there at figure 9 shows the double the prevalence of mental health problems, over double the prevalence in the most disadvantaged kids compared to the least. That's

figure 9.
Q. I'm not sure if I have a figure 9 but you do say at paragraph 73 that in 2017 those children and young persons living in the lowest income quintile were twice as likely as those living in the high income quintile to have a mental health diagnosis?
A. That's correct. It's page 23. I don't know if that helps.
Q. Thank you. Yes, thank you.
That draws out the point I was just making about the differential according to someone's child poverty, a child's positioning in --
A. Yeah. This shows that the children in the highest fifth of income households have -- 6.8% of kids have a diagnosis of any mental disorder compared to, you know, the 16% in the most disadvantaged.
Q. Thank you.
At paragraph 76 of your report, you say this: that the pre-pandemic child mental health was already in crisis, with evidence of rising prevalence in mental health problems for UK children, and that was increasing the inequalities and unsustainable pressure on services.
Is that an accurate summary of the position?
A. Yeah, there was an editorial in the BMJ titled "Child mental health in crisis", and, you know, there were

clearly concerns about rising incidents, but also the ability of services to treat children. You know, we're still -- and we're still trying to catch up with that, because of pressures on clinical services.
Q. Looking slightly beyond your parameters, you're dealing with pre-existing inequalities prior to the pandemic, has mental health been an area where there has been significant issues in relation to child health since the pandemic?
A. Yeah, absolutely. So in that NHS digital survey there's a step change, there's almost a doubling in the prevalence of mental health problems and also a doubling of the social inequality, the difference between the highest and the lowest groups. So certainly that data that was published early in the pandemic showed that the pandemic had had a major impact on children's mental health, particularly for disadvantaged children.
Q. We've touched upon mental health. Physical health is something which you have dealt with in your reports, a number of areas which I'm not going to ask you about and we have in writing, about diabetes, epilepsy and asthma, but you do talk about child obesity, and you mentioned that again in your evidence this morning.
That was described in 2019 by the UK Government as one of the biggest health challenges this country faces;

is that correct?
A. Indeed, that was from a report on obesity from the government.
Q. Again, we have been talking about health inequalities or equity issues in relation to health; were there any equity issues as to health impacts of those children who had child obesity?
A. Yeah, absolutely. Like mental health, obesity is profoundly socially patterned and much more common in disadvantaged children, and I think one of the -- am I allowed to refer to the graphs in the -- I mean, the graph --
Q. Yes, if the figure helps --
A. Figure 14, which, you know, shows -- which is on page 31 --
Q. Yes.
A. That shows over time --
Q. I think we're just going to bring that up now, and we have it in front of us.
So figure 14, yes?
A. That shows the proportion of children aged 10 or 11 in England who are obese --
Q. So the least deprived is the bottom graph --
A. Yeah.
Q. -- line on the graph, and the most deprived is the

darker blue, and you're about to describe the differential between 2006 and 2017.
A. Well, you can see on -- children living in the most deprived areas are twice as likely, roughly, to be obese at age 10, and that gap was widening prior to the pandemic. So inequalities were increasing. Obesity was just about stable for children in the most affluent areas but it was increasing in the most disadvantaged areas.
Q. Educational attainment is another topic you deal with and one which is in itself a significant and important topic. Perhaps we can touch upon that briefly at paragraph 126. How would you say inequalities in relation to educational attainment arise and are important?
A. So I guess this goes back to, you know, the life course story, and we know that when you measure children's development, even -- so we have known national data for children aged 2 and a half, we assess all children's development at age 2 and a half, and then at age 5 when they enter school, and you see social differences. You see differences, big differences, in children's development, which then track through to influence educational attainment at every level.
So we know that it's the early years environment,

those material factors, whether you're in a safe, stable home environment with access to books, a healthy learning environment in the early years.
And, you know, one of the big problems is that when children enter school at age 5, there are big gaps. You know, some kids are a year, a year and a half behind their peers, and those differences track through school to influence differences in attainment in GCSEs and A levels. And we saw that pre-pandemic, and in the latest data that's coming out you see that those differences are increasing, those inequalities in attainment are becoming wider.
Q. The "education gap" I think is a phrase which is used?
A. Yeah. So, often that's measured on the basis of free school meals because that's what's collected in the data, so you can look at the attainment gap on the basis of children who are eligible for free school meals, who are disadvantaged compared to the rest. Pre-pandemic there was a persistent gap across all countries in attainment, at GCSE level for example, for children who were on free school meals.
But the important thing is that you see that also at reception, when children enter school, meaning that socio-economic circumstances influence children's cognitive development, socio-emotional development,

which influences children's attainment ultimately as they emerge from school.
That's the process of the intergenerational transfer of inequalities, where adversity in the early years affects children's development, which affects their attainment in school, which affects their entry to the labour market, productivity as a society, et cetera.
Q. I'm going to move on to deal with vulnerable children. A subgroup, and a significant subgroup, is children who are in care. You deal with that at paragraph 131 of your report.
What was the position in relation to the number of children in care in the lead-up to the pandemic, Professor?
A. Well, it's easiest to refer to the graph, also, if that's okay.
Q. Yes, of course.
A. That's plotted -- that's on page 46. So we were seeing -- there was major concern about the rising number of children entering the care system. So from about the time of the financial crisis, around 2008/9 onwards, we saw a rise in children entering the care system. Prior to that there had been a narrowing of inequalities, but the graph shows that the rise particularly occurred in the most disadvantaged

children, and that's continued. So more disadvantaged kids are more likely to be taken into the care system.

What we've shown in various analyses is that the rise in children entering care was driven by the rise in child poverty. It was also affected by cutbacks to preventative services that helped -- youth justice spending, et cetera, spending on children that helps prevent them entering -- helps prevent families who are at risk of entering care.

Q. Thank you, Professor. So we see from that graph that there was overall an increase, and that increase was more focused on those who were from the most deprived quintile?

A. That's correct.

Q. Drawing your oral evidence to a close before you're asked by one of the core participants, with permission from my Lady, how would you assess in January 2020 the vulnerability of children to the impacts of the pandemic?

A. I think it was -- there was clear concern pre-pandemic about health in the UK, about both child health and adult health. So we were seeing rising inequalities in infant mortality, we were seeing rising inequalities in life expectancy, we were seeing life expectancy going backwards, particularly for women in disadvantaged

areas. That's clearly important for children's health.

People have described mental health as being in crisis; we were seeing more and more children being taken into the care system, we were seeing rising inequalities in childhood obesity, which is one of the biggest public health challenges we face.

So I think it's fair to -- you know, there was agreement beforehand, and lots of people had raised concern and had written about these worrying trends in children's health prior to the pandemic, and these had occurred at the same time as rising levels of child poverty, and also cuts to services that support the most vulnerable children.

MR KEATING: Thank you. Professor Taylor-Robinson, those are the questions I propose to ask you today.

My Lady, there's questions now that -- Ms Twite is going to ask some questions which you've provided leave to.

LADY HALLETT: Indeed, yes, she may, except I can't see her.

MS TWITE: My Lady, I'm behind you.

LADY HALLETT: I appreciate it's difficult, but I would prefer it if those who are going to speak were in places where I could see them without having to move and upset the cameras.

MS TWITE: No, indeed, my Lady, I apologise. We had tried

to move me to somewhere the witness could see me and I'm afraid we failed to move me to somewhere where you could see me, and I apologise for that, next time I will try and get into a better position.

LADY HALLETT: It's not your fault. It's what happens when you have a hearing room with great pillars.

MS TWITE: Indeed.

MR WEATHERBY: Before Ms Twite starts, I'm very happy to move. I didn't know Ms Twite was asking questions, but as a generality I'm happy to move.

LADY HALLETT: That's very kind of you, Mr Weatherby, and we'll bear that in mind. Thank you very much indeed.

MS TWITE: Thank you, Mr Weatherby.

Questions from MS TWITE

MS TWITE: Professor, I'm going to ask you just a few extra questions on behalf of the children's rights organisations, Just for Kids Law, Children's Rights Alliance for England and Save the Children Fund.

Firstly, I wanted to take you to paragraph 55 of your report, where you talk about the right to play. Some people may think that the right to play for children is a relatively trivial right when compared to other policies that the government have to consider. Do you agree with that, and can you explain what is particularly important about play for children?

A. I don't agree with that, and it is important, as enshrined in the UN Convention on the Rights of the Child, and it's -- play is important for the reasons that we've touched on already. In terms of -- you know, it's the key factor in children's early development, so access to play, interaction with family, with friends, in the early years lays down the -- you know, we know children's brain development, the architecture of the brain is layered, skills beget skills in the early years, and that comes from social interactions with peers and with other people. So a safe play environment for kids is really important from young kids, and I guess one of the things we -- you know, the incredible rise in obesity that we saw, that we've seen over the period of the pandemic is partly testament to the fact that children didn't have -- older children didn't have opportunities for outdoor play. So it's incredibly important for a whole host of reasons and it's not frivolous.

Q. Thank you.

Just building on that, is the ability to play with other children particularly important?

A. Yes.

Q. Again, building slightly further on that, would you therefore say there was a difference between an adult

missing three months of socialising with their friends and a child missing three months of socialising with their friends, and if so what is that difference?
A. Yes, they're completely un -- they don't -- you can't compare. Time -- because of the critical and sensitive periods in children's development that again I've already described, the life course approach to health means that you never get those windows of opportunity back again. And, you know, a lot of the action in children's development happens in the first thousand days, as it's been termed, but, you know, interaction in those early periods is completely different to missing a few months as an adult. They're not comparable at all.
Q. You've partly answered this, but, as you've just said, it's difficult to get them back, and you say that at paragraph 55 of your report, that these opportunities in the early years cannot be recovered.
Can you just explain why they can't be caught up on?
A. Well, you shouldn't be fatalistic about these things, because you can -- there's -- you know, the brain, we talk about neuroplasticity, so the brain has incredible potential to recover subsequently, but it's much more difficult, you know, the brain -- brain development and the development of those early social skills -- as

I say, skills beget skills, and if you don't have those firm foundations it's much more difficult to recover and much more costly for services and treatments, et cetera, to try to recover that missed time later in life. Which is why -- you know, which speaks to the critical importance of the first five years of life.
Q. I have one final question, and again you've touched briefly on this, but can you just explain in more detail how relevant it is to have access to outdoor space or playgrounds or green space for children?
A. It's very important for children's physical and mental health, as I've already outlined. It's important in -- with regards to what happened with obesity over the period of the pandemic, those interactions are important for children's development, socialisation, and for their mental health.
MS TWITE: Thank you, Professor, I don't have any further questions.
Thank you, my Lady.
LADY HALLETT: Thank you very much indeed.
Thank you very much, Professor. Just to say that, as I'm sure you will know, there will be a separate module dealing specifically with children and young people, so I suspect we're not saying goodbye today as my guest, and also to emphasise that I will obviously

bear in mind all that's contained in your very helpful report. So thank you very much for your help.
THE WITNESS: Thank you, my Lady.
MR KEATING: Thank you, Professor.
(The witness withdrew)
MR KEATING: My Lady, could we call Anne Longfield, please.
MS ANNE LONGFIELD (affirmed)
Questions from COUNSEL TO THE INQUIRY
MR KEATING: Good morning.
A. Morning.
Q. Could you give the Inquiry your full name, please?
A. Anne Elizabeth Longfield.
Q. Ms Longfield, thank you so much firstly for your report, your evidence, and attending to assist the Inquiry today.
A few matters by way of introduction, could I invite you to keep your voice up, as you are. Between the two of us we'll have to pace our conversation, as we have a stenographer to our left, who is doing a wonderful job in recording it. And lastly, if you could ask, if any of my questions are unclear, for me to rephrase them if that arises.
You produced the statement dated 18 September of this year, that's INQ000273750, and you've read that recently?

A. Yep.
Q. At the last page, can you confirm that you've signed that statement and the contents are true?
A. I have.
Q. Thank you so much.
By way of professional background, I'm going to put it very briefly. You are somebody who has devoted her professional life to the welfare of children. Is that a fair summary of what --
A. Well, certainly -- yeah, absolutely. My whole working life has been around improving the lives of children over several decades, both in charities and in other roles.
Q. Yes. And the other role, and a significant role, is that you were former Children's Commissioner for England between April 2015 and February 2021?
A. That's right.
Q. So during the pandemic, as it broke, you were the Children's Commissioner for England?
A. I was. It was my last year.
Q. Your statements and the numerous exhibits you have provided show the extensive amount of material you have been involved with, dealing with a wide range of issues which affected children during the pandemic, and as my Lady said to the last witness, there is a module

solely dealing with the impacts and the factors which affected children, and those matters will be explored in proper detail there.

Today you're assisting us by providing a high level summary of the impacts on children during the pandemic.

A. Yeah.

Q. We talked about the Children's Commissioner for England. Some will be familiar with what that is, but some may not be. Could you briefly explain what that role is?

A. Yes, absolutely. It's a statutory role which was adopted in England in 2004. It came out of Lord Laming's Inquiry, which followed the dreadful death of Victoria Climbié, who was seen to disappear from view and was murdered by relatives. Lord Laming said no child should ever go unseen again.

The first Children's Commissioner came into post in 2005. It's a role which has a statutory duty to represent the views -- to learn about the views and represent the views of children and represent those to decision-makers. It acts in the best interests of children, and puts forwards those relevant views. It has powers to gather evidence and to visit children who live away from home. It has a particular relevance for and responsibilities for children who are particularly vulnerable, those are the children who are in care or

living away from home. And the person is able to undertake enquiries into specific policy areas or practice that are seen to be most at risk of infringing children's rights.

Q. Perhaps in one line, you were there to be the voice for children?

A. The voice of children, the advocate for children. We're decision makers who were making, during the pandemic, decisions on a whole range of issues which affected children's lives.

Q. The application of that role during the pandemic, is this a fair summary, that you provided advice and proposals to government and other agencies about the impact of policy and decisions on children in order to protect and promote their best interests?

A. That's right, and recommendations of what action could be taken both there and then but also in the future. I often saw myself as kind of the eyes and ears of children in the system, with access to those that made decisions and a responsibility to inform them about the impact of their potential decisions on children.

Q. At paragraph 23 of your statement, you describe the Covid crisis as an extraordinary time for children to live through and to grow up in, and you recognise the dedication and commitment of the many teachers,

social workers and other professionals and communities who worked, as you say, tirelessly to support children during that time.

Whilst recognising those efforts, what was your overall assessment of the impact of the pandemic on children?

A. Well, there was a significant impact on children. They weren't most at risk of some of the health concerns in society, but there was a toxic mix, I believed, of secondary issues that were likely to impact them, many drawing from what you've just heard in the previous witness.

My belief, and what I could see from the evidence, clearly there were some children that were more at risk, and the outcomes for those children I think has been devastating, and still leaves in a position where they may for the next 10, 20 years, have the long shadow of the Covid experience.

Q. We're just going to explore that during your evidence this morning. You talk about this toxic mix and how this had a devastating effect on certain groups of children. Let's explore more about the differential in impact on children. Which groups of children were affected more adversely?

A. Well, there was a wide -- a huge difference in

experience of children during the pandemic. Of course some children living in wealthier homes had a summer, often with their parents, who were working at home or furloughed, and they would expect those first few months -- experience those very differently.

For those children living in high-rise blocks, with cramped accommodation, sometimes with unsafe homes, possibly with domestic violence and addiction, severe mental health in the house, without the digital devices to be able to get online in the first place, it was a period of -- you know, that they really had never experienced to this extreme before.

It meant that whilst other children were able to get online and continue their schooling relatively easily, these were struggling to share a mobile phone, sometimes broken, between siblings. Whilst other children were able to be with family, play in the garden, these children were locked in a home unable to get out. And whilst others had support from their family to be able to get through this crisis, some children were suffering from unsafe environments where their parents were already in crisis before the pandemic.

Q. Thank you.

You mention at paragraph 8 of your statement that this was of course a major challenge for most children,

it was a disaster for many disadvantaged children who were already living with risks and vulnerabilities, and as your role as Children's Commissioner for England you were concerned about those children and had focused much of your advice in reducing the risks that they faced. Did you consider that the government took into account that advice and those concerns, by way of an overview?

A. I think that my understanding was, what I saw was that on occasions government seemed to understand what being vulnerable was, in some of these situations, but that it didn't often follow through in terms of the policy and the practice, and the implementation of what that meant. There was an example here. Schools were kept open for vulnerable children, which was a very good thing. I was very relieved when that happened, and really supported that. But very few vulnerable children came in, often 4%. It rose to about 10% or 12%.

There wasn't the follow-through, there wasn't the understanding of the complexity for those children to attend, and there wasn't the follow-through to support those children, encourage them to get into the classroom.

So I think that on occasions there was an understanding, but I think often that slipped from view, it was incoherent, and as a result children were

often overlooked, and there was even occasions where it felt that they, government, was indifferent to children's experience during Covid.

Q. We'll explore those in a moment, and you mentioned schools as one of those areas where you consider that there was understanding but not follow-through in relation to the interests and needs of children.

Let's turn to schools, then. What was the impact on those groups of children which you were concerned about by the closure of schools?

A. Well, the immediate impact was for many children in disadvantaged families that they were not able to continue with their studies for significant periods of time. The vast majority of children in more affluent families, attending private schools or schools that were already providing digital learning, were able to almost seamlessly continue their learning online. Others were left without online learning, with sporadic lessons that they had to download at home. Many, 1 to 1.8 million, didn't have the digital devices to be able to do that, they didn't have the support, and many families just didn't have the home learning environment, the space, the support, the quietness needed to do that.

So children lost significant amounts of time out of school.

The other part of that, which links to the safeguarding element, is that they lost the structure of the day, they lost the -- they lost the oversight of teachers and those around the school. So in both those ways, they were left very much to their own devices in the first instance and isolated.

Q. Can I invite you just to pause there, just to help out stenographer, and just to break down your evidence a little bit more.

A. Yes.

Q. We talked about schools and how things such as the digital divide we heard about impacted those who were more disadvantaged and those families and children who were more disadvantaged. You also mentioned the loss of the structure for school. Would it be fair to say that the schools form a sort of anchor in terms of social support for children in communities?

A. Yes, it's the school where children will often have trusted relationships with adults, it's the school where many of the teachers will see signs that children are having a difficult time, that's where referrals will often come from for social services. And, of course, you know, the structure of the day, children learning, children being around other children.

Q. Of course.

A. So without that there's the learning loss but also the social loss.

Q. In terms of schools, we've used the words the "closure of schools", but in fact the schools never closed for all, they were open throughout, through the dedication of teachers and administrative staff, to keep the school key workers and those, who you have touched upon already, who were vulnerable children.

Was that effective in ensuring that vulnerable children were attending school?

A. No, it wasn't, because the vast majority of vulnerable children didn't attend. There were very slow -- low percentages in the first instance, 2, 3%. By the end of that period it climbed up to about 12%. It came alongside the messages "stay home, stay safe, don't go out", and there hadn't been consideration about the impact of that universal message, which was obviously hugely impactful on families, on all families including vulnerable families, and there wasn't the follow-through to be able to support those families to go into school.

I mean, I do believe it would have been possible to find, to get more children into school. In fact, one school told me, that had very good relationships with families, they'd managed to get 80% of vulnerable children in, but they did that through many phone calls,

many visits, many emails, and that just wasn't the experience for most areas.

Q. You have been publicly critical of the decision to keep schools generally for all pupils closed during the lockdown. What was the alternative, in your view, to having the schools closed when they were?

A. Well, I mean, I support the first closure, clearly that was necessary, but it became very clear as the month of May went on that actually there was scope to start increasing socialising. I felt that schools should have been the last to close and the first to open. But it became very clear at that point that there was a move that was moving away from schools actually opening at the first opportunity they could.

What happened was that in June and July, when we should have had a period of schools starting to open, planning being undertaken for the September term, planning for any possible future outbreak or variant to take place. Instead, schools stayed closed and instead we had pubs, we had theme parks, we had restaurants, we had the Eat Out to Help Out, instead of schools opening. And that for me was a terrible mistake and one which played a huge part in children's very negative experience of the lockdown period.

Q. I want to continue with the theme regarding vulnerable

children at risk, and we described how, although the schools were open for those to attend, the numbers remained relatively low for their attendance, and you set out in your report, in your statement, at paragraph 62 that the concern was, in relation to those children who require safeguarding, that they were impacted most detrimentally, and I want to touch upon some of those features you describe about the impact on that group.

Visibility, you say that there was reduced visibility; was that right?

A. That's right. Children in homes that were unsafe were out of sight, which was something wouldn't have been the case if services had been operating in a normal way, schools had been open and nurseries had been open.

Q. And referrals of vulnerable children to children's services dropped by 50% at the peak of the lockdown?

A. Yes, that's right.

Q. There was, you say, an increase in the frequency and severity of risks and harms, at paragraph 63 of your report. Was that the position?

A. Yes. There was an increased number of children -- and this is government data to bear this out -- who were harmed, especially under 1s, there was real concern about increased harms to children under 1, but also to

teenagers, who were seen to be particularly vulnerable to safeguarding at this time.

Q. You've mentioned this, and it was one of your reports in relation to domestic abuse, that local authorities between March 2020 and March 2021 reported increased concerns in relation to domestic abuse and violence and mental health difficulties amongst parents and children, and that there was acute family crisis situations.

Was that something which you --

A. Yes.

Q. -- experienced as a real issue during the pandemic?

A. Yes, absolutely. And this came from a starting point where I'd been very clear in putting forward evidence that said that -- my estimate was around 2.2 million children who were already living in vulnerable family situations before the pandemic, that would be mental health, severe mental health problems, addiction or domestic violence. So during this period, I was particularly heightened to the problems those children might be experiencing. We saw very quickly police reporting to me that the reason they were getting phone calls most often was around domestic violence. Domestic violence helpline skyrocketed in terms of the numbers of people using it, 67% increase, I think, in a very short period of time.

So it was very evident that where there were children in vulnerable homes -- and let's remember that 2.3 million children is actually one in six children, so this is a significant number of children -- were essentially locked up in homes in unsafe environments.

Q. As to the serious harm, you've mentioned how there was an increase between April and September 2020 of serious harm incidents involving children and, as you said, in particular infant children or those aged under 5; is that correct?

A. That's correct.

Q. I want to move on to deal with one topic in relation to children and public space, and that's something again which you have been vocal at the time as Children's Commissioner for England as to the needs for children to be considered in relation to children having access to public space. Again, briefly if you can, what was important in relation to this and child welfare?

A. That's right. Well, going back to my comments there about children being in cramped accommodation, sometimes unsafe accommodation, you know, they would normally go to the park, they would normally meet their friends. None of that was possible. And the whole kind of, you know, socialising in public space policy seemed to be geared towards adults. We had the one hour for

exercise. Well, children don't generally exercise, they play together.

And when we started having allowances for families or for individuals to be able to meet and then a rule of six where groups of six could meet, children often in that equation meant that families couldn't meet together or grandparents meet together. Now, in Scotland and Wales children under 12 were exempt from that rule of six. In this country there was a firm decision to keep it simple, to say it must mean children were still part of that calculation. And that for me means that, you know, they were further isolated, they couldn't play, they couldn't take part in, kind of, sports, they -- obesity would be a threat and a risk, and socialising and their mental health would continue to suffer. It would have been a really almost no cost, financially, way of recognising the disadvantages but also the impact that the pandemic had already had on children, to exempt them, and in this country we chose not to do it.

Q. We have heard from Professor Taylor-Robinson that in relation to mental health and physical health, obesity, that there was significant increases in those areas as a result of the pandemic?

A. That's right.

your own words, what would you say -- if you had one wish to try to improve the welfare of children going forward as a result of the pandemic, what would it be?

A. I think we have to recognise that the pandemic exposed the precarious nature that many children were living their lives in, and also the levels of disadvantage in our country, alongside the machinery of government that in no way is set up to be able to support children and represent their best interests.

It was very clear that there was no one at the Cabinet table who was taking children's best interests to those decisions. When I've put forward, in the past, recommendations for a minister for children -- I've always been told it was the Secretary of State for Education -- it was very clear he wasn't part of those discussions, there was an empty chair at the table.

So I think we have to change the structure of government for children, we have to build in an understanding of the need to recognise their best interests, and then work on a government structure, including a minister for children, that can truly represent their needs, especially if there's an emergency.

MR KEATING: Ms Longfield, I'm very grateful for your evidence today and your statement.

Q. One final topic I'd like you to help us with, if you can, is, you may have seen the videos, at the beginning of the Inquiry, of this module, in relation to long Covid and how that's impacted families, and it in fact impacted children who had long Covid, and I wanted to ask you whether long Covid for children was an issue you became aware of during your time as Child Commissioner or some of the work you have undertaken thereafter?

A. Well, I was certainly aware during the pandemic that some children had particular health needs, and they were suffering from reduced support during the pandemic, and also the effects of isolation. And since the pandemic, I have become more aware and had more conversations with those groups of families.

I think it's important to understand and recognise this is very real, it's a reality for families, it has a devastating impact on children and on families, and needs to be much more part of not only the debate but also the policy making decisions.

Q. Thank you.

Drawing your evidence together, you've published a number of reforms as to how you consider that the government should put children first going forward and to avoid those detrimental impacts again, but, in

My Lady, that's all the questions I propose to ask --

Questions from THE CHAIR

LADY HALLETT: Can I just ask one before we go to Ms Twite.

Ms Longfield, did anybody ever consider, instead of just keeping schools open for the vulnerable, which you say sadly not enough went, and children of key workers, whether you could have a system of having, you know, one class in one week, so at least there was some --

A. Yeah, well I think --

LADY HALLETT: Did anybody think about it?

A. Yeah, yeah, so you can imagine there were -- you know, there were various discussions that popped up and went down, and I certainly remember those. Morning and afternoons were another.

But I think what you saw in other countries was, you know, governments making a decision to take over public buildings next to schools so you'd have more space, you could do more social distance, you could have better air quality, and also to bring in, you know, reserves of ex-teachers and the like that could actually, you know, step in for staff that often were sick.

I suppose what I felt was that we had, you know, we had the fantastic Nightingale endeavour for health,

furlough in terms of employment, but actually for schools we failed quite miserably, we weren't very creative, we weren't ambitious, and we didn't have the recovery -- you know, the recovery programmes that were put forward weren't backed, they were turned down.

So it was as if children were very much at the back of the queue, coming second, and always being overlooked when it came to an important decision.

LADY HALLETT: Thank you very much.

I think I will allow -- obviously I've said I will and I stick by it -- Ms Twite to ask some questions. I think we might have already covered a couple of them, Ms Twite.

Oh, you have moved, taken Mr Weatherby up.

Questions from MS TWITE

MS TWITE: Can I say that I'm grateful to Mr Weatherby KC for allowing me to move.

And yes, indeed, some of them have been covered so I only have a couple left to ask, but I'm grateful, my Lady, for the opportunity.

Ms Longfield, I ask questions on behalf of a number of children's rights organisation, Just for Kids Law, Children's Rights Alliance for England and Save the Children Fund, and, as I say, you've already answered some of my questions, but can I just ask -- you have

talked about political priority for children, but can I ask, prior to the first lockdown, so in March 2020, in your experience were children then a low political priority in Westminster?

A. They were, and I think that could be seen through the decisions that were made across government.

You've already heard this morning about very high levels of children's mental health. The disparity in spending between adult and children on mental health is and remains huge. Children are, you know, 25% of the population but at various points were getting 7%, 8%, 9% of the budget.

Children often were overlooked when universal decisions were made, and actually the previous Prime Minister, David Cameron, introduced what he called a "Family Test", because he recognised that families, and with that children, were often overlooked. It didn't get far, but he introduced it.

When it came to decisions around austerity, children were often the ones that were most at risk of losing out there, and we saw a huge reduction in services, about 70% of services around early intervention and prevention, which just drove vulnerability and disadvantage, and of course really fuelled the fact that so many now are in crisis.

Q. As far as you can answer this, do you think anything's changed since March 2020? Have children become a greater political priority for government?

A. Well, I momentarily thought that seeing the real life impact of vulnerability during Covid might be a change-maker, actually. People understood what this concept meant, if you like, living in a high-rise, not being able to go to the park, not having food in your cupboard. You know, this is the reality of something that can be discussed in quite kind of opaque terms. I think it was quickly forgotten.

The recovery programme and the -- turning down the funds for the recovery programme, where Sir Kevan Collins put forward a £15 billion recovery programme on the request of the Prime Minister, which would have had, you know, a really significant impact on children's lives, not only to recover from the pandemic but also to help them bounce back to a better place. That was turned down and replaced for a very narrow, much cheaper option, and that was another one of those huge mistakes of that time.

Q. Ms Longfield, I think you've covered what was going to be my next question, which was to ask what was particularly inadequate about the non-pharmaceutical interventions during the pandemic. But can you tell us,

do you think what you've said is now with the benefit of hindsight or was some of this impact stuff that had been predicted by others, you or others, in the early months of the first lockdown?

A. Well, the first thing to say is that it was predicted. There had been -- you've heard the raft of evidence this morning. There is no shortage of evidence, academic reports, that show disadvantage up to that point, and certainly in my five years I'd been Children's Commissioner I'd been publishing reports on a whole range of issues very, very frequently.

I don't think you need hindsight to know that if you close schools and open restaurants, it's not going to be in the best interests of children. I don't think you need hindsight to know that if you're going to be making assessments about vulnerable children and homes through a screen, where people can send you photos of what they want to send you photos of, rather than being in the room, you know that that's not going to be in the best interests of children. And I know -- you know, I think that we know if you close down playgrounds, close down open parks and keep kids in situations at home where we know there are already disadvantages and vulnerabilities, that's not going to be in the benefits of children -- best interests.

So on all those counts I think that, yes, of course, we have to look back and see what can be done differently, that's an important part of it, but it was clear to see from the absolute start of the pandemic, and clearly predicted, what would happen unless those issues were mitigated.

Q. Finally, Ms Longfield, you told us a little bit about the differences in Wales and Scotland, and we know that there were different approaches for children in those areas. Can you say anything about those different approaches and the impact of them?

A. Well, of course, many of the practical -- or great commonalties with many of the practical things, you know, schools closed -- schools closed, exams didn't happen, you know, there were and are concerns, of course, about mental health as a result of the pandemic, but there was a very different approach because they have a much more strengthened approach to their adoption of the United Nations Convention on the Rights of the Child, which is the framework for the Children's Commissioner. They had impact assessments not only on particular policies but they also had it on their approaches overall for children.

The Children's Commissioners were consulted much more, especially in Wales, when it's hard to think

a decision would have been made without that conversation taking place. And when it came down to making those decisions, that showed, because it showed in terms of the decision to exempt children from the rule of six and other restrictions, but also really understand the need for support for families, understand the need for support for families in poverty.

So it demonstrated that with similar legal powers, if you like, the Children's Commissioner could be very differently involved. And also nations that set out to try to put children and families at the front.

One thing that I did was -- and others too -- constantly asked the Prime Minister to do a briefing in the evenings for children, especially for children. They did it in many countries. And it was really important for children to know that they weren't alone and that this time -- you know, people were thinking of them. It nearly got there several times, but it never did.

MS TWITE: Thank you, Ms Longfield.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Longfield. You are obviously a very passionate and eloquent advocate for children. I suspect we might meet again in the next module --

THE WITNESS: Thank you very much.

LADY HALLETT: -- where we focus on education and young people. Thank you very much indeed for your help.

(The witness withdrew)

LADY HALLETT: I think we will take the --

MR KEATING: My Lady, can I press you just for five more minutes?

LADY HALLETT: Of course. Is there a summary?

Summary of questionnaire responses

MR KEATING: There is a summary, and then that may be a natural break, but I'm conscious of our stenographer who has been working very hard this morning.

My Lady, in relation to the impact questionnaires for children, we had a significant response from a wide cross-section of groups, and there was a commonality in relation to what's said and for those reasons the summary is going to be perhaps shorter than for others, but respondents highlighted the differential impacts of poverty on learning outcomes, on children's mental health, and there was a view that there was a lack of engagement with the sector. The majority of respondents considered that regulations and decisions were taken without due consideration or consultation of the impacts on the sector and the different subgroups within it, such as schools, children in care and children with

disabilities.

Three broad themes emerge. Firstly, the impact of poverty on learning outcomes, and increased hardship, and of course we've heard from Professor Taylor-Robinson about that this morning.

Action for Children established an emergency fund for families using this service, and they pressed the government to move quickly to support children to have adequate resources to learn from home and their emergency fund supported families to buy equipment, and their view was that, throughout the pandemic, government action on digital exclusion took too long and provision was too limited.

In relation to the next theme, government decisions and consultation, a theme which many respondents commented upon, Save the Children stated that their core hypothesis is that children's rights and wellbeing were not considered as a priority by decision-makers in UK Government and that this has been the case for many years, and they say that this can be evidenced both through the lack of specific approaches such as children's rights assessments and policy developments and the absence of analysis of impacts on children in the key documents which officials prepare for ministerial decision-making.

Playing Out, another organisation, raised the lack of consideration of children in regulations, and that's something we've heard of course this morning evidence in relation to.

The UK Youth consultation mentioned how decision-making was too narrow. When decisions were taken to close schools, there was little consideration of how other sectors might help alleviate the impact, such as youth workers supporting vulnerable young people, and this reflected a broader lack of recognition for youth work and that youth workers weren't initially recognised as essential workers, and re-opening guidance was produced for schools but not youth clubs.

The Children's Rights Alliance for England comment upon the invisibility of children in decision-making and that this was a long-standing problem which is not and was not specific to the current UK Government, something which was, as I said before, long-standing.

Finally, and again something we've heard evidence about today, is the long-term impact regarding mental health; a number of respondents touch upon the significant effects the pandemic had on children.

Action for Children, an organisation, talk about how the work on recovery for children has lost momentum after the end of health restrictions and there's been

little concerted effort to put in place the proportionate service response, particularly beyond tutoring provision, to help children and young people recover and bounce back from the impact of the pandemic.

My Lady, we had a significant response, and we're very grateful for the material which we have received and of course is being considered.

That concludes this section.

LADY HALLETT: Thank you very much indeed, Mr Keating. Right, we'll break now and I shall return at 11.30. Thank you.

(11.16 am)

(A short break)

(11.30 am)

LADY HALLETT: Mr O'Connor.

MR O'CONNOR: My Lady, between now and what I imagine will be the lunch break, we're going to call two witnesses from the frontline worker category, that is Kate Bell from the TUC and Mr Adeyemi from the organisation FEHMO.

You can see that Ms Bell is in the witness box, but before I ask her to begin her evidence, I'm going to read out the summary relating to that area of the evidence, as you have heard with other areas of --

LADY HALLETT: Thank you, Mr O'Connor.

Just before you do, just to emphasise for those who

are following online, Mr Adeyemi has been brought forward from this afternoon --

MR O'CONNOR: He has, yes.

LADY HALLETT: -- just to let people know that they need to stay watching this morning if they wish to see his evidence.

Summary of questionnaire responses

MR O'CONNOR: That's exactly right.

Well, madam, as has been explained to you now more than once, what I'm about to read is a summary of the various questionnaire responses we have received that are relevant to this area of the Inquiry's work.

First of all, some of the responses related to the economic impacts of the pandemic on workers in low paid or precarious employment.

The organisation United Voices of the World stated that their members had to continue working through their illness in order to survive financially rather than self-isolating, at great risk to themselves and the wider public health. They noted that many workers had no access to full pay sick pay and suggested that the rate of statutory sick pay was inadequate to cover basing living costs, such that many workers could not financially afford to be absent from work through self-isolation.

It was also noted that some workers, such as those in the gig economy, had no access similarly to statutory sick pay.

United Voices of the World called for public sector organisations to stop what they describe as two-tier outsourcing and ensure that all workers in workplaces are accorded the same protections.

The same organisation, United Voices of the World, cited the story of their member, Mr Gomes, who died from suspected Covid-19 when working as an outsourced cleaner at the Ministry of Justice in April 2020. They claim that Mr Gomes was forced to work through his illness as he couldn't afford to live on statutory sick pay alone, and indeed was working a shift just a few hours before his death. They reported that the lack of sick pay prevented Mr Gomes from properly resting and self-isolating, increasing his risk of serious illness, and that he was forced to risk wider public health by exposing others to the virus.

Another area of concern, although obviously linked to the matters I've just mentioned is safety of working environments. Respondents to the Inquiry indicated that frontline workers in outsourced service roles such as cleaners were further impacted by substandard or absent PPE, and the precarious nature of their

employment made it difficult for them to challenge this with their employer.

The Independent Workers' Union of Great Britain responded to the Inquiry and noted that couriers and logistic workers were already handling the transport of biological samples for Covid-19 testing as early as January 2020, but, they said, whilst medical staff were provided with PPE, couriers received no protective equipment from their employers and collected these samples at significant risk to themselves and their households.

Moving to a few responses relating more directly to impacts on healthcare workers, the TUC stated that they raised the adequate availability of PPE across the healthcare sector on several occasions, and there was acknowledgement from the government that most hospitals were close to running out of supply as early as 19 March 2020, four days, of course, before the country entered lockdown.

The British Medical Association similarly underlined that government decisions and actions in relation to PPE supply, procurement and domestic manufacturing of PPE, also the adequacy of PPE guidance and PPE fit testing, all contributed to healthcare workers in general, and certain groups of healthcare workers in

particular, being placed at greater risk of exposure to Covid-19 and adverse physical and mental health outcomes as a result.

Doctors from ethnic minority backgrounds more commonly experienced shortages and pressure to work in environments without sufficient PPE, and ethnic minority doctors and those with a disability or long-term health condition were more likely to report feeling worried or fearful to speak out about a lack of PPE.

FEHMO highlighted the disproportionate impact of Covid-19 on BAME staff, particularly in the health and care sectors. Delays in addressing impact and the provision of national guidelines and policy led, they said, to inconsistencies between hospital trusts as to how to protect staff, and NHS employers did not provide updated guidance on prioritisation and management of risk, including ethnicity, until July 2020.

Little progress was made on implementing the recommendations of the June 2020 Public Health England report on the impact of Covid on BAME groups, they said.

Finally by way of this introduction, the TUC, as we'll hear from Ms Bell shortly, provided, as her second statement, a series of descriptions of individual experience, and one of those was from an NHS employee

and it reads as follows:

"Talking about Covid gives a lot of people flashbacks because people were dying in front of us and our morgue was full. We had no body bags left in the trust in order to cover the number of deaths. We were asked to change at work but not provided with any showering facilities for staff, so we had to use the patient facilities. PPE was in shortage, yet we had to change each time we assisted a new patient. My hands were painful from the process of de-gloving, washing hands and applying sanitiser on a daily basis.

"Whilst this was going on, we were asked to keep silent and carry on. Whilst worrying about relatives of our own, I didn't see my family for two years. I lost colleagues whilst I was working each day and the government barely acknowledged that fact. Most of my colleagues now suffer with an anxiety disorder or PTSD, and many have lost their passion for working in our NHS. How were we rewarded no pay increase or recognition of national service through a pandemic?

"Long Covid has affected many of my colleagues, and some people have even had to come out of work, a place many had worked in for up to 25 years.

"My worst day was walking home after we lost eight patients in one shift. I couldn't bear to look in the

mirror. I cried for two days and was sick to my stomach. A week later I was told that my colleague's daughter had passed away through Covid. She was 35 and a teacher. The frightening thing is that no one has addressed the mental health impact which the pandemic has had and continues to have on the staff. No one wants to talk about it. Even writing this statement, I feel sick thinking about the many awful things which happened."

So, my Lady, that is the end of that summary, and may I ask that Ms Bell is -- I'm afraid I'm not sure if she's going to be sworn or affirmed.

MS KATE BELL (affirmed)

Questions from COUNSEL TO THE INQUIRY

MR O'CONNOR: Could you give us your full name, please.

A. It's Kate Bell.

Q. Ms Bell, you are the assistant general secretary of the TUC.

A. I am.

Q. I know you've worked for the TUC for some time. I think it may be right you didn't hold that post during the pandemic?

A. That's right, I was previously head of our rights, international, social and economics department.

Q. I think that was a post that you had held since 2016?

A. That's right.
Q. You have provided the Inquiry, Ms Bell, with two statements. We'll look at them both in the course of the next half an hour or so. First of all, there was a lengthy statement dated 24 May of this year.
Perhaps we could have it on screen, please. It's INQ000215036.
Ms Bell, I'm sure you're familiar with that statement.
A. I am.
Q. We don't need to go to the last page, but it's been signed by you. Is that your statement?
A. It is.
Q. Are the contents of it true to the best of your knowledge and belief?
A. To the best of my knowledge and belief.
Q. Let's now just look briefly at your second statement, which I mentioned while I was reading out that narrative. This is a much more recent statement, it's dated 27 September this year. Again, we will go to some parts of this, but that's the statement which contains a series of short narratives from members of your unions.
A. That's correct.
Q. Is it, insofar as it contains your own evidence, true to

the best of your knowledge and belief?
A. To the best of my knowledge and belief, yes.
Q. Thank you.
I want to start, Ms Bell, with what I think will be a brief overview of the organisation of the TUC and its aims and objectives. I say brief because it is, of course, a very well known organisation. It's also true that you deal in some detail with the structures of the TUC in your statement, and we of course have that, so we don't need to cover it in length with you orally.
In brief, we learn from your statement, first of all, there are 48 member unions within the TUC?
A. Yes.
Q. And that comprises something like 5.5 million working people?
A. That's right, it's just over 5 now.
Q. Those unions, those people, are drawn from all over the UK, so England and Northern Ireland, Scotland and Wales?
A. So the TUC represents, yes, workers across the UK as far as national matters are concerned.
Q. Just then descending into a little bit of detail, there is within the TUC an organisation called the Welsh TUC?
A. That's part of our organisation, yes.
Q. Exactly. And I think, as I understand your statement,

you describe that that organisation, as part of the TUC, has, as it were, devolved responsibility for certain matters relating to Welsh employment relations?
A. Exactly, in relation to the Welsh Government, yes.
Q. Rather separately, there are also the Scottish TUC and the Irish Congress of Trade Unions, the latter of which includes members both from Northern Ireland and Republic of Ireland; those two organisations are not part of the TUC in the same way as the Welsh TUC is?
A. That's right, they're independent organisations.
Q. But no doubt you do work closely with them?
A. We work closely together in a formal body which is called the Council of the Isles which brings us together to discuss matters of common concern.
Q. Yes. As I've said, the TUC is a very well known organisation and I'm sure we all know that the TUC represents working people and campaigns for their interests.
A. That's right.
Q. We've heard, of course, particularly in the last couple of days, about the disproportionate impact that Covid had on elderly people, many of whom would have been retired and not in the employment market, but it's also of course true that Covid had a very grave impact on workers, some of whom, of course, were also elderly, and

we've heard something of that in the narrative that I read out immediately before you gave evidence.
Many people of working age died from Covid. Your statement gives a figure of 15,000 people of working age who died; is that right?
A. That's correct.
Q. And many of those, as we've heard, were frontline workers, working in health, social care, transport, food processing and so on. Again, as has also been mentioned, many more of those workers caught Covid, no doubt many of them suffering amongst those who have long Covid, experiencing protracted symptoms.
Also many workers were severely impacted because of the nature of the work they were required to do. Again, we've heard something of that in the narrative document. Their working conditions changed dramatically during the pandemic.
For all of those things, we know from your statement, the TUC campaigned and represented those interests during the pandemic.
Perhaps we can just look at page 3 of your first statement, the lengthy statement, and look at paragraph 7, which is the bottom half of that page. You state at the beginning of paragraph 7:
"The TUC engaged in numerous interactions (and

attempts at engaging) with the UK Government during the pandemic ..."

Correspondence, meetings and so on.

Then you list seven particular focuses of that engagement. If we just look at them together, dialogue between unions and employers in the workplace, at a national and sectoral level. Then the second one, NPIs. We've heard something about -- tell us a little about the particular concerns in regard to NPIs.

A. So we were particularly concerned around the guidance on safety at work. We met the government on numerous occasions and brought evidence to the government on how -- before guidance was in place, how the ability to follow social distancing and other measures to protect workers at work was difficult due to the lack of guidance, and we repeatedly pressed the government to clarify its guidance, and in particular raised issues around mandatory publication of risk assessments, we talked about the need for specific risk assessments for those groups who were particularly at risk. And if you look at the last bullet point, that disparate impact of the pandemic on protected and vulnerable groups, was something that we were raising in our evidence around the guidance for workplace safety.

Q. Yes.

The question of guidance relating to lockdowns perhaps also falls -- clearly lockdown is one of the NPIs which you've probably already covered, but the next bullet point, PPE, again a recurring theme but something which the TUC was very active in campaigning about?

A. Absolutely, yes.

Q. And perhaps the last one, that you haven't mentioned so far, relating to schools, was that primarily from the point of view of those who worked in schools?

A. That's right, so that was representing the views of our education unions, representing -- both teachers, classroom assistants, headteachers, were raising the concerns around safety both for pupils and staff within schools.

Q. Thank you, Ms Bell. We will, in the course of your evidence, touch on a number of those points, come back to them in more detail, but on a very general level, can you give us an idea of how successful you felt your engagement was with the government across these issues during the pandemic?

A. Well, I think going into the pandemic it's important to note there was no regular or overarching forum for trade unions to engage with the government, and one of the calls we made on repeated occasions was for a kind of overarching forum bringing together unions,

government and business to discuss the NPIs and the other measures that would be needed to be taken in the workplace.

I think our engagement was successful in some ways in convincing the government to -- you know, of the need for clearer guidance, but there were clearly issues we raised which were not taken up in that guidance, and those included the need for specific risk assessments for black and minority ethnic workers, sector-specific issues.

We'd called for a bus safety summit very early in the pandemic; that's not a call that was heeded, and we know about the devastating impact on workers in that area of the sector.

We called for areas which could have given a greater confidence in the return to work, so for example the publication of risk assessments and the need for workers to have a clear sense of what their own employer was doing.

We called repeatedly for the need for additional resources for inspection and better enforcement, and of course, as I think we may go on to discuss, the need for better support for self-isolation, the need for better financial support, was something we repeatedly raised and we did not think we had an adequate response

to.

Q. Yes, well, as you say, I'm going to come on to that last issue in just a moment.

Before we leave the general picture, I suppose we should observe that one thing the government did do, and you refer to this in your statement, is of course fund the furlough scheme and the related sort of sister schemes to it, which was obviously of great benefit to the working population?

A. Absolutely. And that was something we called for, a good area of engagement with government where we did have that union/business/government engagement which we thought would have benefited other interventions across the rest of the pandemic response.

Q. Yes.

As I said, let's come back to that point now, which of course we -- well, in fact, we heard something about this issue of self-isolation and sick pay yesterday when we looked at a medical article before the pandemic, forecasting, as it were, that workers in care homes would be amongst those who would be reluctant, perhaps, to stop working even if they did get ill with some sort of respiratory virus.

Then we've heard more in the summary that I just read about this particular issue of workers on the one

hand knowing they're ill, knowing they're infectious, being told they need to isolate, but on the other hand finding it very difficult at least to make the financial sacrifice that that involves.

If we look at again, please, your longer statement, page 44, this is where you pick this theme up.

It's paragraph 147 of the statement. 147 -- I might have the wrong page. Yes.

So you say, the assertion you have there:

"... the effectiveness of self-isolation was hampered by the availability of adequate financial support for the very many who have limited or no right to adequate sick pay."

That was an issue, as I think you've said, that you campaigned on, as we will see, from the very earliest days of the pandemic?

A. That's right.

Q. I'm going to take you to a document, we'll talk a little bit about the particular issues, but in general terms did in fact the government ever provide what you regarded as adequate financial compensation for isolating during the course of the pandemic?

A. No, this was an area where we did not see sufficient progress and we think that had devastating implications.

Q. Let's go, then, Ms Bell, to a document -- can we call it

up, please -- it's INQ000192239.

I know this is a document you're familiar with, Ms Bell. It's a TUC press release, is it not?

A. That's correct, from 3 March 2020.

Q. Yes, so the first thing we can see is the date, which is 3 March 2020, so what's that, three weeks even before the first lockdown?

A. That's right.

Q. We see the bullet points there, the fact that it said:

"Nearly 2 million workers aren't eligible for Statutory Sick Pay, including a third of zero-hours contract workers."

And your call, the TUC's call, for:

"... emergency legislation to provide sick pay for all workers from day one of sickness, regardless of how much they earn."

A. That's right. And there was a third call in that press release for the level of statutory sick pay to be raised to enable people to be able to take time off work and claim statutory sick pay without falling into financial hardship.

Q. Yes, so let's come on to that. There is a reference to the letter, which I think we can skip over because we'll get to the detail, but you see the paragraph starting "Currently", so:

"Currently, nearly 2 million of the lowest-paid workers don't earn enough to qualify for statutory sick pay."

So, just pausing there, there was a threshold, was there not, that unless one earned a certain amount of money -- which was £120 a week, was that right?

A. That's right.

Q. Then one simply wasn't entitled to sick pay, statutory sick pay, at all?

A. That's right, it's a remnant of the national insurance system, it's called the lower earnings limit, and if you don't earn enough you don't qualify for any statutory sick pay.

Q. So people in that category simply -- if they were isolating, they wouldn't have got the statutory sick pay at all?

A. They would have no statutory sick pay.

Q. The bullet points you then set out refer to: 34% of workers on zero hours contracts; one in ten women in work, more; than a fifth of workers aged 16 to 24; and more than a quarter of workers aged 65 and over.

So it would seem, certainly from those bullet points, that this problem was focusing in on women, the very youngest people in the workplace, and also the very oldest people in the workplace.

A. That's right. And there are other disproportionate impacts which we highlighted in later reports, so for example, black women are twice as likely to be on zero-hours contracts as white men, so that exclusion of sick pay for those in insecure work has disproportionate impacts on black communities as well.

Q. If we can scroll up a little bit further, please, because we then see what it was that you were calling for at this -- perhaps let's remind ourselves -- very, very early stage, perhaps it's even too early to describe it as being during the pandemic, in those first few days of March.

So the first point you were calling for was:

"Emergency legislation to ensure Statutory Sick Pay coverage for all workers from the first day of sickness, regardless of how much they earn."

So if we just separate those two points. The "first day of sickness", even those who were entitled to statutory sick pay weren't entitled to it, at that stage, for the first three days, I think --

A. There was a three-day waiting period. Then that bullet -- that specific bit was addressed in the budget of, I think, 11 March 2020.

Q. That's my note. So in fact just over a week after this press release --

A. Yeah.
Q. -- that particular point. So if you were above that threshold of £120 a week, there wasn't the three-day gap --
A. The three-day waiting period was removed for coronavirus.
Q. But the second part of that bullet point "regardless of how much they earn", there you are calling for a sort of abolition of that threshold; and did that ever happen?
A. That never happened.
Q. The next point, you're calling for:

"An increase in the amount of sick pay to the equivalent of the real living wage of £320 a week."

So does this address a concern that, even for those who were entitled to statutory sick pay, the amount was very low?
A. Absolutely. So at that time average earnings were around £500 a week, so you can see it would be a significant income drop to go to £90 a week, so we called for the level to be increased so that people could afford to not be at work.
Q. I was going to come to this, I don't think we have introduced this yet, but the level of sick pay for those entitled to it, I think it was £94.25 a week?
A. That's right.

Q. So far below what, as you say, the average worker would have been earning, which introduced its own question of whether people could afford to go on to that?
A. Absolutely. And we'd said in that press release, in fact, as it stands many people won't be able to meet basic living costs if they stay home from work.
Q. Then just skipping down to the fourth bullet point, you call for an emergency fund to assist employers with the cost and to cover workers not currently eligible for statutory sick pay.

So obviously there might have been various ways in which your concerns could have been met, but an emergency fund sounds a little bit like the furlough scheme and a sort of block of money being allocated to solve this problem during the pandemic?
A. Yes, so employers are responsible for the costs of statutory sick pay, so we were suggesting that government may need to offer them some additional financial support in this particular emergency situation.
Q. There was an amount of money allocated by the government to address this problem, but it came much later; is that right?
A. That's right. So in -- I think in 28 September, the government introduced --

Q. Just pause there, of 2020?
A. Of 2020, sorry -- the government introduced the £500 Test and Trace Support Payment. That's not something they'd consulted the TUC on and was administered through local authorities in a way where people, rather than getting it through their normal work processes, through the normal process of sick pay, they needed to apply from that payment. And when we did some research into the operation of that payment, we found that 70% of applications for a Test and Trace Payment were being rejected by local authorities, and later on that was the first series of freedom of information requests we did into the operation of that scheme, because we were worried it was not providing the support needed, the second set we found that only a fifth of workers had actually heard of that payment, whereas of course sick pay is well known about as a normal workplace intervention.
Q. So on its face the £500 Payment was the type of level that you had been calling for, but the problem with the scheme lay in the accessibility of the funds for workers?
A. It was, of course, a step forward that some financial support was made available, and of a, you know, magnitude which provided more support, but the

complicated application process, the discretionary nature and the fact that funds were limited for local authorities, so some people were applying and being told, you know, "There's no money left", meant that we didn't think this was an adequate form of financial support.
Q. Did you discover the amount of money that was made available by the Treasury for this scheme? Let me suggest a figure which is in your witness statement, £50 million, and how did that compare, to your mind, with the types of funding that had been given, for example, to the furlough scheme and Eat Out to Help Out and these other large schemes during the pandemic?
A. Well, I think it was very clear that it was inadequate. As our research went on to show, many people were being turned down for this financial support.
Q. That was September 2020 and you've explained the freedom of information requests and so on that you made after that date. Did you continue to campaign on this issue throughout the pandemic?
A. Yes, we published numerous reports on it. If I just find my note, I have a list of them somewhere.
Q. In some --
A. But we published numerous reports on it, we continued to highlight the issue, we continued to try to undertake

research and -- with workers to understand the impact. We also worked with business organisations to try to put pressure on the government to fund an adequate statutory sick pay scheme and to remove that lower earnings limit. So it's something we raised, I think, in -- I would be confident in saying in almost every interaction we had with ministers and civil servants.

LADY HALLETT: Can I pause you both there, please. We do have another module where we're going to be looking at government support, Mr O'Connor.

MR O'CONNOR: Yes.

LADY HALLETT: I think probably we've had sufficient on this for this module.

MR O'CONNOR: I was about to move on to other issues, my Lady.

LADY HALLETT: Thank you.

MR O'CONNOR: Let's move on, Ms Bell, to impact issues, and in a later part of your statement, the long statement, you cover various particularly vulnerable groups, and describe some of the particular impacts which you became aware of as an organisation that they were suffering during the pandemic, and steps you took to try and address those issues.

So can we go, first of all, please, to page 78 of your statement. I may have the numbers slightly wrong.

I'm looking for paragraph -- yes, sorry, can we go to the page before, please. Yes, so paragraph 258.

At paragraph 258 you list a series of reports that the TUC produced during the pandemic relating to the impact of the pandemic on BME workers, and we can see there, I won't read them out, that the dates cover the period of the pandemic.

I'm just going to ask you a few questions about the second of those reports, *Dying on the Job - Racism and risk at work,* which was published by the TUC in July 2020.

For those purposes, can we go, please, to paragraph 265 of the witness statement, a page or two on.

You describe there, Ms Bell, a call for evidence in June 2020; is that right?

A. That's right.

Q. Which was responded to, you say, by 1,200 or more workers. What were the key conclusions drawn, the key pieces of evidence given in that report which are set out there?

A. Well, I think this was clearly showing the disproportionate impact on BME workers. So this was a call for evidence, so it was self-reported, but one in five of those responded said they had been treated

unfairly at work because of their ethnicity during the pandemic. Around one in six said they'd been put at more risk of exposure to coronavirus because of their ethnic background. And they described things like being forced to do frontline work that white colleagues had refused to do. They also talked about being denied access to proper personal protective equipment, refused risk assessments, and singled out to do high-risk work. And I do have an example from one particular worker which I could share with you, if that's appropriate.

Q. Yes, do, please.

A. So this was a member of the bakers union, and she says she's black British, she's a middle-aged mother of one, and had worked for her employer for almost seven years. Her husband had very sadly passed away from Covid. And then she was asked to -- she says:

"I was informed by my employer that I would be responsible for the lateral flow Covid testing of contractors and visitors to our busy site. I refused, I expressed my fear, grief and safety concerns to my line manager. I was informed it was a reasonable request."

And she says:

"My grief, trauma, ethnicity, age and multiple Covid Infections did not trigger any reviews, specific

assessments or compassion from my employer."

And she goes on to describe how she then caught Covid multiple times and suffered as a result of that.

Q. Let's move on, Ms Bell, to another one of the areas of concern that you describe in your statement, and that's pregnant women and mothers.

So I'm now looking at paragraph 271 of the statement. In fact, if we can -- that's the start of that section -- go on, please, to paragraph 275, because it's there that you refer to a report published by the TUC in June 2020 entitled *Pregnant and precarious: new and expectants mums' experiences*. This again the results of a survey, this time 3,400 people, pregnant women and mothers, responded. But if we can just draw out a bit and see the bullet points, do we see that the report highlighted that one in four pregnant women and new mothers had experienced unfair treatment or discrimination at work, including, for example, being singled out for redundancy or furlough, their rights being routinely disregarded, feeling unsafe at work, and so on? Also suggestions that they had been forced to stop work; they were the first in a workforce to be told to leave because of -- when there were issues around reducing the workforce because of Covid. Those were the types of issues, were they, that pregnant women and

mothers reported experiencing to you?
A. That's right, and the Royal College of Midwives, who is one of our affiliates, were repeatedly reporting concerns from May 2020 onwards about a lack of clear guidance for keeping pregnant women safe.
Q. Yes. Sticking with women generally, I'd like to go on, please, to paragraph 280 of your statement. You list there some very striking statistics about women in the workforce during the pandemic, which are worth noting. You say:

"Of the 3,200,000 workers at highest risk of exposure to COVID-19, 77% are women."

77% of healthcare workers were women, 83% of the social care workforce, and 70% of those working in education.

"Mothers are more likely to be key workers than fathers or non-parents, 39% of working mothers were key workers before this crisis began, compared to 27% of the working population as a whole."

As I say, striking statistics. Were those issues that the TUC campaigned on during the pandemic?
A. That's right. The overrepresentation of women in many key worker sectors was something we were raising, and therefore the disproportionate risk on them. And also pulling out issues like the lack of suitable PPE for

women, so Prospect members, for example, reporting that even before the Covid Inquiry that women were being -- sorry, the Covid pandemic, the lockdown, reporting that women were being overlooked when it came to appropriate PPE.
Q. Ms Bell, thank you.

I want now, as I said I would, to go -- this is the last series of questions I'm going to ask you -- I want to go back to your second statement.

You have read a passage from it, we had a passage from it in the summary I read before you gave evidence, but I want to now just look at a different part of it, which records the experiences of a worker in the care sector. I'm going to read it through and then ask you just a few questions.

So for those who want to follow, it's paragraph 4 of this statement. It starts on page 2.
LADY HALLETT: You're not going to read the whole of the paragraph?
MR O'CONNOR: I'm sorry?
LADY HALLETT: Are you going to read the whole of the paragraph?
MR O'CONNOR: Well, I was going to just read it through, madam, but perhaps I can take it more shortly.

Let me do it this way, Ms Bell, because I know

you're familiar with this passage. It refers to a worker in the care sector, the experience of having to work in the early days or in the autumn of 2020, experiencing a sense of isolation in the care home, dealing with patients dying of Covid, how that relates to the experience of then having to go home, concern for the family and so on.

Those sorts of experiences, were they something that you found reported to you during the pandemic?
A. Yes, I think so, and I think you can see that throughout this statement, and I think you can see kind of the terrible emotional toll for many of these workers of working in a pandemic, whether that was the awful impact of, as this worker, watching somebody die in a care home without their family, whether it was the consistent worry of perhaps taking the virus home to your family, or whether it was the uncertainty which, you know, caused by some of the issues we've talked about previously, of not knowing what support you were meant to have in the workplace, not having clear guidance in place, and therefore sort of feeling like you were at the whim of an uncertain system and some managerial discretion.
Q. One other theme that comes through from this passage and also from some others in your statement is a feeling

amongst care workers and NHS workers of something close to resentment at the public clapping during the pandemic. Can you tell us a little about that?
A. I think it does come through, and I think "resentment" is not quite the right word --
Q. Tell me --
A. -- but perhaps a feeling that it didn't -- that people could not understand the scale of what they were experiencing.
LADY HALLETT: They were underappreciated.
A. That they were underappreciated, underappreciated the scale of what they were experiencing, the lack of clarity or guidance that they needed in order to do their jobs, and of course their long-running concerns before the pandemic, which we have talked about, about their pay and conditions not being -- claps, you know, claps don't pay the bills, as many workers have been chanting this year.
MR O'CONNOR: Yes.

Yes, thank you very much, Ms Bell. As I've said, we're very grateful for those two statements you've provided. We've got them in writing, and it's been very useful to hear you touch on some of the points today.
THE WITNESS: Thank you.
MR O'CONNOR: My Lady, those are all the questions I had for

Ms Bell. I don't believe there are any --
LADY HALLETT: I don't believe there are any --
MR O'CONNOR: -- questions from core participants.
LADY HALLETT: Thank you very much indeed, Ms Bell.
THE WITNESS: Thank you.
(The witness withdrew)
MR O'CONNOR: My Lady, we're going to move straight on to the next witness, who is Mr Adeyemi.
LADY HALLETT: I gather you've flown in this morning?
THE WITNESS: Yes, my Lady.
LADY HALLETT: Thank you very much. I hope you're not too bleary eyed.
THE WITNESS: No, no, I'm looking forward to this actually, thank you very much.
MR ADE ADEYEMI (sworn)
Questions from COUNSEL TO THE INQUIRY
MR O'CONNOR: Could you give us your full name, please.
A. Mr Ade Adeyemi.
Q. Mr Adeyemi, you are a healthcare professional, and I think you have been a healthcare professional for 14 years or thereabouts; is that right?
A. Yes. I've worked at various levels in the National Health Service for over 14 years, and I'm now in the Department of Health. But I'm here in my act as a general secretary for FEHMO.

Q. Exactly. You're of particular interest to us, did you say the general secretary of the organisation --
A. Yes.
Q. -- the Federation of Ethnic Minority Healthcare Organisations, FEHMO for short?
A. Yes, that's right.
Q. You've helpfully provided us with a witness statement, which is dated 22 September of this year. We've got it on screen. Is that your statement?
A. That is my statement, yes.
Q. You've signed it, I think, but are you familiar with its contents?
A. I am.
Q. Are they true to the best of your knowledge and belief?
A. Yes, they are.
Q. I want to start, if I may, Mr Adeyemi, with just a brief overview of your organisation, what it's about, what it tries to achieve.

Let's look, if we can, at paragraphs 5 and 6 of your statement, so on the second page. You describe FEHMO as being:

"... a voluntary multi-disciplinary consortium comprising 55,000 individual members belonging to some 40 organisations and networks."

Can you put a bit of flesh on those bones for us,

please?
A. Of course. Across the National Health Service, there are a number of informal networks and organisations that come together, normally around professional and kind of diaspora or ethnic status. The full list of organisations that form FEHMO are in the back --
Q. Yes, I was going to suggest we looked at those, so let's go, it's the last pages of this document, I think probably page 22, if my pages are right. Yes.

I'm not going to read them out, but we can cast our eye down, there's the second page as well, but we can see that these are organisations which are linked by an interest in medicine and healthcare sector and membership from ethnic groups; is that fair?
A. Yes, and they're all voluntary.
Q. Yes?
A. So these are things people have come together around particular interests, as you say, particular professions sometimes, or a particular country of origin. Often within the National Health Service it's of value for people of black and minority ethnic status to congregate, to share knowledge, to uphold ourselves, kind of share interests and advice, because the issues that affect us, both professionally and healthcare-wise, are quite stark and quite different. And so it's a safe

space often, and FEHMO is made of over 40 of these, which you see listed there. Some are quite large and some are a little bit not as large, but overall we represent at least over 50,000 NHS and care --
Q. Yes?
A. -- staff members.
Q. If we can go back to page 2 of your statement, please, again if we look at paragraph 6 of your statement, there is a very helpful list there, again I'm not going to read them all, but we see starting third line there, doctors, nurses, midwives and many other healthcare-related professions, all of which form part of those organisations which themselves combine to form FEHMO?
A. Yes, that's right.
Q. I think it's right to say that FEHMO was actually founded fairly recently. During the pandemic or -- is that right?
A. No. We had been coalescing together beforehand --
Q. Right?
A. -- and actually there was a Continental grouping of these African networks that had formed as well. Leading up to before the pandemic, we realised that it was useful to, you know, strengthen numbers and so to come together and to have the area of key decision-makers

within the health ecosystem.

So we had formed at least a year before the pandemic. The pandemic really forged us together -- unfortunately -- but yes, we have an eclectic mix of members, a very inclusive list of professions, speaking for black and minority ethnic healthcare members across the NHS ecosystem.

Q. Yes. And you state in your witness statement that, and tell me if this is right, the aim of FEHMO is to eliminate systemic and underlying inequalities faced by your members within the NHS?

A. It's a big aim, one we still strive for, one I hope to achieve in our generation, but that's one of the main reasons why we come together, yes.

Q. And it's equally clear from your statement, Mr Adeyemi, that you, the organisation, believes that there is a lot of work to do, there are a great deal of inequalities within the NHS?

A. A great deal. The evidence has been clear for many years. I don't want to waste time, if I listed all of them I'd use up all my time. The evidence is very clear. Both as patients, as users, as service users of the NHS and social care system, and also as professionals, both in a professional sense and a work capacity, the difference that we see with our white

counterparts is stark, and it's been existing for many years. And so we've had to form these clusters, these networks, to galvanise, share knowledge, to try to address the problem, because so far it hasn't been meaningfully substantively addressed.

Q. It's apparent from what you've said that your work is of a much broader scope than simply trying to address issues that arose during the pandemic, but it's right, though, isn't it, that FEHMO, and in particular some of your member organisations, were very active during the pandemic trying to address problems as they arose relating to their membership?

A. Yes, many were active. As I said earlier, a voluntary organisation, so doing this alongside their day jobs within the National Health Service and the care system, sharing knowledge, having webinars, writing letters to decision-makers, to try and implore attention to these issues.

Q. Yes.

A. Yes.

Q. I wanted to show you just a couple of the letters that you refer to in your witness statement as a way of seeing what was going on, and the first of those, please, is a letter dated 7 April 2020.

It's INQ000148476. Yes.

So, first of all, Mr Adeyemi, we can see this is in fact a letter from the British Association of Physicians of Indian Origin. I was going to note it with everyone when we were looking at that annex at the end of your statement, we won't go back to it, but it's one of the organisations which is part of FEMHO?

A. Yes, one of our most active, yes.

Q. And we can see that this letter, first of all, was written in the early days of the pandemic, so a week or so, a couple of weeks, after the first lockdown was announced, and it's written to a series of very senior people within the NHS, if I can summarise, Simon Stevens, the CEO, Chris Whitty, Chief Medical Officer, and others?

A. Yes, that's right.

Q. The letter draws attention, does it not, to the developing picture, even at that early stage, of a disproportionate impact on BAME medical staff of the pandemic as it was developing?

A. That's right.

Q. Was that something that you were aware of -- presumably many of the organisations within FEHMO, this was a matter of discussion in those early days?

A. It was, it was something that was well known to us, and we were surprised, upset, a number of other range of

emotions that's difficult to describe, at the response from the top of the office of the National Health Service, if you will.

This is just one example of one of our networks writing a letter, trying to stimulate activity within the healthcare system to address this thing. Within the health ecosystem there is a popular trade journal, the HSJ, which had put this on blast across -- so we had known it was -- it was a known thing, and we were surprised and disappointed it wasn't being taken seriously, even in terms of the response, from our recollection, from what we were feeling on the ground.

Our members were sending WhatsApp messages, texts, calling each other, "Is -- what's happening in your area?" "What's happening your area?" And it's true, it was true in so many different spaces. And, yeah, this is an example of trying to stimulate activity.

Q. So perhaps if we just scroll down just a little bit, we can see at the end of the second paragraph there is a question, really:

"A matter of concern to our members and our wider communities is whether race and ethnicity are linked directly or indirectly to the disproportionate morbidity and mortality."

Those early days, it was still something that was

not clear. And then, immediately below, again raised not just that, but being male, being BAME and older adults appear to be at greater risk.

These are obviously all risk factors which are now well established but in those early days the question was being raised: this is what we need to look at.

A. It was, yes.

Q. If we can go over to the next page of the document, please, we see what it was that -- it was actually someone called Dr Mehta, I think, who wrote this letter, but we can see what it is he is asking Chris Whitty, Simon Stevens and others to think about. First of all, we see at the top there:

"We would therefore expect that all employers to provide a safe working environment ... and to perform a comprehensive risk assessment ..."

At the end of that paragraph we see again the expectation that employers should carry out a stratified risk assessment so that those on the frontline of tackling the disease are not unnecessarily put in harm's way. So that was one of the requests?

A. One of the many requests, yes.

Q. Then in the paragraph below, there is a request or an emphasis on the need for data to be gathered for consideration to be had about whether -- what was going

on with these disproportionate deaths.

Finally, in the last paragraph, there is a reference to the situation of older doctors, older BME doctors, who are being asked to come back to the NHS at that time and how they should be dealt with in light of the apparent vulnerability of older people.

So those three issues all seem to have been in play at that time.

I'm going to ask you a few questions relating to your statement about those -- well, two of them. Let me deal first of all with a matter which I don't think you do deal with in your statement, which is that last one, the position of older doctors. Tell us a bit more about that issue and about how it was resolved or whether it was resolved in the period after this letter.

A. Most of our members that I represent would feel that it wasn't well resolved. We know at the beginning of the pandemic there was the direction from NHS England to work with regulators to, you know, invite recently retired and returning doctors and nurses and other allied health professionals to the frontline. And for particularly older ethnic minority health professionals, as you say, there was concern that the comorbidities and other situations here would place them at greater risk.

We had so many instances of those concerns being

raised at the local level, in trusts, in healthcare centres, and not necessarily being taken seriously or believed. And this is on top of, you know, an imbalanced power relationship, on top of some healthcare professionals who also -- you know, agency workers. Visa issues also create an asymmetrical relationship. And those concerns not being listened to at the local, regional, national level.

But seeing some of those concerns be held and listened to from their white counterparts, which again creates a sense of unease and, well, why is it that another health professional can raise concern about being on the frontline and they're listened to and they're redeployed or things are done to help manage the situation, but black workers, ethnic minority workers do and they're not listened to or believed or, you know, ignored?

Q. Thank you. That's that issue of the older doctors returning.

Let me now ask the operator if we can go back to your statement, please, and it's page 11, paragraph 29. This is the issue about data, which was one of those questions raised in that letter we were just looking at.

We saw in the letter, April 2020, the request for urgent data to be gathered, examination, consideration

of whether there really was a disproportionate impact, in order to help take steps, if necessary. Was that undertaken? Were there sort of urgent steps taken to gather the sort of data that was envisaged in that letter?

A. Not in the view of our members, no. And some of our network organisations, for example, the Filipino Nurses Association had to go out of their way to collect this evidence, which -- you know, I've described this sort of pattern of voluntarily working on these issues on top of their day jobs, which is exhausting and tiring when you're trying to tell a system, "Look, there is an issue with us, please believe us", and to do something about it. Which we see in other areas being done and in this instance it wasn't done quickly enough and so, no, we had to go above and beyond to do our own surveys, reach our own communities, to gather that evidence.

Q. And you refer in fact in this paragraph we're looking at to a different member organisation, the Filipino Nurses Association, beginning to do just that and collecting its own data and submitting it to Chief Medical Officer?

A. That's right, yes.

Q. Were there other examples, then, of independent groups, perhaps some of your member organisations, doing similar -- taking similar steps?

A. Yes, holding surveys, holding webinars to gather information, to collate it so that we could present it to seniors within the National Health Service, either because this data wasn't being collected or we weren't seeing it being acted upon, but, yes, there were so many other examples of our different network constituents doing the same thing.

Q. You refer at the end of that paragraph to Independent SAGE expressing a view on this, and I think if we can zoom out and go to the next paragraph, paragraph 30, we see what it was that Independent SAGE said. I think this is a quote from them:

"... all relevant research studies should collect and present disaggregated ethnicity data, national minimum data sets should include ethnicity data, all existing data sets should be reviewed and ethnicity should be included in mortality reporting."

Was that the comment by Independent SAGE that you refer to?

A. Yes, that's it.

Q. Then, a little bit further down the page, you in fact give an account from a FEHMO member which touched on the consequences of poor data collection. It's up on the screen. Essentially, if you don't have the data you don't know what steps should be taken, and in a pandemic

that leads to serious consequences.

A. Yes, and there's another interesting contextual bit of information to share here, which is, across the National Health Service, before and during the pandemic, there was a set of data called the Workforce Race Equality Standard that measured the progress of ethnic minorities within the NHS. This was stopped, they stopped collecting that data, which again creates a kind of culture and understanding that actually they don't really care about this issue.

We know the NHS works on what's measured, what's collected, you know, and you can't progress, you can't say how well you're going on something you don't measure. We also know that the NHS works on rules and there's no rules that protects the people that work for it, or all of the people that work for it. So, again, that leaves us with a sense that they don't care or ... yeah, it's just a very tough thing for ethnic minority workers to see happening and to have to then go out of their way, on their own back, on their own energy, to try and correct.

Q. You also mention in your statement another feature of this, which is that the RIDDOR reports, which might have been one way in which this type of data could have been gathered, perhaps should have been gathered, in your

experience anyway, don't seem to have been properly undertaken during the pandemic?

A. No, not -- and again, we have a -- our members have a deep appreciation of how the NHS works, with, you know, mandates from the Secretary of State directing how the chief executive of NHS England, you know, should prioritise objectives, and there's a difference between a memo and a letter of intent and a standard operating policy procedure, and all of the things that were coming out about RIDDOR assessments and risk health assessments weren't of the directness that we see with other medical issues, which again leaves us with a sense of it -- it's not a priority. Because that's what health managers on the other end will receive. Ward managers, chief executives of trusts, they will pay attention to those directives, those mandates from the NHS, from NHS England, and the deployment of risk assessments for ethnic minority healthcare workers was confusing, so we saw healthcare managers, we saw ward managers, some doing it and some not doing it. Which, you know, you multiply over a nation leads to what we saw.

Q. You mention risk assessments, that was going to be the next -- you will recall that was one of the points raised in that letter, it was going to be the point I was coming on to. So can we look, perhaps, at

paragraph 39 of your statement, please, I think it's on page 14.

We'll recall that the letter we looked at was April 2020, and what you suggest or state in this paragraph is that for some months at least into the pandemic risk assessments don't seem to have been carried out in your experience and the experience of your members. You say:

"Most of [your] members did not have any risk assessment carried out until later in the pandemic ... not assessed for risks arising from known disparities ... for minority ethnic [healthcare workers]."

Then there is a reference to a June 2020 study into risk assessments for minority ethnic healthcare workers, which said that 65% of doctors at that stage, so that's two or three months after the letter, still hadn't known of or been given a risk assessment.

So there was an issue with delay at the very least?

A. An issue of delay which came from, as I said before, the urgency within which that directive and the message came from NHS England that healthcare trusts and care settings were supposed to do risk assessments.

Q. Clearly it was an emergency, institutions were struggling to respond to what was a very unusual event, are you able to say whether the risk assessment -- the

delay, the problems with the risk assessment was a general problem or was it one where issues around assessment of risk for ethnic healthcare workers were particularly marked?

A. We definitely feel it's a racial element, definitely. Again, speaking to the culture and feeling from members of FEHMO, we see British institutions generally, like the NHS, are able to respond to great tragedies. So a recent example, we see there's a response to Martha's Rule, we see the speed within which a statutory inquiry has been suggested for the horrible crimes in the Letby situation. We see Harper's Law, that protects emergency healthcare workers or emergency service workers. And there is a tragedy here with black and ethnic minority healthcare workers and it's a message from the chief people officer of NHS England: it's not a mandate, it's not a law, it's not a rule. Which again creates the sense and the culture that there's one response for tragedies of a certain type of workers and another response for another type of workers. And that's what led to, yes, that imbalance and the difference of risk assessments across the country.

Q. I think there is a further point you make in your statement. We've talked about the delay, the initial delay in risk assessments being undertaken, but you go

on, I think, to suggest that even once the risk assessments started to be made, they fell short of what you would have expected?

A. Yeah. We have members across all levels of the National Health Service, so we understand that it was a difficult time. We had people working in NHS England, in the nerve centre itself. So, yes, it takes some time to develop those risk assessments, but yes, there was the delay in its roll-out, and its implementation as well, variance across the country, which unfortunately played out in terms of different outcomes for black and ethnic minorty healthcare workers versus white workers.

Q. Thank you, Mr Adeyemi.

I want to show you just one other letter.

In fact it was written by the same organisation, in fact I think the same person. This one dated a couple of weeks later.

Yes, we have it on the screen.

So the first one was 7 April. This one, we will see from the top, was 22 April, and we see this time it's not written to Simon Stevens and Chris Whitty, but rather to chief executives of NHS trusts, so still written to some very senior people, and presumably, this time, probably circulation a lot wider across the country. Is that right?

A. That's right.

Q. I'm not going to dwell on the first page. It covers a lot of the same information, statistics, concern about disparities and so on that we saw in the letter that had been written a couple of weeks earlier.

Let's turn, if we can, to the second page, because there we see, again, what it was that the British Association of Physicians of Indian Origin was asking the chief executives of the NHS Trust to do.

First of all, we see a request for stratified risk assessments, something we've already discussed, and it's expanded on in the first numbered point, it's:

"... a priority [for] all staff [at] frontline are risk assessed for age, sex, ethnicity, pre-existing medical conditions ..."

And so on, and we see that there is again a reference there to retired and returning doctors; is that right?

A. Yes.

Q. We also see at point 2 there is a request that BAME staff are either tested for vitamin D deficiency or given vitamin D supplements. Is that because at that early stage of the pandemic there was a thought at least that vitamin D supplements would provide greater immunity or resistance to the Covid virus?

A. Yes. And if I may expand just for a few seconds, I think this also shows the uneasiness of talking about race in the National Health Service. No one of my colleagues, no one -- a member of FEHMO would like to think it's because of racism that there is a difference in outcome for black, Asian and ethnic minority staff, that you could be going to work and the colour of skin, which you can't change, makes a difference in whether you leave alive or not.

So something like vitamin D -- and, you know, science tries to obfuscate and say actually racism isn't involved here and there should be another biological reason, so -- it's now been debunked, but it kind of masks and -- it's something that's very uneasy for us to talk about, that it shows that actually -- we kind of scramble around for: there must be another reason, it can't be because of racism that there is difference in outcomes here.

But "yes" is the short answer to your question.

Q. Well, the longer one was very valuable, thank you.

Moving down the list, then, this is an issue I want to explore in a moment with you in a bit more detail, of course, the question of PPE was raised, which was a big issue, was it not --

A. Yes, it was.

Q. -- for your members at this time?
A. Yes, it was.
Q. And the last point:
"No employee must feel bullied or harassed for racing concerns about unsafe working conditions ..."
Standing here, it may even seem surprising that that was ever a thing, but is that something that your members experienced at the time?
A. Yes, it is. And they continue to experience. There is a fear of speaking out, of exposing situations that aren't quite right, anxiety that, "Will it affect my career? Will some other thing come and limit me, or will they harass me in some other way?" So, yes, there was a fear of that and of the PPE as well.
Q. Yes. Well, let's come, and I think this will be the last short topic, and look at the question of PPE, and that is covered in your statement, so let's go back to your statement, if we may, and it's page 12 of your statement, paragraph 33.
At paragraph 33, Mr Adeyemi, perhaps, you set out the general concern, which was that minority ethnic healthcare workers suffered disproportionately from the failure to facilitate adequate PPE, both in the sense that it was unavailable and that it was inadequate for what was needed and that your members were more likely

than their white British colleagues to find themselves in hazardous work environments without adequate PPE.
Can you just give us a sense of, then, the general concerns as they arose in the -- well, certainly in the early days of the pandemic, tell us how they developed.
A. Yeah. So our black and Asian, ethnic minority colleagues on the frontline in ICUs, in intensive care units, in wards, feeling that, and some with -- just zooming out a little bit, actually. You know, most of the PPE that was procured fit a certain type, and it was mostly industrial, so for people of different race, different genders, some with religious, you know, head scarfs and other ornaments, it was difficult to find the right PPE. And this gave us a sense of a lack of, again, a belief of what we were saying, that the system can pick up signals and noise and disruption in other areas, but when there's noise and disruption of black and Asian ethnic minority workers, it's not heard and it's not responded to immediately.
So, you know, we're not immediately clear whether it was, you know, a buy problem or a distribution problem, but it certainly was a problem on the wards where, when we did say these things, and when systemically it's happening across the NHS system, across the country,

it's not being immediately believed, it's not being immediately responded to, it creates that understanding or perception that there is an institutional systemic response for one set of problems, and for our members, black and Asian ethnic minority workers, there is a different systemic response that's quick, that's not proportionate to the scale of the problem.
Q. I mean, what you're describing, Professor Nazroo was here yesterday, he would term that structural racism. Is that how you define it?
A. If it quacks like a duck and it walks like a duck, it's a duck.
Q. In particular, going back to PPE, you've mentioned the issue around the fitting of PPE. This was a problem with BAME healthcare workers, simply a question of whether the PPE that was provided fitted was culturally appropriate. You give an example in your statement of people who wear turbans or who have beards. Tell us a little about those problems.
A. So, you know, a face fit test is needed to make sure that the PPE fits securely, and, you know, that the Covid microbes and et cetera and what have you don't pose a risk to the healthcare workers. And we have so many examples of, again, just WhatsApp messages, and it's -- it's so traumatic to receive them and feel

powerless, because we're hearing those things, we're hearing that the face fit test isn't done properly, some ward managers aren't seeing the results that it's not fitting well and they're actually still being encouraged to work. You know, there's a kind of toxic mess here, I described earlier, about the power imbalances which mean, one, most of our members didn't feel able to raise those concerns, and the brave ones that did weren't listened to. But it was a palpable thing, that we said these things don't always fit us well, there are some people who need extra appendages so it can go around the hijab, et cetera, not listened to, not believed, not responded to.
Q. If we look at -- this might involved going over the page -- paragraph 35 of your statement, you give some statistics. This is evidence submitted to the Women and Equalities Committee:
"... 64% of BAME doctors reported feeling pressured to work in settings with inadequate PPE compared with 33% of white doctors."
I'm just looking at the footnote there. And that seems to have been dated July 2020. Does that sound right?
A. Yeah.
Q. We've all probably read on. We can see in the next

sentence you say that some of your members reported having to use bin bags as PPE?
A. We've had reports of that, yes. And, again, it's a very uncomfortable thing to recognise that that could happen to someone. Someone could be in a ward in the National Health Service where they're not given the right kit to do their job. And our beloved NHS, you know, you would think that wouldn't happen, but I think many of our members would be glad that we're sharing that evidence here today, so that it is understood that there were pockets of this practice happening.
Q. On a related matter, this is a couple of paragraphs later in your report, not PPE, but oximeters, so I think I'm right in saying those small gadgets that you put your fingers into which measure both your pulse but also oxygen levels in the blood, so they are a diagnostic tool to see whether people have Covid; is that right?
A. That's right.
Q. They were used. Tell us, I think the experience was that they -- well, tell us what the problem with the oximeter was.
A. The problem is that they work on infrared technology, which -- there's a wider industrial systemic problem, which is that the tests and trials used to verify them

were mostly done with white skin trial participants, so the technology doesn't work as well on people with darker skin, because it relies on infrared bouncing back from pigmentation. And a feeling that, again, when we raise these problems, and we have members who worked with the Department of Health, with the medical health regulator, MHRA, it wasn't quite believed. We had an institution that was set up for ourselves, the NHS Race and Health Observatory, which did research into this. And again, there's an issue with a medical device, we know it doesn't work on a certain population, and the response from the system, from the ecosystem, feels slow, feels sluggish, feels like it's not believed. And it went around in that MHRA cycle for a while, and that's what our members feel and see.
MR O'CONNOR: Yes.
Mr Adeyemi, thank you very much. As we've said to other witnesses, we've got your evidence in writing, we've touched on some of the points today, we're very grateful for you having provided it.
My Lady, those are the questions I have.
LADY HALLETT: Thank you very much indeed, you've been extremely helpful, and you're obviously far better at recovering from belong flights than I am.
Thank you, it's been very interesting, if

disappointing.
THE WITNESS: Thank you.
LADY HALLETT: Thank you.
(The witness withdrew)
LADY HALLETT: Right, I shall return at 1.45.
(12.48 pm)
(The short adjournment)
(1.45 pm)
LADY HALLETT: Yes, Ms Cecil.
MS CECIL: Yes, Chair. May I call Dr Clare Wenham, please.
DR CLARE WENHAM (affirmed)
Questions from COUNSEL TO THE INQUIRY
MS CECIL: Thank you, Dr Wenham.
You have prepared a report for the Inquiry entitled "Structural Inequalities and Gender"; is that correct?
A. Yes, that is correct.
Q. That's dated 22 September of this year, and can be found at INQ0002800.
Now, just to deal with some formalities, if I may, at the outset of that report, on the very first page, you have made a statement of truth.
A. Yeah.
Q. That confirms that this report is your own work, those facts are within your own knowledge, and that you understand your duty as an expert to provide independent

advice. I've summarised it, but can I just confirm that's the position?
A. Absolutely, understood, yes.
Q. Thank you.
If I may again begin, then, with your expertise and your professional background, you set that out in detail within your report, I don't propose to go through that in detail now, but in short you're an associate professor of global health policy at the London School of Economics, and your area of expertise is in the gendered impact of epidemics and broader health policy?
A. Yes, correct.
Q. Now, just to deal with some matters, if I may, before we begin. Firstly, your report is entitled "Structural Inequalities and Gender", and you go on to speak about gender inequality, structure inequality and patriarchy.
Can I ask you first of all, in terms of gender inequality, what is the position within the UK? How does it fare globally?
A. So the UK ranks relatively highly in terms of gender inequality, but that's not to say that gender inequality doesn't exist within the UK, and there are lots of examples I've given in this report of the ways in which gender inequality still exists within the UK.
Q. How do you define gender inequality?

A. So I think gender inequality is the differences of experiences and outcomes between men, women and other genders, mainly due to the structural inequalities that play out, which are governed by particular norms and particular policies, which don't ameliorate the social and cultural norms of gender across this country.
Q. I think you say gender inequality is, at its heart, a structural issue?
A. Absolutely.
Q. And you see the manifestation effectively of that structural issue in gender inequality in everyday interactions in life?
A. Absolutely, because the structures and the policies which are created have a particular world view which are less easy for women to navigate than men in many instances.
Q. Then what you deal with, following on from that, is the persistence of the patriarchy. What do you mean by patriarchy?
A. So by the patriarchy I mean that there are certain cultural and social norms which exist whereby women are considered differently to men, and that the systems, structures, policies, way institutions are set up, way we live our lives in society, are all structured in a way whereby women are not able to exist in the same

way as men.
Q. Thank you, Dr Wenham. Just to remind you, we have a stenographer, and so if we can take things just a little more slowly.
A. Sorry.
Q. It's my fault, not yours.
Leading on from that, a very simple question in some respects, perhaps more complex in others: is the UK in your mind a patriarchal society, in your opinion?
A. Yes. Absolutely, yes.
Q. Thank you.
How does that manifest? If you can just give us some high headline examples.
A. So we know, for example that, the gender pay gap exists, men on average earn more than women. We know that women perform the burden --
LADY HALLETT: Slowly, please.
A. That women perform the burden of unpaid care within societies, they're the ones who are more likely to be looking after children, looking after neighbours.
We know that gender-based violence exists, where, you know, women are at risk of violence from male counterparts.
These are just some high-level examples demonstrating the existence of the patriarchy.

MS CECIL: Thank you.
Now, I just want to talk about the scope of your report. We're going to go into some of those areas in more detail in due course, but just dealing with the scope of your report, the questions I'm going to be asking you about are in relation to those pre-existing inequalities, so inequalities that existed as at or before January 2020, so before the outset of the pandemic.
Just dealing with the position of the devolved nations for a moment, your report covers each of those devolved nations; is that correct?
A. To the extent that their data was available.
Q. Quite. And where it's possible to break down that data and provide nation-by-nation specific data, you have done so?
A. I have done so. And where I have been unable to do so I've noted which administration it refers to.
Q. Thank you. Then in general terms in the observations you make, do they apply across the devolved nations or are there any significant differences?
A. In general they apply across the whole of the United Kingdom.
Q. Thank you.
Within your report, you touch upon the position

since 2010 and, in relation to commitment across the United Kingdom, to issues of equality and institutional mechanisms, including impact assessments.
Now, is it fair to say that, in relation to those impact assessments and policy and differences across the devolved nations, there is an insufficiency of body of evidence or data to make any meaningful observations?
A. There is insufficient data to demonstrate a systematic difference between the way the different devolved administrations undertake impact assessments, although anecdotally there are different tendencies in the way the governments are going it.
Q. Thank you.
Just again building on those inequality and the impact assessments, in terms of how that translates to policy, do challenges remain?
A. Yes.
Q. Thank you.
I now wish to turn to, if I may, paragraph 9 onwards of your report, which relates to the impact of epidemics and pandemics, in terms of the state of knowledge, of international knowledge.
Now, it's fair to say that there is a wealth of international research and knowledge that you set out within your report with regard to the impact on women as

a consequence of pandemics, epidemics, health and other crises.

Just to headline those for you for a moment, you note the impact of the Ebola outbreaks in West Africa and the Democratic Republic of Congo, Zika outbreaks in Latin America, cholera in Yemen.

Now, picking up on that, you then identify those impacts. I just want to go through them if I may in broad terms. The three main areas, the first of those is healthcare. What impacts were seen globally and internationally in relation to crises?

A. Absolutely. So what we saw during the Ebola outbreak in West Africa and again during the Democratic Republic of Congo was that the diversion of healthcare resources towards the epidemic meant that there was less provision of healthcare for women, particularly in maternal health services, and the impact of that, quite alarmingly, for example in Sierra Leone, during 2016, was that the same amount of women died of obstetric complications as did died of Ebola -- people, both men and women, died of Ebola.

And in DRC, when we saw many women scared to go to healthcare facilities when pregnant or when needing maternal healthcare because they were scared of contracting Ebola, we saw increased rates of maternal

mortality amongst those women.

So there's a direct correlation there between people being scared to visit facilities and diversion of resources.

Q. Thank you.

The second area is in relation to gender-based violence. What lessons were to be learnt there?

A. Well, we've known from Ebola and from the Zika outbreak in Brazil, and from other crisis events such as Hurricane Katrina, that these crisis events have a knock-on effect on domestic violence in a myriad of different ways, but the headline is they do have an effect.

Q. So one sees an increase in gender-based violence in terms of international crises and, indeed, epidemics, pandemics, but more broadly other crises that impact?

A. Absolutely, yes. And it's hard to disaggregate between whether it's the crisis event itself or the policies that are brought in to mitigate the effects of that crisis, but those two things are connected.

Q. Thank you.

Then economic impacts, very briefly, if I may, Dr Wenham.

A. Absolutely. So we know that from previous outbreaks such as Ebola, when interventions were brought in to try

to limit social interactions to stop the pathogen spreading, such as the closure of markets, that disproportionately affected women. Women were more likely to be working in those locations that were closed. And this wasn't just in the short term but in the long term it took longer for women to return to work after the epidemic event than men.

Q. Thank you. I think you refer also to the fact that women tend to work in face-to-face roles, which are often either typically the first to close or obviously proximity to potential infection, and that they, in addition to that, take on that caregiving role?

A. Absolutely, yes.

Q. Thank you.

Now, in terms of international recognition -- I'm going to turn to domestic in due course, but just very briefly with regard to international recognition -- you note the Global Preparedness Monitoring Board in 2019, so proximate to the pandemic, that recognised:

"... that care givers are women, and their engagement ensures that policies and interventions are accepted ... and it is important to ensure that the basic health needs of women and girls, including those for reproductive health, are met during an outbreak."

A. Absolutely, yes, and that was also mirrored in the

United Nations Security Council related to Ebola.

Q. Thank you.

Now, a key and critical question that might be asked by some or posed by some is that, with the exception of Hurricane Katrina in the United States, these are all less affluent countries in the global south. So, essentially, why are they relevant to the UK, a western and industrialised country?

A. Well, because the thing that we see across all these outbreaks, whether they be in Brazil or in Sierra Leone or in Yemen is the same trends. It's the same ways in which women are impacted by these crisis events. It's always about unpaid care, it's always economic impacts and women losing work or financial security. It's always challenging access to healthcare for women and particularly sexual productive health needs. So it's the same trends globally, so, we know the concern is: why would it be any different here in the UK?

Q. Thank you. And is that a view that you've heard expressed at all in the UK, or by government?

A. It was something I heard expressed early on in the course of 2020, yes, I heard comments around the differences here in the UK to that of Liberia, for example.

Q. In what context was that?

A. In a meeting with officials working in government.
Q. What area of government?
A. In Cabinet Office.
Q. In the Cabinet Office?
A. Yeah.
Q. What was the sentiment that was expressed?
A. The sentiment was it was London, it wasn't Liberia, and that there wouldn't be the same impacts here for women.
Q. Thank you.

I now want to turn, if I may, to a separate topic, which is that in relation to public funding cuts since 2010 that you raise in your report, and you explain in relation to that that significant cuts had been made to healthcare, by 2015 over a billion, 6.3 billion from social care, 13 billion from education, and indeed, by 2020, £37 billion had been cut from welfare payments.

Can you, in headline summary form, for us, please help the Inquiry with how that specifically, in your view, exacerbates gender inequality?

A. Sure. So the two headline messages from the austerity-related cuts in the UK for women are this. The first one being that women are more likely to use public services, they're more likely to need interaction, whether that's through benefit support, whether that's through healthcare services, whether

that's through a range of different ways that we see women engaging with these services, so they're more likely to be users, but we also know that women are disproportionate employed in the public sector as well, as healthcare workers in the education sector, for example.

Q. If I can ask you just to pause there for a moment. Thank you.

You say that women form the majority?

A. Majority of the workforce in the public sector. So women are both impacted by these cuts as users of services and as staff and employees within public services.
Q. I'm going to pick up on workforce in due course but it's effectively women form almost two-thirds of the public sector workforce. Just to follow on in terms of impact there, you relate to other characteristics as being important and that not all women are affected as a homogenous group. Can you just explain the importance of that in relation to public welfare cuts?
A. Absolutely. Well, we know that women are not a homogeneous group, we know that particular groups of women, whether they be particular ethnic groups, whether they be different socio-demographic groups, whether they be migrant groups, might be more likely to use these

services than others.
Q. Thank you.
A. Can I just say, my screen has gone blank.
Q. I don't believe we'll be needing it, Dr Wenham, so please don't worry. If we do, I'll pause for a moment so that can be rectified.

If I can focus in on one aspect of those public sector cuts, we've just dealt with, very briefly, women as part of the public sector workforce but also as users effectively of public services.

Benefits. I'm looking at financial autonomy and benefit cuts.

A. Yeah.
Q. You note within your report that in relation to Universal Credit caps that came into force, those apply predominantly to single parents, and 90% of those are women, is that right?
LADY HALLETT: Sorry, Ms Cecil, I think we are straying a bit here. I mean, the fact that there were inequalities and that many witnesses have attributed that to austerity is obviously relevant, but I think we are going perhaps into a little detail away from Module 2. Sorry.
MS CECIL: No, not at all, thank you.

I was going to move on in any event after this

question to gender inequality and health, if I may, and looking at gender and interactions with healthcare systems.

Now, you point out a number of structural differences in the way in which women interact with healthcare systems as opposed to men. Could you, again, just set those out, please, in summary form.

A. Sure. So to start with, women are more likely to use healthcare services in their lifetimes than men, mainly because of the need for maternity and/or sexual reproductive health services. But gender also determines and influences health knowledge and health behaviour and how you might listen to advice given, and also how you might access services and when you might access health services. And this then has a knock-on effect on outcomes, depending on when you might have a visit -- visit a practitioner or whether you might follow advice or not. But it's on the supply side as well: the gender of a patient might impact on how a medical professional interacts and gives guidance in a consultation. So --
Q. If I can pause you there just for a moment. Just to pick up on that final point, if I may, is it correct that women, and in particular black women, are less likely to have pain-related symptoms believed?

A. Absolutely, consistent evidence is showing that women, and particularly black women, are less likely to have pain-related symptoms believed.
Q. Thank you.
Turning now, if I may, to mental health and women, you say one in five women compared to one in eight men; why is that, in terms of suffering from mental health illnesses and conditions?
A. It's hard to say conclusively, I think there's a range of different factors, and there's also differences over age and differences over ethnicity which I think are important to point out.
So there is not one reason, but the trends are consistent that particularly younger women suffer from greater mental health issues than their male counterparts.
Q. I think immediately prior to the pandemic, young women's mental health, in terms of the impact upon them, was increasing at quite a great rate in comparison to boys; is that correct?
A. Yes, that's correct.
Q. I just wish to touch, if I may, very briefly on suicide. I am asked by one of the core participants to make it clear that certainly men, in general, have greater rates of suicide. Is that correct?

A. Yes, it's correct, and indeed the data from the Office of National Statistics show that men do have higher suicide rates than women. But I think it's also important to note that the data from 2021 show the largest increase in suicide in women under 24 on record.
Q. Thank you.
Then just turning to women and clinical research, the position pre-pandemic, you describe that there is a lack of research on how conditions affect women in comparison to men, that women are less likely to be enrolled in clinical trials, but often subject to the same clinical guidelines. Can you just elaborate on that, please.
A. Of course. Historically most clinical research and most health research has been done on men and therefore most of the information we have about how to treat people with different conditions is based on men, and evidence in men, and so we don't necessarily have the same data quality, standards and volume of evidence about how conditions manifest differently and how treatments might work differently in women.
Q. Thank you.
You describe the overall consequence of all of those factors within your report, and note that the UK has one of the largest female health gaps worldwide?

A. Yes.
Q. Just for clarity, that's referring to the difference between outcomes for men and women for the same conditions?
A. Yes, that's correct.
Q. Thank you.
You've touched upon this already, at the very outset of your evidence, in terms of women and their engagement with healthcare, reproductive services, antenatal services, maternity services, in relation to that. Just dealing with one aspect of that for a moment, are there differential outcomes in relation to race and maternity?
A. Yes, across the UK some research in 2018 and subsequently has shown that the maternal mortality rate is up to four times higher amongst black women than their white counterparts in the UK.
Q. And ancillary to that, the Care Quality Commission found that stillbirths predominantly occur in the most deprived areas?
A. Yes, that's correct.
Q. One aspect of maternal care relates to the charging regime for migrant women for hospital treatment during pregnancy and antenatal care, midwifery and obstetric care. What have you seen as the impacts of that charging regime?

A. The impact is that vulnerable pregnant women are maybe not seeking care or not seeking care following the NHS guidelines in the same way or the frequency of visits, because it has a deterrent effect, the charging regime.
Q. Thank you.
Dealing now and turning to unplanned and unwanted pregnancies, you explain that approximately half of pregnancies in the UK are unplanned and approximately half of those again result in abortion. Just dealing with the position across the nations, in relation to England and Wales, you describe that it's a combination of NHS and independent sector provision. What are the consequences for women of that in terms of access?
A. Well, we know that even in places where there is a legal provision of abortion there are a number of structural barriers, such as: how close they might be to you; if you're using an independent service, whether that costs; for example, whether you're able to take time off work or other childcare to access these services.
So, you know, even with legal provision, there are a number of barriers to accessing abortion for many women across this country.
Q. One of those issues is the inconsistent provision in geographic reasons, so necessitating travel?
A. Absolutely.

Q. Thank you.

That's different in Scotland, where abortion provision is by the NHS. Northern Ireland, is it correct that specific challenges still remain in terms of travel and geographic availability?

A. Absolutely. So although the repeal of criminalisation of abortion took place in 2019, there remain a significant number of physical and structural barriers for women being able to access that particularly in terms of geographical proximity to services.

Q. Thank you.

And you note key developments during the pandemic, which of course will no doubt be covered by a later module.

If I may turn now to the labour market, and of specific relevance to this module is women as healthcare workers. What proportion of healthcare workers are women?

A. So the data from England shows that 77% of those in the NHS workforce are women, and that's a similar number across the devolved administrations.

Q. Thank you.

To break further workforces down, in terms of health and social care, education and early years, that's predominantly, is that correct, staffed by women?

A. Absolutely, yes, those are all sectors predominantly staffed by women.

Q. Up to 96% in early years care, 75% in education, and 58% of social care?

A. Yes.

Q. You describe that as occupational segregation?

A. Yes.

Q. What do you mean by that?

A. There are differences in who works in different labour sectors and different industries across the UK and across the globe and we know that healthcare, health and social care, education and early years are predominantly staffed and worked in by women compared to men.

Q. Thank you.

You then, just if I may, look at industries and role types. Do you see any similar patterns there in terms of occupational segregation?

A. We know that women are more likely to be in the lower paid jobs and men are more likely to be in the higher paid and/or managerial positions within those industries as well.

Q. You point out engineering, finance, those sorts of occupations.

A. Yes.

Q. Then, in terms of roles, men typically occupying

director, managerial, senior roles within organisations?

A. **(Witness nods)**

Q. That leads me on, if I may, to the gender pay gap, very briefly. What is the gender pay gap?

A. So the gender pay gap is now a statutory requirement across the UK for companies to report the difference in average hourly wages between men and women.

Q. As at 2019, just to place this in context, the gap at that point was 17.3%, as a median figure; is that correct?

A. Between --

Q. In 2019. It's at paragraph 39 of your report, if that assists.

A. Well, 8.6% across all full-time workers and up to 17.9% when including part-time workforce.

Q. That's what I thought. You then talk about feminised sectors in relation to the pay gap and look at various professions. Can you just set out the differences there in relation to early years, doctors and clinical academics so that we get a broad picture?

A. Sure. So the feminised sectors such as early years care and a lot of healthcare activity is devalued in the labour market. That means that people are earning less in those industries than in other industries. So we know, for example, that, you know, there are much

lower wages amongst early years and nursing professions compared to hospital doctors or other clinical higher grades.

Q. To what extent can any of the pay gap be attributed to part-time work, and choice?

A. I think that's a really hard question because I think we have to look at the structural factors of why people are in part-time work, and it tends to be because of the burden of unpaid care within the households and childcare. And the lack of affordable childcare provision across this country is a key reason why people have to take part-time work. So it's unfair to say that women always have a choice to -- you know, want to work part-time compared to full-time. That completely misses the drivers of why people have to work and the need to be able to afford to live, to feed your children and the vast cost of childcare.

Q. Thank you.

That brings me in to the issue of childcare and other caring responsibilities, including unpaid work. You speak within your report at paragraph 44 of the "motherhood penalty", and I'm going to ask you just to explain what that is, because it has some impact in relation to unpaid work later.

A. Sure. So the motherhood penalty is the phenomenon which

exists whereby when a woman has a child and is out of the labour force for maternity leave, and then gets in, they're not necessarily at the same level, and the longer term implications of that, of having to, you know, leave on time to pick up a child, of having to, you know, take days off when your child is sick, for example, means that -- you know, data has shown that by the time a mother's first child is 12, her hourly rate of pay will be 33% that of a man at the same level of them. So they consistently don't get promoted and don't have the same earning potential once you have children.

Q. Thank you.

With regard to the role in terms of childcare and other caring responsibilities, how do we see that in terms of gender division?

A. So we know that across the UK, the burden of childcare -- you're talking about unpaid childcare?

Q. Yes?

A. Falls disproportionately on women.

Q. With regard to unpaid care falling disproportionately on women, does that just relate to their children or also relate to relatives, friends or other individuals?

A. Yes, we also know that women are more likely to be unpaid carers to those who have specific care needs,

whether that be elderly relatives, parents for example, and they're also more likely to be engaged in looking after neighbours, working in voluntary associations within communities to support people.

Q. Thank you.

I now wish to move, if I may, to another topic, and that is of domestic abuse and gender-based violence. Turning, if I may, to women's exposure to violence, can you just give a snapshot of what the picture was in 2019 in the UK?

A. Well, we know that domestic violence exists, we know that it had increased since the 2008 financial crisis because we know there's a connection between financial stability and violence, and, combined with austerity measures at the same time, put a downward pressure on households, and that in 2019 the Domestic Abuse Bill --

Q. Can I ask you to slow down a little, Dr Wenham.

A. Sure.

Q. Please continue.

A. Okay. The Domestic Abuse Bill came into law in 2021, having been agreed in 2019, to try to facilitate better prosecution of abusers, noting that it's estimated that about one in five adults in England and Wales will experience domestic abuse in their lifetime.

Q. Thank you. You talk about a downwards pressure, what do

you mean by that expression?

A. We know that there are various structural factors which affect the chances of domestic abuse occurring, such as financial insecurity, whether that be caused by losing your job or lack of access to public funds, for example, through austerity cuts, and that creates more tension within households, which then can turn into violence.

Q. Thank you.

With regard to the third sector, and funding for women's shelters and other programmes to support victims of crime, what state was that sector in in 2019, how would you describe it?

A. Well, it had also been impacted by the cuts to public sector spending, and we'd seen significant changes both at the local authority level and through grants available to independent and non-governmental actors in this space, so there was less provision and less finance provision for support.

Q. Thank you.

Turning to sexual violence, at paragraph 53 you explain that there were over 55,000 reports of rape in 2019, immediately prior to the pandemic, and that Rape Crisis England had a wait list of over 6,000 at the time, in terms of support to be provided. I just want to touch on the position in the devolved nations. In

Northern Ireland you say there was no specialist rape crisis support, only a counselling charity; is that correct?

A. As I understand it, yes.

Q. Thank you.

You will be asked questions in due course in relation to migrant and refugee women and domestic abuse, and so as a consequence of that, I'd like to turn, if I may, to missed opportunities, and those that you see as the most significant going into the pandemic.

A. Absolutely.

So I think, referring to one of the first things we talked about earlier, which is that -- the impact that epidemic events can have on how women interact with maternity provision, for example, the evidence from Ebola shows that moving antenatal care and maternity services out of hospitals increased women's utilisation of those services. So women not feeling scared that they're going to contract a virus when they go into hospital for a completely different reason meant that they felt more likely they were going to, you know, get better care and more likely to use that service.

So that could have been something we could have looked at across the UK, moving maternity services.

Q. Just to pause you there just for a moment. So maternity

services and antenatal provision.
A. Yeah.
Q. Turning to the next aspect --
A. Sure.
Q. -- does that relate to health and social care workers?
A. Absolutely.

So, we know that the majority of the healthcare and social care workforce are women, and therefore efforts could have been made to mitigate the impacts for those women, particularly when we know that women disproportionately suffer from mental health issues, particularly younger women in the healthcare workforce, those who are on lower pay and lower role jobs.

Efforts could have been made to try and mitigate those impacts, but also, knowing that the workforce is predominantly women, PPE could have been procured to better fit women's bodies rather than generic male size PPE being ordered.

Q. Thank you.

Then if I may just pull together two aspects: in relation to unpaid care, obviously you say that aspect ought to be something that should be accommodated and considered in decision-making?
A. Absolutely. So if you know that women are the people who are going to do the childcare, if you are going to

close schools, and that that would have an impact on women's paid employment, then mechanisms could have been put in place so that those women didn't have to leave their jobs, reduce their hours, and security could have been given to those women who were performing both paid and unpaid care at the same time that they had financial security to do so.
Q. Thank you.

Other aspects in your report speak about feminised labour forces -- we're not going to deal with that in any greater detail now -- and you've made comments already and observations in relation to domestic abuse, so I don't consider that we need to go into that further.

In relation to moving forwards and general recommendations, with regard to gender and sex being taken into account, do you have any specific recommendation there?
A. I do. The first -- mainly being that, you know, we don't know to what extent equality impact assessments were undertaken, they weren't made public in the initial months of the pandemic, or gender advisory and how this was considered and whether government considered the downstream secondary effects of the policies they were bringing in and how they might affect different sectors

of society, and women differently to that of men, and what could have been -- how these could have looked different, had the question been asked: how will this affect women? How will this affect a particular social group?
MS CECIL: Thank you, so looking at gender as part and parcel of decision-making and of course, as I said at the outset, your report really deals with the pre-pandemic looking forward position -- or looking backwards, rather, position and then looking at potential missed opportunities.

Chair, you've granted permission for a number of Rule 10 questions to be asked by Ms Davies on behalf of Solace Women's Aid and Southall Black Sisters.
LADY HALLETT: Thank you very much.

Yes, Ms Davies.

Questions from MS DAVIES KC

MS DAVIES: Thank you, my Lady.

Dr Wenham, I represent, as you've just heard, Solace Women's Aid and Southall Black Sisters, and I have permission to ask you questions on three topics, and they will be brief.

So the first topic relates to the point that you make in paragraph 48 -- and indeed Ms Cecil asked you about earlier -- poverty puts downwards pressure on the

poorest people, exacerbating unequal power relations between highly stressed men and women, violent crime has increased since the 2008 financial crisis and this, combined with austerity measures, manifested itself in an increase in domestic violence.

That's pre-pandemic. Looking at pandemic and specifically lockdown, rather than the health side of the pandemic, can you comment on whether the pressures of lockdown could produce a similar pressure on those locked down, thus exacerbating the possibility of an increase in domestic abuse?
A. Yes, absolutely, this is what we've seen in previous epidemics that, you know, these effects, lockdown, being put under some sort of restriction of mobility, has that effect and has in previous epidemics as well.
Q. That's restriction on mobility being in the same house together?
A. Yes.
Q. What about the point that you directly make in the paragraph, the financial costs of lockdown and indeed anticipated financial costs and worries about future finances, loss of employment, what's going to happen to welfare benefits and so forth; can that produce a similar pressure exacerbating the possibility of domestic abuse?

A. Yes, I would believe so.
Q. Yes. And in the specific sector of those working in healthcare and in social care, they were under a great deal of very specific pressure in lockdown. Again, would that pressure on those workers increase the possibility of domestic abuse?
A. I would imagine so, yes.
Q. Thank you.
The second topic is about migrant women, and it's paragraph 51 of your report, and you talk about asylum-seeking women, migrant women and refugee women, and I just want to break those three statuses down, because they have slightly different eligibility for welfare benefits, so that we're clear.
So the first status is asylum-seeking women, and all asylum seekers -- men or women -- don't have access to mainstream public funds, welfare benefits and so forth; they have a specific arm of the welfare state which is accommodation and support provided by the Home Office, it tends to be referred to as NASS accommodation.
So that's one status, and you say in relation to asylum-seeking women that they're particularly vulnerable to violence and abuse due to their precarity, so that's waiting on the decision on their asylum application. Then you also say many of these women had

already been subjected to violence prior to coming to the UK, so that's again likely to be asylum-seeking women?
A. Yes.
Q. Then refugee women. They were asylum-seeking women, their claim for asylum has been successful and they are given various forms of leave to remain, sometimes indefinite, sometimes finite, but it is a more stable immigration position, and they do have access to mainstream welfare benefits, the right to work and so forth, as any British citizen does.
So although they, like any woman, might be subject to domestic abuse, there isn't an additional aspect of precarity hanging over them?
A. Well --
Q. Those who have refugee status and the right to live in the UK.
A. So I am not able to comment on that --
Q. That's perfectly all right, yes.
A. -- but I think it's fair to say that we know that risk of domestic abuse is intersectional and there are varying different vulnerabilities that women face. Asylum seekers, migrant status might be one of a multiple variety of different risk factors that any particular woman might face.

Q. Moving on to the third group of migrant women that you talk about in this paragraph, and those are women who are here and they have leave to remain but their leave to remain is subject to a "no recourse to public funds" condition, and that means that they cannot claim welfare benefits and are therefore financially dependent on their sponsor, who sponsored their leave to remain.
Are those the women that you are talking about when you say, "Perpetrators use women's precarious immigration status, poor access to alternative housing", and then just in the preceding sentence, "risk of destitution to threaten them"?
A. Well, yes. I mean, the research shows that those women with no access to -- with no recourse to public funds have fear around accessing support services, therefore they are more vulnerable to the impacts of domestic violence.
Q. So the fear is a fear of being reported to the Home Office and therefore their leave being cancelled, a fear about that?
A. I would imagine, I'm --
Q. You don't know.
A. I don't know.
Q. That's fine. And a fear that, because they have no recourse to public funds, if they leave their abuser, if

their abuser is also their sponsor, that they will be destitute. That's where you say "risk of destitution", that's their fear. And so that is both the real thing that they worry about and also something that a perpetrator of abuse can threaten them with; yes?
A. I would imagine so, yes.
Q. So that puts them in an even more vulnerable position than women who are British citizens who are subject to domestic abuse, because they have that additional fear and threat hanging over them?
A. I would imagine so, yes, but I don't think I'm the right person to comment on that particular detail. But I would say that there are multiple different layers of risk, both of domestic violence and how -- what you would do in that situation and where you would turn for help, if indeed you feel you can turn for help.
Q. Thank you.
Then the third and final topic, which you deal with at paragraph 47, and Ms Cecil asked you a bit about:
"At the same time that domestic violence has increased ..."
And you're talking pre-pandemic, you're talking in the years since the financial crash in 2008. You say:
"... funding for women's shelters and other programmes to support victims have been cut which, along

with differences in commissioning practices in local councils, has created a geographic lottery for women survivors of domestic abuse."

So you make the point that, on one hand, in the years leading up to the pandemic, domestic abuse had increased and, on the other hand, funding to support the resources had decreased.

So given that that was the state of the violence against women and girls sector on the eve of the pandemic, and given that they then saw an escalation in domestic abuse and an increase in demand for their services, are you able to comment on how that left the violence against women and girls sector in an attempt to meet that demand for their services?

A. I imagine your next speaker is better qualified to answer that, but my assessment would be that, you know, they would be struggling to manage the demand that they are given.

MS DAVIES: Thank you very much, Dr Wenham.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Davies.

MS CECIL: Thank you, my Lady. Do you have any questions?

LADY HALLETT: No, I don't.

Thank you very much, Dr Wenham.

THE WITNESS: You're very welcome.

LADY HALLETT: Thank you for all your help.

(The witness withdrew)

MS CECIL: My Lady, I understand that the plan now is to have a very short five-minute break.

LADY HALLETT: I'm not even sure, do we need a five-minute break?

MS CECIL: It's perhaps a matter for -- yes.

LADY HALLETT: Is that a yes?

MS CECIL: Yes.

LADY HALLETT: Five-minute break.

(2.32 pm)

(A short break)

(2.38 pm)

LADY HALLETT: Ms Cecil.

MS CECIL: Indeed. My Lady, may I call Ms Goshawk, please.

MS REBECCA GOSHAWK (affirmed)

Questions from COUNSEL TO THE INQUIRY

MS CECIL: Thank you, Ms Goshawk. If you could state your name, please.

A. Sure. Rebecca Jane Goshawk.

Q. As you will be aware, there's a stenographer taking a note and so, as a consequence, I'm going to ask you to go at a slow pace. And it's my fault if you don't, not yours, so it may be that I ask you to slow down or pause at various points.

Ms Goshawk, you have provided a statement to the Inquiry; is that correct?

A. Yes.

Q. Just to, for the assistance of others, if I can, it can be found at INQ000280726. Thank you. That statement is dated 20 September of 2023; is that right?

A. Yes.

Q. You explain within that statement that at the very end, at page 63, you provide a declaration and statement of truth; is that correct?

A. Yes.

Q. Thank you.

Ms Goshawk, is it correct that you are the head of public affairs and partnerships at Solace Women's Aid?

A. Yes.

Q. I'm going to ask you now, if I may, some questions about Solace Women's Aid.

Can you provide a brief overview of the organisation for us?

A. Yes, we are a violence against women and girls charity, we have been established for over 48 years, and in 2020/21 we supported just under 11,000 women and children.

Q. Thank you.

Solace provides, it's fair to say, a broad and

impressive array of services in relation to gender-based violence, and reflective perhaps of many in your sector, but in terms of those services you provide refuges?

A. Yes.

Q. Therapeutic services, community-based interventions and programmes?

A. Yes.

Q. Advice lines, and other aspects including training?

A. Yes, we do.

Q. Indeed, you've referred to a snapshot of your work in 2020 providing that support to nearly 11,000 survivors of domestic abuse, and in 2020 you accommodated 920 women and children in refuges; is that right?

A. We did.

Q. Thank you.

If I can turn, then, to the pre-pandemic position and the sector, the violence against women and girls sector, going into the pandemic, you describe that sector -- at paragraph 25 -- as being woefully underfunded and struggling.

What was the impact of that position in terms of the services that you could provide at that time, and how you could serve that client base of women and children?

A. Yes. So, as mentioned, there had been a reduction of funding whilst also seeing an increase in demand for our

services. This meant that we were often having to turn away women from refuge or we were having more enquiries for refuge spaces than we would have places.

Our community services were often having to work with significant caseloads, higher than we would want to and, yeah, we'd often have waiting lists for things like counselling and therapeutic services.

Q. Thank you.

If I may just ask a specific question in relation to the black and minoritised refuge sector, were they in a similar position or were they facing additional struggles?

A. Generally black and minoritised by and for organisations actually had seen a further increase -- a decrease in funding, so that had affected them more. For example, there tended to be around 50% less specialist refuge spaces since 2010.

Q. If we can just get a sense of what that means in real terms with regard to women and children facing gender-based violence, and you set it out very helpfully at paragraph 31 of your report, and you explain that in 2019, in a research report involving 100 women, 30% of women had been turned away six times or more, from local authority services, that were coming to you; is that correct?

A. Yes, that's when they are trying to get temporary accommodation or emergency accommodation when fleeing abuse, yeah, they were facing significant challenges with local authorities in providing that accommodation that they were entitled to.

Q. Thank you.

I now want to turn, if I may, to the impact of the pandemic as experienced by Solace.

Firstly, was there an increase in domestic abuse during the pandemic?

A. From our advice line, we would say so, yes. We saw significant increases in the number of calls that we were getting. I think in March 2020 there was a 117% increase in the number of calls we were getting. We saw that quieten down a little bit when the lockdown actually went into -- actually started. Our staff called that quite eerie, that women weren't able to contact us.

Q. I'm just going to ask you just to pause there for one moment, and just pick up on the interactions with Solace and the advice line and the patterns that you saw. You just explained that in March 2020 you saw a 117% increase. Is that coinciding, essentially, with the decision to lock down, the announcement to lock down?

A. So I think some of that came before as well, because

women were fearful that a lockdown would happen. I think when they saw what was happening in other countries, many women thought "I need to get out, I cannot spend that period, if the UK goes into lockdown, in this relationship, in this house", essentially, and in danger for them and their children. So I think that led to an uptick actually before announcements were made.

Q. And then you describe a subsequent period where calls dropped and decreased, and eerily quiet. When was that?

A. That was late March and early April, is my understanding.

Q. Then in April you describe within your statement a second increase, in April to May, and what did you connect that to?

A. I think that was when for some women it was because it became too much living in that household, living in danger for them and their children. For others I think it was when there was starting to be an understanding that we may leave lockdown and people were getting that chance, that opportunity to get in contact with services.

LADY HALLETT: Can I just go back for a second.

You said that there had been an increase in calls before lockdown, then during lockdown what you called

the eerie -- and I can see why you say that -- reduction in calls.

Was that a reduction from the increase or was that a reduction on what you would normally see?

A. From the increase in March. I think there was generally higher levels during that time, but I think it was noticeable that we'd gone up in March and then sort of back down again, but that is in comparison to March 2020, rather than the year before.

LADY HALLETT: Sorry to interrupt, Ms Cecil.

MS CECIL: No, not at all. Not at all.

Sorry, I believe that we were then looking at the April to May period, and I just want to take a specific example that you refer to within your statement, and you describe the announcement effectively of lockdown ending and a "stay alert" announcement in terms of public messaging being made on 10 May, and in the following week you received triple the number of calls?

A. Yeah, that's my understanding from the staff at the time, yes.

Q. Just continuing through with that pattern then, they then drop over those summer months; is that right?

A. There is a reduction from that period in May, yes. It does kind of settle, I suppose, but yes, we still got a high level of number of calls during that summer.

Q. In terms of that demand throughout that period, was that a demand that you were able to meet at Solace in terms of answering those calls?
A. I think we didn't answer every call that we got. We -- I know a lot of our staff worked incredibly hard to answer as many of them as possible, people were doing long hours, were overstretched, and I know that was something across the sector. So it was, perhaps, we were not meeting them all, but the ones we were meeting were due to the dedication of staff at that time.
Q. Then August/September, effectively the time when children were going back to school, did you see any increase in those calls at that point?
A. Yeah, September was the highest month we saw.
Q. In your view, in Solace's view, why was that?
A. Our impression was that it was women were getting the chance to call us, that's perhaps when the children were returning to school. Sometimes the school run is an opportunity to leave the house.
Q. Thank you. So essentially the opportunity to leave the house to take the children to and from school and that was, in your view, what was driving that increase in calls?
A. I think as well time, perhaps where children weren't there, to make that call.

Q. Was that a pattern, generally speaking, that was replicated across the sector, to your knowledge?
A. I think my knowledge and from what other organisations have shared with us, I think from April there was significant increase in the demand for services, whether that at the national helpline level or we saw a particular increase of calls and requests for support from black and minoritised organisations.
Q. You do refer in your statement to the national domestic abuse helpline and seeing a 65% increase in April and June compared to January and March of 2020; is that right?
A. Yes.
Q. Similarly from Victim Support, in May 2020 they were seeing reported rapes as being 23% higher than that in early of 2020?
A. Yes.
Q. Thank you.
Just looking at one other aspect in relation to those calls, at paragraph 208 of your statement you note conversely, is it correct, that calls to police decreased, was your understanding?
A. That's the understanding from, yeah, police evidence.
Q. I just want to ask you, if I may, about the refuge spaces that you had available and the demand for those

spaces. So at paragraph 48 you describe that before lockdown you had two referrals for every single space.
A. Yes.
Q. And what was the impact on that demand during the pandemic, did it increase or decrease?
A. So we saw that for every space we had, we'd have four referrals, and actually in April 2020 all 23 of our refuges were full at one point.
Q. And you explain in paragraph 49 of your report that Solace then opened a 70-bed emergency accommodation project on 12 May of 2020. Was that in consequence of that uptick in terms of demand?
A. Yes, we were seeing that there were so few options for women to go to when they were seeking to flee, and I think it's quite important to say that it took less than a month for that 70-bed accommodation project to be filled and, of the spaces for women with no recourse to public funds, the 20 spaces we had, they filled up within a week.
Q. Thank you.
By the end of 2020 -- so looking then at the position moving on from April when you opened the emergency bed space, and looking at December of 2020 -- you note that you were turning away approximately 40% of refuge referrals; is that right?

A. Yes.
Q. Is it correct that, looking at refuge spaces and beds that were available, that picture was further complicated by the inability within the sector to then move individuals out of that emergency accommodation and into other more long-term accommodation?
A. Yes, we saw real challenges either moving people from the, I suppose, the house that they were in danger from or from a refuge to temporary accommodation or more permanent move-on options. That was due to the lack of -- the inability to contact many local authorities to organise that housing for them, even when they had an advocate.
Q. Thank you. If I can just ask you to slow down a little.
A. Sorry.
Q. Not at all.
Just turning to other facets of support available to individuals and women and children facing violence and abuse, there was obviously a move within the pandemic to less face-to-face contact and a move to online services and telephone services.
Did you see any impact of that with your client base in terms of the support they could seek?
A. Definitely. For example, housing often was requested face-to-face. That could have been going to a council

office to represent as homeless to get that support, it could have been a GP that identified abuse or that someone disclosed to. A significant number of women disclose in healthcare settings.

Q. Thank you.

Touching, then, on the role of schools and early years provision in relation to identification, safeguarding and signposting, to your knowledge was there any advice provided to those organisations and institutions with regard to children facing risks of domestic violence?

A. There was a category of vulnerable children and being able to access schooling, but our understanding, it wasn't hugely clear on whether that was specifically for children that had been experiencing domestic abuse or in a domestic abuse household.

Q. Thank you. So, absent the criteria for vulnerable children, were there any other measures that you were aware of put in place?

A. In schools specifically?

Q. In schools and early learning establishments.

A. Not that I'm aware of, no.

Q. Turning to the type and nature of the cases that you've seen at Solace, was there any change in the complexity of those cases in terms of their presentation?

A. We definitely saw that women were coming to us with that one chance, I think, to leave, in real emergency states. We also saw that women came with higher mental health needs, that could be self-harming or suicidal ideation.

Q. And that really follows into the next question in terms of intensity and frequency of domestic abuse: did you see any emerging patterns during the pandemic that were different to the pre-pandemic position?

A. We definitely saw that the intensity of abuse that women had been through during the lockdown had increased. Women described the environment as a pressure cooker in some cases.

Q. At paragraph 208 you note there has also been an increase in domestic homicides during the pandemic; is that right?

A. Yes. Home Office did research into that, and I think in that early window there was research to show that there had been five -- I think five domestic homicides per week compared to two in normal times.

Q. That's at the early stages of the pandemic?

A. Yes, in those first few weeks.

Q. Thank you.

Now, looking back, from your perspective and that obviously of Solace, was the rise that you're reporting in domestic abuse foreseeable?

A. Yes. I think the conditions of lockdown were conducive to an increase in abusive behaviour, any time -- domestic abuse is around power and control, and lockdown was a control measure, and that meant both from the pandemic but also a control measure that perpetrators could use against women to restrict their movement or to control them.

Q. The NPIs that were put in place -- lockdowns, school closures, staying at home, working from home -- how do you see that as having a role?

A. So I think working from home meant the perpetrator and the victim were there more often. I think the tensions that that could have created at a time of high stress for everyone, I think, is likely to again breed those conditions for sort of control and stress that are related to domestic abuse.

Q. And what challenges, practical challenges, were you seeing in women and children or others facing abuse of process in seeking and obtaining help in practical terms?

A. I mean, some of it was just that -- I think as I talked about, the window of opportunity to call a service like ours. So when were they alone and when were they safe enough to be able to call? Did they understand that they could call us, that services like ours exist? And

actually were they able to leave their house, was that something they could do under lockdown restrictions?

Q. Just looking at one facet of assistance that individuals can turn to is the police. You identify trust in police as being an issue. Why do you identify that as being an issue?

A. I think many women have experience of being let down by the police or disbelieved by the police. It's not a universal experience but, yeah, many women have had their experience of abuse belittled or undermined or not really believed, and that's particularly prevalent for black and minoritised women.

Q. Indeed, within your statement you set out a number of individual experiences. If I can please ask that paragraph 71 be brought up on the screen for a moment. I'm not going to go into --

LADY HALLETT: I'm afraid, Ms Cecil, I'm trying to avoid individual experiences, given we've got to focus on the module's main issues. So I think --

MS CECIL: No, I appreciate that, my Lady.

LADY HALLETT: Also, this is the police, this isn't government. I think I would find it helpful to know what steps the sector took to bring the problems you were facing and your -- do you call them clients?

A. Service users.

LADY HALLETT: Service users. Oh, I don't like "service users". Can I --
A. Victims or survivors as well.
LADY HALLETT: Okay. The problems that they were facing, what steps did the sector take to bring this to the attention of the government?
A. Yeah, I can absolutely cover that.

So we took a number of steps to write to government to alert them to some of the challenges. There was a quite broad sector letter sent to the Prime Minister and a number of the key Cabinet positions on 3 April which outlined for us what were four key priorities for protecting victims of domestic abuse.

We were in the media talking about the challenges that we saw. I know other groups were talking directly to government when they could and to the -- at that time -- designate domestic abuse commissioner.

We also, at Solace and along with Southall Black Sisters, submitted a pre-action protocol letter to outline a need for a significant investment in safe accommodation.

LADY HALLETT: Did you detect any movement as a result of your representations?
A. We did see some, yes. I think those early representations meant that we saw public statements

about the ability to leave and domestic abuse being an exemption from that --
LADY HALLETT: They changed, didn't they, I think?
A. They did. I know the first announcement did not have any mention of domestic abuse, and actually no announcement of a lockdown had a mention of domestic abuse until January 2021, which is a real concern that those large platforms that many of us were watching didn't reference the exemption. It was sort of hidden in guidance and regulations, which was a real concern to us.
MS CECIL: Perhaps, my Lady, if I pick up on public messaging at this point.
LADY HALLETT: Yes, do, please. I'm so sorry to have taken over.
MS CECIL: No, no, not at all, please feel free.

Public messaging, then, just picking up on the matters that you've identified in terms of the Prime Minister's speech with respect to lockdown, there being no mention of an exception.

There was, subsequently to that, an article in the Daily Mail by the Home Secretary on 28 March of 2020. Is that a source of messaging that the women you see facing domestic abuse and gender-based violence were likely to see or access? How effective was that

messaging?
A. It was one, we would have seen it as a positive development, but that message was coming directly from the Home Secretary and from government, it's certainly not enough to ensure that all the women at risk were aware that there was an exemption.
Q. And the government did institute a "You Are Not Alone" campaign from 11 April. What are your views on that?
A. We were pleased when the campaign was launched. Again, I think it was a positive step, but we saw on our own advice line that that wasn't cutting through to all woman who needed our support. We were getting women saying they didn't know they could leave, when they called us, and we actually had that across all three lockdowns.

So the messaging certainly didn't get through to all women. I think that was the same experience for the national helpline as well. We felt that that messaging was too late. It could have been pre-empted.

From the messages from the sector and from international comparisons, and our understanding of pandemics and emergencies more generally, that this was a message that needed to be there from the beginning.

I also think an online campaign is one tool to reach people, but there are many people where a campaign like

that will not be effective, whether that's those with communication barriers, for example, so ...
Q. You pick up on that within your statement. I don't intend to take you through it in detail, but the communication, language barriers and accessibility barriers in short?
A. Yes.
Q. Thank you.

Turning now to the particular position of migrant women and children, because that is an area that both Solace, and indeed Southall Black Sisters, and you've dealt with in partnership during the pandemic, you describe those individuals as facing -- at paragraphs 184 to 187 -- a triple threat.

What do you mean by that?
A. So we talked about the pandemic as being sort of a dual pandemic, that is the restrictions, the risk of -- to health that the Covid-19 brought to women, the threat of violence and abuse that they would experience in their own home, and then I think for migrant women we saw that threat of immigration enforcement and destitution.
Q. Picking up on the theme and the questions you've just been asked, what did you, as an organisation, do in respect to that?
A. So this was highlighted to government on 31 March 2020,

a campaign, "Step Up Migrant Women" campaign raised this with government, that they were really concerned about the ability of migrant victims to get help during this period. That was repeated to the Prime Minister and Cabinet ministers in that letter on 3 April that I mentioned. Yeah, and I know that in conversations with the Home Office and other departments it was brought up regularly, that this group were being left without an ability to get support.

Q. Thank you. And you describe specific lobbying, at paragraph 36 of your statement, in relation to what is now the Domestic Abuse Act.

A. Yes.

Q. And the exclusion, the refusal of the government to extend measures to migrant women with insecure status and women with no recourse to public funds.

What could the government have done, in your view?

A. So firstly there could have been a suspension or a cancelling of the "no recourse to public funds condition", which would have been a broad step they could have taken, but there are also specific provisions for migrant victims of domestic abuse -- the DDVC, as it's often referred to -- and that could have been extended to those that had non-spousal visas, because at the moment only certain types of visas could access that

concession. That could have been lengthened to give more time to do so.

Yeah, it's just --

Q. Not at all. And on the other side of the coin, obviously, aspects of the Domestic Abuse Act were very much welcomed by the sector; is that fair?

A. Yes, it definitely had a positive element, but I think it was clear and made clear to government that migrant victims were being left out of support in that Bill.

Q. Thank you.

In your view, were women and children facing domestic abuse adequately considered by the government with regard to its Covid-19 response?

A. Our view is that they were not considered and, when they were, it was too little and a bit too late for women and children.

Q. And specifically where do you see those failings?

A. So we are not aware of domestic abuse and wider violence against women and girls being considered in the emergency preparedness that government undertook before the pandemic.

It appears that they were slow or -- to react or ignore from international experience of the increase in domestic abuse, or some of the understanding and experience we had from other international emergencies

that was referred to by the previous witness.

There was a lack of consultation with the sector, and when we were consulted it was quite late, and small groups. It didn't look at the impact on marginalised women, so that's black and minoritised women, older women, older women, disabled women.

Q. We've already touched upon your views on messaging, so I don't propose to go back over those, and also the structural barriers, in short, in relation to children and women facing violence or domestic abuse.

You set out a number of other key issues for you within the statement and, as I say, we've got the statement so I don't propose to go through those, we've touched on aspects of those briefly already.

Were there ever also any examples of good practice that you can point to?

A. Yes. I think we worked with the Mayor of London to set up the emergency accommodation project that I referred to earlier, that was done and was launched by 12 May to give 70 further bed spaces.

There was some funding from government, and that was positive. We certainly don't -- that was hugely important for the sector, we just didn't think it met the demand that was there.

We -- there were schemes like Rail to Refuge which

gave women the ability to get to refuges through free transport.

So there certainly were positive things, but I think with the messaging it was some steps were taken, it was not enough and it didn't think about marginalised women and their impact to understand their ability to leave. And I think there's a concern that as well where funding was given, yeah, it didn't meet demand.

Q. Indeed, when it comes to recommendations for the future, from the perspective of Solace, you've set those out in detail from paragraphs 212 of your statement onwards, and funding is indeed one of those aspects where you describe underfunding of the sector, and you've provided some evidence of that today, and there's more evidence within your statement in relation to where you were or were not able to meet need.

With regard to any other recommendations, are there any specific ones that you'd seek to bring to the Inquiry's attention for the assistance of the Inquiry?

A. Yeah, I think --

LADY HALLETT: Remembering that this is about the pandemic, rather than --

MS CECIL: Exactly. Yes, not general.

LADY HALLETT: -- my being able to change society, which sadly I can't.

A. Yes, I mean, I think of course we want to see prevention of violence against women and girls, but for the Inquiry I think early consultation and emergency preparedness that looks at violence against women and girls, and domestic abuse specifically, and how the measures they may have to take in those moments may impact women and children who are at risk.

Adequate funding during emergency times, having a sector that is adequately funded more generally to -- so we can weather such emergencies, particularly that provision of safe accommodation and refuges during emergencies, akin to something like the "Everyone In" scheme that we saw for rough sleeping, and that other countries took a more kind of -- yeah, took an approach like that for domestic abuse victims.

Clear and consistent messaging, I think I've sort of made the point on that.

The suspension of "no recourse to public funds", and the broadening of the DDVC, I think as we talked about, for migrant women.

And I suppose the final one is key worker status for domestic abuse workers who were often putting their own health at risk to support survivors and, you know, worked incredibly hard during that period but often were not included for PPE, testing or early vaccination.

MS CECIL: Thank you very much.

My Lady, those are all the questions that I have. There are no Rule 10 requests that have been granted, or indeed made. Does your Ladyship have any questions?

LADY HALLETT: No, I think I've probably intervened too much already.

Thank you very much indeed for your help. If only I could say you'd be out of business but, I'm afraid, never.

THE WITNESS: Unfortunately not.

LADY HALLETT: Anyway, thank you very much indeed.

THE WITNESS: Thank you.

(The witness withdrew)

MS CECIL: My Lady, that concludes the evidence for today.

LADY HALLETT: Thank you, Ms Cecil.

We shall start again at 10.30 on Monday. I hope you all get a decent weekend. Thank you.

(3.08 pm)

(The hearing adjourned until 10 am on Monday, 9 October 2023)

INDEX