

Friday, 6 October 2023

1  
2 (10.00 am)  
3 **MR KEATING:** Good morning, my Lady.  
4 **LADY HALLETT:** Good morning, Mr Keating.  
5 **MR KEATING:** Could I call Professor Taylor-Robinson, please.  
6 **PROFESSOR DAVID TAYLOR-ROBINSON (affirmed)**  
7 **Questions from COUNSEL TO THE INQUIRY**  
8 **MR KEATING:** Thank you. Do sit down.  
9 Could you give the Tribunal your full name, please.  
10 Thank you.  
11 **A.** Professor David Carlton Taylor-Robinson.  
12 **Q.** Professor, thank you so much for attending today and  
13 assisting the Inquiry.  
14 Just a few preliminary matters. Firstly, keep your  
15 voice up. It's important that the stenographer, who is  
16 just to my left, hears what you say. If a question is  
17 unclear, please do say and I'll just rephrase it.  
18 You've produced a report to assist the Inquiry,  
19 a child inequalities report, dated 21 September of this  
20 year, and that's at INQ000280060. And we see that  
21 there. And at the bottom of that page you have signed  
22 a declaration setting out your compliance with your duty  
23 as an expert.  
24 **A.** Yes.  
25 **Q.** Is that correct?

1

1 the question, "Why are health inequalities impacting  
2 children important?" We see at the top of that page.  
3 Perhaps can I invite you to provide an answer to that  
4 question by way of overview.  
5 **A.** Yes. Yes, thank you. I mean, I work in Liverpool in  
6 child public health, in a city that's at the sharp end  
7 of health inequalities, and if you take the life  
8 expectancy of a child born in Kensington round the  
9 corner from where I work, Kensington here, there is  
10 a gap of ten years in terms of life expectancy, 20 years  
11 in terms of healthy life expectancy for children.  
12 Those are social inequalities in health, and we can  
13 say a number of things about those differences. They're  
14 profoundly unfair, there's nothing natural about them,  
15 they're a consequence of how we organise society, and we  
16 can do something about them. We can do something about  
17 them through the organised efforts of society.  
18 And inequalities that affect children are  
19 particularly important, because we know that early  
20 childhood inequalities track through and layer on top of  
21 one another over the course of children's lives to  
22 generate inequalities in adult health. So lots of the  
23 problems we face in society around pressures on systems,  
24 health services, et cetera, have their origins in  
25 inequalities in children's health. So that's the life

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1 **A.** That's correct.  
2 **Q.** We see at the top your professional background and  
3 expertise, and perhaps you'll forgive me for just  
4 dealing with it briefly. You are a professor of public  
5 health and policy at the University of Liverpool, you  
6 also are a professor of child health at the Copenhagen  
7 University?  
8 **A.** Yes, yeah.  
9 **Q.** And you're an honorary consultant in public health at  
10 Alder Hey Children's Hospital?  
11 **A.** Yeah.  
12 **Q.** You have done significant work in the field of research  
13 into child inequalities and their impacts during  
14 the pandemic?  
15 **A.** That's correct.  
16 **Q.** If we could just turn to page 2 of your report, we see  
17 the contents. It's an extensive report, which we're  
18 very grateful for, nine areas you consider in relation  
19 to child health inequalities, focusing on the period  
20 leading up to the pandemic in 2020, and they range from  
21 poverty, mental health, and educational attainment.  
22 I'm not going to cover them all. We have your  
23 written evidence. But I want to draw out some of those  
24 in the hearing today.  
25 If we turn over to page 3, please, you pose

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1 course perspective on health. If we want to address  
2 inequalities in adult health, we need to address early  
3 gaps in health affecting children.  
4 **Q.** That's something that runs through your report, that  
5 there is that linkage between childhood inequality which  
6 follows it through into adulthood?  
7 **A.** Absolutely, if you don't get things right in childhood,  
8 it's very problematic in adulthood. But inequalities  
9 affecting children are a moral imperative in of  
10 themselves. It's unfair that children across different  
11 parts of the country have a different risk of dying in  
12 childhood, of developing asthma, of having poor  
13 educational outcomes, et cetera, as outlined in the  
14 report.  
15 **Q.** You mentioned the role of socio-economic circumstances  
16 in child health. Again, just a short overview about  
17 the relevance of socio-economic circumstances and how  
18 that impacts child health?  
19 **A.** I guess my expertise is in the impact of socio-economic  
20 conditions on children's health, and we measure those in  
21 a number of ways. We often look at family income, we  
22 look at parental education or occupation, so it's about  
23 the circumstances of families into which children are  
24 born, and then you can look at how those kids grow and  
25 develop on the basis of those circumstances.

4

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

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

8 "Child poverty is a disaster for child health."

9 Why is that?

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

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

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

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

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

23 **A.** That's correct.

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

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

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

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

16 **A.** Yeah, that's correct.

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

19 **A.** Yeah.

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

23 **A.** That's correct.

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

25 "Rising relative poverty rates, and high absolute

6

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

7 **A.** That's right, yeah.

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

13 **A.** That's correct.

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

17 **A.** Yeah.

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

22 **A.** Yes, indeed.

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

25 **A.** Yeah, that's correct.

8

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

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

11

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

10

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

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1 pandemic.

2 **A.** That's correct.

3 **Q.** I want to turn to child and adolescent mental health,  
4 and that's found at your report at page 22,  
5 paragraph 58.

6 What was the position in relation to child mental  
7 health prior to the pandemic, in the lead-up to the  
8 pandemic?

9 **A.** The best data we have is from the NHS Digital survey in  
10 England, which clearly showed that mental health  
11 problems, children with a likely diagnosis of a mental  
12 health problem were rising incrementally. So the  
13 prevalence of mental health disorders in 5 to 15-year  
14 olds had risen from 9.7 in 1999 to 10.1 in 2004  
15 to 11.2 in 2017. And then the next data wave of that  
16 survey was in 2020, just at the start of the pandemic.  
17 It's not included in this report, but what we see is  
18 a dramatic rise in the levels of mental health problems  
19 and in the social inequalities in mental health problems  
20 affecting children.

21 **Q.** So this dramatic rise, you mentioned that, as a health  
22 problem, this is one of the leading areas of childhood  
23 disability globally and nationally?

24 **A.** Yeah. I guess obesity and mental health problems have  
25 been described as the modern epidemics of childhood, and

13

1 figure 9.

2 **Q.** I'm not sure if I have a figure 9 but you do say at  
3 paragraph 73 that in 2017 those children and young  
4 persons living in the lowest income quintile were twice  
5 as likely as those living in the high income quintile to  
6 have a mental health diagnosis?

7 **A.** That's correct. It's page 23. I don't know if that  
8 helps.

9 **Q.** Thank you. Yes, thank you.

10 That draws out the point I was just making about  
11 the differential according to someone's child poverty,  
12 a child's positioning in --

13 **A.** Yeah. This shows that the children in the highest fifth  
14 of income households have -- 6.8% of kids have  
15 a diagnosis of any mental disorder compared to,  
16 you know, the 16% in the most disadvantaged.

17 **Q.** Thank you.

18 At paragraph 76 of your report, you say this: that  
19 the pre-pandemic child mental health was already in  
20 crisis, with evidence of rising prevalence in mental  
21 health problems for UK children, and that was increasing  
22 the inequalities and unsustainable pressure on services.

23 Is that an accurate summary of the position?

24 **A.** Yeah, there was an editorial in the BMJ titled "Child  
25 mental health in crisis", and, you know, there were

15

1 they're of particular concern for the reasons I've  
2 outlined, because they affect children and there are  
3 inequalities in those outcomes, but they also predict  
4 outcomes in later life. So the majority of mental  
5 health problems present, you know, before the age of 20,  
6 and they tend to track forward into adulthood if they're  
7 not picked up and treated. And if you have a childhood  
8 mental health problem, you're much more likely to  
9 develop a persistent mental health problem as an adult,  
10 and that leads to comorbidity, impacts on productivity,  
11 education, et cetera, over the life course.

12 So poor mental health in children is a critical  
13 societal concern.

14 **Q.** You've touched upon how socio-economic factors impact  
15 this, and how certain groups of children are more  
16 impacted than others; is that fair?

17 **A.** Yeah. You know, there are social gradients whereby  
18 disadvantaged kids are most likely to have poor health,  
19 but it's particularly the case for mental health  
20 problems. So mental health problems in children appear  
21 particularly sensitive to social conditions and  
22 the impact of poverty, and, you know, the graph there at  
23 figure 9 shows the double the prevalence of mental  
24 health problems, over double the prevalence in the most  
25 disadvantaged kids compared to the least. That's

14

1 clearly concerns about rising incidents, but also  
2 the ability of services to treat children. You know,  
3 we're still -- and we're still trying to catch up with  
4 that, because of pressures on clinical services.

5 **Q.** Looking slightly beyond your parameters, you're dealing  
6 with pre-existing inequalities prior to the pandemic,  
7 has mental health been an area where there has been  
8 significant issues in relation to child health since the  
9 pandemic?

10 **A.** Yeah, absolutely. So in that NHS digital survey there's  
11 a step change, there's almost a doubling in the  
12 prevalence of mental health problems and also a doubling  
13 of the social inequality, the difference between the  
14 highest and the lowest groups. So certainly that data  
15 that was published early in the pandemic showed that  
16 the pandemic had had a major impact on children's mental  
17 health, particularly for disadvantaged children.

18 **Q.** We've touched upon mental health. Physical health is  
19 something which you have dealt with in your reports,  
20 a number of areas which I'm not going to ask you about  
21 and we have in writing, about diabetes, epilepsy and  
22 asthma, but you do talk about child obesity, and you  
23 mentioned that again in your evidence this morning.

24 That was described in 2019 by the UK Government as  
25 one of the biggest health challenges this country faces;

16

1 is that correct?

2 **A.** Indeed, that was from a report on obesity from the  
3 government.

4 **Q.** Again, we have been talking about health inequalities or  
5 equity issues in relation to health; were there any  
6 equity issues as to health impacts of those children who  
7 had child obesity?

8 **A.** Yeah, absolutely. Like mental health, obesity is  
9 profoundly socially patterned and much more common in  
10 disadvantaged children, and I think one of the -- am  
11 I allowed to refer to the graphs in the -- I mean, the  
12 graph --

13 **Q.** Yes, if the figure helps --

14 **A.** Figure 14, which, you know, shows -- which is on  
15 page 31 --

16 **Q.** Yes.

17 **A.** That shows over time --

18 **Q.** I think we're just going to bring that up now, and we  
19 have it in front of us.  
20 So figure 14, yes?

21 **A.** That shows the proportion of children aged 10 or 11 in  
22 England who are obese --

23 **Q.** So the least deprived is the bottom graph --

24 **A.** Yeah.

25 **Q.** -- line on the graph, and the most deprived is the  
17

1 those material factors, whether you're in a safe, stable  
2 home environment with access to books, a healthy  
3 learning environment in the early years.

4 And, you know, one of the big problems is that when  
5 children enter school at age 5, there are big gaps.  
6 You know, some kids are a year, a year and a half behind  
7 their peers, and those differences track through school  
8 to influence differences in attainment in GCSEs and  
9 A levels. And we saw that pre-pandemic, and in the  
10 latest data that's coming out you see that those  
11 differences are increasing, those inequalities in  
12 attainment are becoming wider.

13 **Q.** The "education gap" I think is a phrase which is used?

14 **A.** Yeah. So, often that's measured on the basis of free  
15 school meals because that's what's collected in  
16 the data, so you can look at the attainment gap on  
17 the basis of children who are eligible for free school  
18 meals, who are disadvantaged compared to the rest.  
19 Pre-pandemic there was a persistent gap across all  
20 countries in attainment, at GCSE level for example, for  
21 children who were on free school meals.

22 But the important thing is that you see that also at  
23 reception, when children enter school, meaning that  
24 socio-economic circumstances influence children's  
25 cognitive development, socio-emotional development,  
19

1 darker blue, and you're about to describe  
2 the differential between 2006 and 2017.

3 **A.** Well, you can see on -- children living in the most  
4 deprived areas are twice as likely, roughly, to be obese  
5 at age 10, and that gap was widening prior to the  
6 pandemic. So inequalities were increasing. Obesity was  
7 just about stable for children in the most affluent  
8 areas but it was increasing in the most disadvantaged  
9 areas.

10 **Q.** Educational attainment is another topic you deal with  
11 and one which is in itself a significant and important  
12 topic. Perhaps we can touch upon that briefly at  
13 paragraph 126. How would you say inequalities in  
14 relation to educational attainment arise and are  
15 important?

16 **A.** So I guess this goes back to, you know, the life course  
17 story, and we know that when you measure children's  
18 development, even -- so we have known national data for  
19 children aged 2 and a half, we assess all children's  
20 development at age 2 and a half, and then at age 5 when  
21 they enter school, and you see social differences. You  
22 see differences, big differences, in children's  
23 development, which then track through to influence  
24 educational attainment at every level.  
25 So we know that it's the early years environment,  
18

1 which influences children's attainment ultimately as  
2 they emerge from school.

3 That's the process of the intergenerational transfer  
4 of inequalities, where adversity in the early years  
5 affects children's development, which affects their  
6 attainment in school, which affects their entry to  
7 the labour market, productivity as a society, et cetera.

8 **Q.** I'm going to move on to deal with vulnerable children.  
9 A subgroup, and a significant subgroup, is children who  
10 are in care. You deal with that at paragraph 131 of  
11 your report.

12 What was the position in relation to the number of  
13 children in care in the lead-up to the pandemic,  
14 Professor?

15 **A.** Well, it's easiest to refer to the graph, also, if  
16 that's okay.

17 **Q.** Yes, of course.

18 **A.** That's plotted -- that's on page 46. So we were  
19 seeing -- there was major concern about the rising  
20 number of children entering the care system. So from  
21 about the time of the financial crisis, around 2008/9  
22 onwards, we saw a rise in children entering the care  
23 system. Prior to that there had been a narrowing of  
24 inequalities, but the graph shows that the rise  
25 particularly occurred in the most disadvantaged  
20

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

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

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

14 **A.** That's correct.

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

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

21

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

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

7 **MS TWITE:** Indeed.

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

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

13 **MS TWITE:** Thank you, Mr Weatherby.

#### 14 Questions from MS TWITE

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

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

23

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

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

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

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

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

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

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

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

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

22

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

20 **Q.** Thank you.

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

23 **A.** Yes.

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

24

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

25

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

27

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

26

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

28

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

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

6 **A.** Yeah.

7 **Q.** We talked about the Children's Commissioner for England.

8 Some will be familiar with what that is, but some may  
9 not be. Could you briefly explain what that role is?

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

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

29

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

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

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

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

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

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

31

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

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

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

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

16 **A.** That's right, and recommendations of what action could  
17 be taken both there and then but also in the future.

18 I often saw myself as kind of the eyes and ears of  
19 children in the system, with access to those that made  
20 decisions and a responsibility to inform them about the  
21 impact of their potential decisions on children.

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

30

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

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

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

23 **Q.** Thank you.

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

32



1 it was a disaster for many disadvantaged children who  
2 were already living with risks and vulnerabilities, and  
3 as your role as Children's Commissioner for England you  
4 were concerned about those children and had focused much  
5 of your advice in reducing the risks that they faced.

6 Did you consider that the government took into account  
7 that advice and those concerns, by way of an overview?

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

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

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

33

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

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

10 **A.** Yes.

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

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

25 **Q.** Of course.

35

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

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

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

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

24 So children lost significant amounts of time out of  
25 school.

34

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

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

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

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

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

36

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

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

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

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

25 **Q.** I want to continue with the theme regarding vulnerable

37

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

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

9 Was that something which you --

10 **A.** Yes.

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

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

39

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

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

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

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

18 **A.** Yes, that's right.

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

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

38

1 So it was very evident that where there were  
 2 children in vulnerable homes -- and let's remember that  
 3 2.3 million children is actually one in six children, so  
 4 this is a significant number of children -- were  
 5 essentially locked up in homes in unsafe environments.

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

11 **A.** That's correct.

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

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

40

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

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

25 **A.** That's right.

41

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

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

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

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

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

43

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

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

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

21 **Q.** Thank you.

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

42

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

3 **Questions from THE CHAIR**

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

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

10 **A.** Yeah, well I think --

11 **LADY HALLETT:** Did anybody think about it?

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

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

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

44

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

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

9 **LADY HALLETT:** Thank you very much.

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

14 Oh, you have moved, taken Mr Weatherby up.

15 **Questions from MS TWITE**

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

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

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

45

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

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

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

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

47

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

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

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

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

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

46

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

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

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

48

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

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

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

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

49

1 **THE WITNESS:** Thank you very much.

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

4 **(The witness withdrew)**

5 **LADY HALLETT:** I think we will take the --

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

8 **LADY HALLETT:** Of course. Is there a summary?

9 **Summary of questionnaire responses**

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

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

51

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

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

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

20 **MS TWITE:** Thank you, Ms Longfield.

21 Thank you, my Lady.

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

50

1 disabilities.

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

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

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

52

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

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

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

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

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

53

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

3 **MR O'CONNOR:** He has, yes.

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

#### 7 **Summary of questionnaire responses**

8 **MR O'CONNOR:** That's exactly right.

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

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

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

55

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

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

8 That concludes this section.

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

11 Thank you.

12 **(11.16 am)**

**(A short break)**

14 **(11.30 am)**

15 **LADY HALLETT:** Mr O'Connor.

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

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

24 **LADY HALLETT:** Thank you, Mr O'Connor.

25 Just before you do, just to emphasise for those who

54

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

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

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

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

56

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

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

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

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

57

1 and it reads as follows:

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

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

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

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

59

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

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

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

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

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

58

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

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

13 **MS KATE BELL (affirmed)**

14 **Questions from COUNSEL TO THE INQUIRY**

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

16 **A.** It's Kate Bell.

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

19 **A.** I am.

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

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

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

60

1 A. That's right.

2 Q. You have provided the Inquiry, Ms Bell, with two  
3 statements. We'll look at them both in the course of  
4 the next half an hour or so. First of all, there was  
5 a lengthy statement dated 24 May of this year.

6 Perhaps we could have it on screen, please. It's  
7 INQ000215036.

8 Ms Bell, I'm sure you're familiar with that  
9 statement.

10 A. I am.

11 Q. We don't need to go to the last page, but it's been  
12 signed by you. Is that your statement?

13 A. It is.

14 Q. Are the contents of it true to the best of your  
15 knowledge and belief?

16 A. To the best of my knowledge and belief.

17 Q. Let's now just look briefly at your second statement,  
18 which I mentioned while I was reading out that  
19 narrative. This is a much more recent statement, it's  
20 dated 27 September this year. Again, we will go to some  
21 parts of this, but that's the statement which contains  
22 a series of short narratives from members of your  
23 unions.

24 A. That's correct.

25 Q. Is it, insofar as it contains your own evidence, true to

61

1 you describe that that organisation, as part of the TUC,  
2 has, as it were, devolved responsibility for certain  
3 matters relating to Welsh employment relations?

4 A. Exactly, in relation to the Welsh Government, yes.

5 Q. Rather separately, there are also the Scottish TUC and  
6 the Irish Congress of Trade Unions, the latter of which  
7 includes members both from Northern Ireland and  
8 Republic of Ireland; those two organisations are not  
9 part of the TUC in the same way as the Welsh TUC is?

10 A. That's right, they're independent organisations.

11 Q. But no doubt you do work closely with them?

12 A. We work closely together in a formal body which is  
13 called the Council of the Isles which brings us together  
14 to discuss matters of common concern.

15 Q. Yes. As I've said, the TUC is a very well known  
16 organisation and I'm sure we all know that the TUC  
17 represents working people and campaigns for their  
18 interests.

19 A. That's right.

20 Q. We've heard, of course, particularly in the last couple  
21 of days, about the disproportionate impact that Covid  
22 had on elderly people, many of whom would have been  
23 retired and not in the employment market, but it's also  
24 of course true that Covid had a very grave impact on  
25 workers, some of whom, of course, were also elderly, and

63

1 the best of your knowledge and belief?

2 A. To the best of my knowledge and belief, yes.

3 Q. Thank you.

4 I want to start, Ms Bell, with what I think will be  
5 a brief overview of the organisation of the TUC and its  
6 aims and objectives. I say brief because it is,  
7 of course, a very well known organisation. It's also  
8 true that you deal in some detail with the structures of  
9 the TUC in your statement, and we of course have that,  
10 so we don't need to cover it in length with you orally.

11 In brief, we learn from your statement, first of  
12 all, there are 48 member unions within the TUC?

13 A. Yes.

14 Q. And that comprises something like 5.5 million working  
15 people?

16 A. That's right, it's just over 5 now.

17 Q. Those unions, those people, are drawn from all over  
18 the UK, so England and Northern Ireland, Scotland and  
19 Wales?

20 A. So the TUC represents, yes, workers across the UK as far  
21 as national matters are concerned.

22 Q. Just then descending into a little bit of detail, there  
23 is within the TUC an organisation called the Welsh TUC?

24 A. That's part of our organisation, yes.

25 Q. Exactly. And I think, as I understand your statement,

62

1 we've heard something of that in the narrative that  
2 I read out immediately before you gave evidence.

3 Many people of working age died from Covid. Your  
4 statement gives a figure of 15,000 people of working age  
5 who died; is that right?

6 A. That's correct.

7 Q. And many of those, as we've heard, were frontline  
8 workers, working in health, social care, transport,  
9 food processing and so on. Again, as has also been  
10 mentioned, many more of those workers caught Covid, no  
11 doubt many of them suffering amongst those who have  
12 long Covid, experiencing protracted symptoms.

13 Also many workers were severely impacted because of  
14 the nature of the work they were required to do. Again,  
15 we've heard something of that in the narrative document.  
16 Their working conditions changed dramatically during  
17 the pandemic.

18 For all of those things, we know from your  
19 statement, the TUC campaigned and represented those  
20 interests during the pandemic.

21 Perhaps we can just look at page 3 of your first  
22 statement, the lengthy statement, and look at  
23 paragraph 7, which is the bottom half of that page. You  
24 state at the beginning of paragraph 7:

25 "The TUC engaged in numerous interactions (and

64



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

3 Correspondence, meetings and so on.

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

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

25 **Q.** Yes.

65

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

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

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

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

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

67

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

6 **A.** Absolutely, yes.

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

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

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

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

66

1 to.

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

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

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

15 **Q.** Yes.

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

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

68

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

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

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

9 So you say, the assertion you have there:

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

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

17 **A.** That's right.

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

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

25 **Q.** Let's go, then, Ms Bell, to a document -- can we call it  
69

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

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

7 **A.** That's right.

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

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

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

17 **A.** They would have no statutory sick pay.

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

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

71

1 up, please -- it's INQ000192239.

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

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

5 **Q.** Yes, so the first thing we can see is the date, which is  
6 3 March 2020, so what's that, three weeks even before  
7 the first lockdown?

8 **A.** That's right.

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

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

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

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

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

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

70

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

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

13 So the first point you were calling for was:

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

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

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

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

72

- 1 **A.** Yeah.
- 2 **Q.** -- that particular point. So if you were above that  
3 threshold of £120 a week, there wasn't the three-day  
4 gap --
- 5 **A.** The three-day waiting period was removed for  
6 coronavirus.
- 7 **Q.** But the second part of that bullet point "regardless of  
8 how much they earn", there you are calling for a sort of  
9 abolition of that threshold; and did that ever happen?
- 10 **A.** That never happened.
- 11 **Q.** The next point, you're calling for:  
12 "An increase in the amount of sick pay to the  
13 equivalent of the real living wage of £320 a week."  
14 So does this address a concern that, even for those  
15 who were entitled to statutory sick pay, the amount was  
16 very low?
- 17 **A.** Absolutely. So at that time average earnings were  
18 around £500 a week, so you can see it would be  
19 a significant income drop to go to £90 a week, so we  
20 called for the level to be increased so that people  
21 could afford to not be at work.
- 22 **Q.** I was going to come to this, I don't think we have  
23 introduced this yet, but the level of sick pay for those  
24 entitled to it, I think it was £94.25 a week?
- 25 **A.** That's right.

73

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

75

- 1 **Q.** So far below what, as you say, the average worker would  
2 have been earning, which introduced its own question of  
3 whether people could afford to go on to that?
- 4 **A.** Absolutely. And we'd said in that press release, in  
5 fact, as it stands many people won't be able to meet  
6 basic living costs if they stay home from work.
- 7 **Q.** Then just skipping down to the fourth bullet point, you  
8 call for an emergency fund to assist employers with the  
9 cost and to cover workers not currently eligible for  
10 statutory sick pay.
- 11 So obviously there might have been various ways in  
12 which your concerns could have been met, but  
13 an emergency fund sounds a little bit like the furlough  
14 scheme and a sort of block of money being allocated to  
15 solve this problem during the pandemic?
- 16 **A.** Yes, so employers are responsible for the costs of  
17 statutory sick pay, so we were suggesting that  
18 government may need to offer them some additional  
19 financial support in this particular emergency  
20 situation.
- 21 **Q.** There was an amount of money allocated by the government  
22 to address this problem, but it came much later; is that  
23 right?
- 24 **A.** That's right. So in -- I think in 28 September, the  
25 government introduced --

74

- 1 complicated application process, the discretionary  
2 nature and the fact that funds were limited for local  
3 authorities, so some people were applying and being  
4 told, you know, "There's no money left", meant that we  
5 didn't think this was an adequate form of financial  
6 support.
- 7 **Q.** Did you discover the amount of money that was made  
8 available by the Treasury for this scheme? Let me  
9 suggest a figure which is in your witness statement,  
10 £50 million, and how did that compare, to your mind,  
11 with the types of funding that had been given,  
12 for example, to the furlough scheme and Eat Out to Help  
13 Out and these other large schemes during the pandemic?
- 14 **A.** Well, I think it was very clear that it was inadequate.  
15 As our research went on to show, many people were being  
16 turned down for this financial support.
- 17 **Q.** That was September 2020 and you've explained the freedom  
18 of information requests and so on that you made after  
19 that date. Did you continue to campaign on this issue  
20 throughout the pandemic?
- 21 **A.** Yes, we published numerous reports on it. If I just  
22 find my note, I have a list of them somewhere.
- 23 **Q.** In some --
- 24 **A.** But we published numerous reports on it, we continued to  
25 highlight the issue, we continued to try to undertake

76

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

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

11 **MR O'CONNOR:** Yes.

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

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

16 **LADY HALLETT:** Thank you.

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

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

77

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

11 **Q.** Yes, do, please.

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

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

23 And she says:

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

79

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

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

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

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

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

17 **A.** That's right.

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

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

78

1 assessments or compassion from my employer."

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

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

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

80

1 mothers reported experiencing to you?

2 **A.** That's right, and the Royal College of Midwives, who is  
3 one of our affiliates, were repeatedly reporting  
4 concerns from May 2020 onwards about a lack of clear  
5 guidance for keeping pregnant women safe.

6 **Q.** Yes. Sticking with women generally, I'd like to go on,  
7 please, to paragraph 280 of your statement. You list  
8 there some very striking statistics about women in the  
9 workforce during the pandemic, which are worth noting.  
10 You say:

11 "Of the 3,200,000 workers at highest risk of  
12 exposure to COVID-19, 77% are women."  
13 77% of healthcare workers were women, 83% of the  
14 social care workforce, and 70% of those working in  
15 education.

16 "Mothers are more likely to be key workers than  
17 fathers or non-parents, 39% of working mothers were  
18 key workers before this crisis began, compared to 27% of  
19 the working population as a whole."  
20 As I say, striking statistics. Were those issues  
21 that the TUC campaigned on during the pandemic?

22 **A.** That's right. The overrepresentation of women in many  
23 key worker sectors was something we were raising, and  
24 therefore the disproportionate risk on them. And also  
25 pulling out issues like the lack of suitable PPE for

81

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

8 Those sorts of experiences, were they something that  
9 you found reported to you during the pandemic?

10 **A.** Yes, I think so, and I think you can see that throughout  
11 this statement, and I think you can see kind of the  
12 terrible emotional toll for many of these workers of  
13 working in a pandemic, whether that was the awful impact  
14 of, as this worker, watching somebody die in a care home  
15 without their family, whether it was the consistent  
16 worry of perhaps taking the virus home to your family,  
17 or whether it was the uncertainty which, you know,  
18 caused by some of the issues we've talked about  
19 previously, of not knowing what support you were meant  
20 to have in the workplace, not having clear guidance in  
21 place, and therefore sort of feeling like you were at  
22 the whim of an uncertain system and some managerial  
23 discretion.

24 **Q.** One other theme that comes through from this passage and  
25 also from some others in your statement is a feeling

83

1 women, so Prospect members, for example, reporting that  
2 even before the Covid Inquiry that women were being --  
3 sorry, the Covid pandemic, the lockdown, reporting that  
4 women were being overlooked when it came to appropriate  
5 PPE.

6 **Q.** Ms Bell, thank you.

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

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

16 So for those who want to follow, it's paragraph 4 of  
17 this statement. It starts on page 2.

18 **LADY HALLETT:** You're not going to read the whole of the  
19 paragraph?

20 **MR O'CONNOR:** I'm sorry?

21 **LADY HALLETT:** Are you going to read the whole of the  
22 paragraph?

23 **MR O'CONNOR:** Well, I was going to just read it through,  
24 madam, but perhaps I can take it more shortly.

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

82

1 amongst care workers and NHS workers of something close  
2 to resentment at the public clapping during the  
3 pandemic. Can you tell us a little about that?

4 **A.** I think it does come through, and I think "resentment"  
5 is not quite the right word --

6 **Q.** Tell me --

7 **A.** -- but perhaps a feeling that it didn't -- that people  
8 could not understand the scale of what they were  
9 experiencing.

10 **LADY HALLETT:** They were underappreciated.

11 **A.** That they were underappreciated, underappreciated  
12 the scale of what they were experiencing, the lack of  
13 clarity or guidance that they needed in order to do  
14 their jobs, and of course their long-running concerns  
15 before the pandemic, which we have talked about, about  
16 their pay and conditions not being -- claps, you know,  
17 claps don't pay the bills, as many workers have been  
18 chanting this year.

19 **MR O'CONNOR:** Yes.

20 Yes, thank you very much, Ms Bell. As I've said,  
21 we're very grateful for those two statements you've  
22 provided. We've got them in writing, and it's been very  
23 useful to hear you touch on some of the points today.

24 **THE WITNESS:** Thank you.

25 **MR O'CONNOR:** My Lady, those are all the questions I had for

84

1 Ms Bell. I don't believe there are any --

2 **LADY HALLETT:** I don't believe there are any --

3 **MR O'CONNOR:** -- questions from core participants.

4 **LADY HALLETT:** Thank you very much indeed, Ms Bell.

5 **THE WITNESS:** Thank you.

6 **(The witness withdrew)**

7 **MR O'CONNOR:** My Lady, we're going to move straight on to

8 the next witness, who is Mr Adeyemi.

9 **LADY HALLETT:** I gather you've flown in this morning?

10 **THE WITNESS:** Yes, my Lady.

11 **LADY HALLETT:** Thank you very much. I hope you're not too

12 bleary eyed.

13 **THE WITNESS:** No, no, I'm looking forward to this actually,

14 thank you very much.

15 **MR ADE ADEYEMI (sworn)**

16 **Questions from COUNSEL TO THE INQUIRY**

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

18 **A.** Mr Ade Adeyemi.

19 **Q.** Mr Adeyemi, you are a healthcare professional, and

20 I think you have been a healthcare professional for

21 14 years or thereabouts; is that right?

22 **A.** Yes. I've worked at various levels in the National

23 Health Service for over 14 years, and I'm now in

24 the Department of Health. But I'm here in my act as

25 a general secretary for FEHMO.

85

1 please?

2 **A.** Of course. Across the National Health Service, there

3 are a number of informal networks and organisations that

4 come together, normally around professional and kind of

5 diaspora or ethnic status. The full list of

6 organisations that form FEHMO are in the back --

7 **Q.** Yes, I was going to suggest we looked at those, so let's

8 go, it's the last pages of this document, I think

9 probably page 22, if my pages are right. Yes.

10 I'm not going to read them out, but we can cast our

11 eye down, there's the second page as well, but we can

12 see that these are organisations which are linked by

13 an interest in medicine and healthcare sector and

14 membership from ethnic groups; is that fair?

15 **A.** Yes, and they're all voluntary.

16 **Q.** Yes?

17 **A.** So these are things people have come together around

18 particular interests, as you say, particular professions

19 sometimes, or a particular country of origin. Often

20 within the National Health Service it's of value for

21 people of black and minority ethnic status to

22 congregate, to share knowledge, to uphold ourselves,

23 kind of share interests and advice, because the issues

24 that affect us, both professionally and healthcare-wise,

25 are quite stark and quite different. And so it's a safe

87

1 **Q.** Exactly. You're of particular interest to us, did you

2 say the general secretary of the organisation --

3 **A.** Yes.

4 **Q.** -- the Federation of Ethnic Minority Healthcare

5 Organisations, FEHMO for short?

6 **A.** Yes, that's right.

7 **Q.** You've helpfully provided us with a witness statement,

8 which is dated 22 September of this year. We've got it

9 on screen. Is that your statement?

10 **A.** That is my statement, yes.

11 **Q.** You've signed it, I think, but are you familiar with its

12 contents?

13 **A.** I am.

14 **Q.** Are they true to the best of your knowledge and belief?

15 **A.** Yes, they are.

16 **Q.** I want to start, if I may, Mr Adeyemi, with just a brief

17 overview of your organisation, what it's about, what it

18 tries to achieve.

19 Let's look, if we can, at paragraphs 5 and 6 of your

20 statement, so on the second page. You describe FEHMO as

21 being:

22 "... a voluntary multi-disciplinary consortium

23 comprising 55,000 individual members belonging to some

24 40 organisations and networks."

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

86

1 space often, and FEHMO is made of over 40 of these,

2 which you see listed there. Some are quite large and

3 some are a little bit not as large, but overall we

4 represent at least over 50,000 NHS and care --

5 **Q.** Yes?

6 **A.** -- staff members.

7 **Q.** If we can go back to page 2 of your statement, please,

8 again if we look at paragraph 6 of your statement, there

9 is a very helpful list there, again I'm not going to

10 read them all, but we see starting third line there,

11 doctors, nurses, midwives and many other

12 healthcare-related professions, all of which form part

13 of those organisations which themselves combine to form

14 FEHMO?

15 **A.** Yes, that's right.

16 **Q.** I think it's right to say that FEHMO was actually

17 founded fairly recently. During the pandemic or -- is

18 that right?

19 **A.** No. We had been coalescing together beforehand --

20 **Q.** Right?

21 **A.** -- and actually there was a Continental grouping of

22 these African networks that had formed as well. Leading

23 up to before the pandemic, we realised that it was

24 useful to, you know, strengthen numbers and so to come

25 together and to have the area of key decision-makers

88

1 within the health ecosystem.

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

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

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

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

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

89

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

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

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

15 **A.** Yes, that's right.

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

20 **A.** That's right.

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

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

91

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

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

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

19 **Q.** Yes.

20 **A.** Yes.

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

25 It's INQ000148476. Yes.

90

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

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

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

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

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

25 Those early days, it was still something that was

92

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

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

7 **A.** It was, yes.

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

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

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

22 **A.** One of the many requests, yes.

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

93

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

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

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

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

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

95

1 on with these disproportionate deaths.

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

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

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

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

25 We had so many instances of those concerns being

94

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

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

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

22 **A.** That's right, yes.

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

96



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

8 **Q.** You refer at the end of that paragraph to  
 9 Independent SAGE expressing a view on this, and I think  
 10 if we can zoom out and go to the next paragraph,  
 11 paragraph 30, we see what it was that Independent SAGE  
 12 said. I think this is a quote from them:  
 13 "... all relevant research studies should collect  
 14 and present disaggregated ethnicity data, national  
 15 minimum data sets should include ethnicity data, all  
 16 existing data sets should be reviewed and ethnicity  
 17 should be included in mortality reporting."  
 18 Was that the comment by Independent SAGE that you  
 19 refer to?

20 **A.** Yes, that's it.

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

97

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

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

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

99

1 that leads to serious consequences.

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

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

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

98

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

3 We'll recall that the letter we looked at was  
 4 April 2020, and what you suggest or state in this  
 5 paragraph is that for some months at least into the  
 6 pandemic risk assessments don't seem to have been  
 7 carried out in your experience and the experience of  
 8 your members. You say:  
 9 "Most of [your] members did not have any risk  
 10 assessment carried out until later in the pandemic ...  
 11 not assessed for risks arising from known disparities  
 12 ... for minority ethnic [healthcare workers]."  
 13 Then there is a reference to a June 2020 study into  
 14 risk assessments for minority ethnic healthcare workers,  
 15 which said that 65% of doctors at that stage, so that's  
 16 two or three months after the letter, still hadn't known  
 17 of or been given a risk assessment.

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

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

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

100

1 delay, the problems with the risk assessment was  
 2 a general problem or was it one where issues around  
 3 assessment of risk for ethnic healthcare workers were  
 4 particularly marked?  
 5 **A.** We definitely feel it's a racial element, definitely.  
 6 Again, speaking to the culture and feeling from members  
 7 of FEHMO, we see British institutions generally, like  
 8 the NHS, are able to respond to great tragedies. So  
 9 a recent example, we see there's a response to  
 10 Martha's Rule, we see the speed within which a statutory  
 11 inquiry has been suggested for the horrible crimes in  
 12 the Letby situation. We see Harper's Law, that protects  
 13 emergency healthcare workers or emergency service  
 14 workers. And there is a tragedy here with black and  
 15 ethnic minority healthcare workers and it's a message  
 16 from the chief people officer of NHS England: it's not  
 17 a mandate, it's not a law, it's not a rule. Which again  
 18 creates the sense and the culture that there's one  
 19 response for tragedies of a certain type of workers and  
 20 another response for another type of workers. And  
 21 that's what led to, yes, that imbalance and the  
 22 difference of risk assessments across the country.  
 23 **Q.** I think there is a further point you make in your  
 24 statement. We've talked about the delay, the initial  
 25 delay in risk assessments being undertaken, but you go

101

1 **A.** That's right.  
 2 **Q.** I'm not going to dwell on the first page. It covers  
 3 a lot of the same information, statistics, concern about  
 4 disparities and so on that we saw in the letter that had  
 5 been written a couple of weeks earlier.  
 6 Let's turn, if we can, to the second page, because  
 7 there we see, again, what it was that the British  
 8 Association of Physicians of Indian Origin was asking  
 9 the chief executives of the NHS Trust to do.  
 10 First of all, we see a request for stratified risk  
 11 assessments, something we've already discussed, and it's  
 12 expanded on in the first numbered point, it's:  
 13 "... a priority [for] all staff [at] frontline are  
 14 risk assessed for age, sex, ethnicity, pre-existing  
 15 medical conditions ..."  
 16 And so on, and we see that there is again  
 17 a reference there to retired and returning doctors; is  
 18 that right?  
 19 **A.** Yes.  
 20 **Q.** We also see at point 2 there is a request that BAME  
 21 staff are either tested for vitamin D deficiency or  
 22 given vitamin D supplements. Is that because at that  
 23 early stage of the pandemic there was a thought at least  
 24 that vitamin D supplements would provide greater  
 25 immunity or resistance to the Covid virus?

103

1 on, I think, to suggest that even once the risk  
 2 assessments started to be made, they fell short of what  
 3 you would have expected?  
 4 **A.** Yeah. We have members across all levels of the National  
 5 Health Service, so we understand that it was a difficult  
 6 time. We had people working in NHS England, in the  
 7 nerve centre itself. So, yes, it takes some time to  
 8 develop those risk assessments, but yes, there was  
 9 the delay in its roll-out, and its implementation as  
 10 well, variance across the country, which unfortunately  
 11 played out in terms of different outcomes for black and  
 12 ethnic minority healthcare workers versus white workers.  
 13 **Q.** Thank you, Mr Adeyemi.  
 14 I want to show you just one other letter.  
 15 In fact it was written by the same organisation, in  
 16 fact I think the same person. This one dated a couple  
 17 of weeks later.  
 18 Yes, we have it on the screen.  
 19 So the first one was 7 April. This one, we will see  
 20 from the top, was 22 April, and we see this time it's  
 21 not written to Simon Stevens and Chris Whitty, but  
 22 rather to chief executives of NHS trusts, so still  
 23 written to some very senior people, and presumably, this  
 24 time, probably circulation a lot wider across the  
 25 country. Is that right?

102

1 **A.** Yes. And if I may expand just for a few seconds,  
 2 I think this also shows the uneasiness of talking about  
 3 race in the National Health Service. No one of my  
 4 colleagues, no one -- a member of FEHMO would like to  
 5 think it's because of racism that there is a difference  
 6 in outcome for black, Asian and ethnic minority staff,  
 7 that you could be going to work and the colour of skin,  
 8 which you can't change, makes a difference in whether  
 9 you leave alive or not.  
 10 So something like vitamin D -- and, you know,  
 11 science tries to obfuscate and say actually racism isn't  
 12 involved here and there should be another biological  
 13 reason, so -- it's now been debunked, but it kind of  
 14 masks and -- it's something that's very uneasy for us to  
 15 talk about, that it shows that actually -- we kind of  
 16 scramble around for: there must be another reason, it  
 17 can't be because of racism that there is difference in  
 18 outcomes here.  
 19 But "yes" is the short answer to your question.  
 20 **Q.** Well, the longer one was very valuable, thank you.  
 21 Moving down the list, then, this is an issue I want  
 22 to explore in a moment with you in a bit more detail,  
 23 of course, the question of PPE was raised, which was  
 24 a big issue, was it not --  
 25 **A.** Yes, it was.

104

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

105

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

107

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

106

1 powerless, because we're hearing those things, we're  
 2 hearing that the face fit test isn't done properly, some  
 3 ward managers aren't seeing the results that it's not  
 4 fitting well and they're actually still being encouraged  
 5 to work. You know, there's a kind of toxic mess here,  
 6 I described earlier, about the power imbalances which  
 7 mean, one, most of our members didn't feel able to raise  
 8 those concerns, and the brave ones that did weren't  
 9 listened to. But it was a palpable thing, that we said  
 10 these things don't always fit us well, there are some  
 11 people who need extra appendages so it can go around the  
 12 hijab, et cetera, not listened to, not believed, not  
 13 responded to.  
 14 Q. If we look at -- this might involved going over the  
 15 page -- paragraph 35 of your statement, you give some  
 16 statistics. This is evidence submitted to the Women and  
 17 Equalities Committee:  
 18 "... 64% of BAME doctors reported feeling pressured  
 19 to work in settings with inadequate PPE compared with  
 20 33% of white doctors."  
 21 I'm just looking at the footnote there. And that  
 22 seems to have been dated July 2020. Does that sound  
 23 right?  
 24 A. Yeah.  
 25 Q. We've all probably read on. We can see in the next

108

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

109

1 disappointing.  
 2 **THE WITNESS:** Thank you.  
 3 **LADY HALLETT:** Thank you.  
 4 (The witness withdrew)  
 5 **LADY HALLETT:** Right, I shall return at 1.45.  
 6 (12.48 pm)  
 7 (The short adjournment)  
 8 (1.45 pm)  
 9 **LADY HALLETT:** Yes, Ms Cecil.  
 10 **MS CECIL:** Yes, Chair. May I call Dr Clare Wenham, please.  
 11 **DR CLARE WENHAM (affirmed)**  
 12 **Questions from COUNSEL TO THE INQUIRY**  
 13 **MS CECIL:** Thank you, Dr Wenham.  
 14 You have prepared a report for the Inquiry entitled  
 15 "Structural Inequalities and Gender"; is that correct?  
 16 **A.** Yes, that is correct.  
 17 **Q.** That's dated 22 September of this year, and can be found  
 18 at INQ0002800.  
 19 Now, just to deal with some formalities, if I may,  
 20 at the outset of that report, on the very first page,  
 21 you have made a statement of truth.  
 22 **A.** Yeah.  
 23 **Q.** That confirms that this report is your own work, those  
 24 facts are within your own knowledge, and that you  
 25 understand your duty as an expert to provide independent

111

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

110

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

112

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

113

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

115

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

114

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

116

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

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

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

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

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

117

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

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

13 **A.** Absolutely, yes.

14 **Q.** Thank you.

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

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

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

119

1 mortality amongst those women.

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

5 **Q.** Thank you.

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

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

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

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

21 **Q.** Thank you.

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

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

118

1 United Nations Security Council related to Ebola.

2 **Q.** Thank you.

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

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

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

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

25 **Q.** In what context was that?

120

1 A. In a meeting with officials working in government.  
 2 Q. What area of government?  
 3 A. In Cabinet Office.  
 4 Q. In the Cabinet Office?  
 5 A. Yeah.  
 6 Q. What was the sentiment that was expressed?  
 7 A. The sentiment was it was London, it wasn't Liberia, and  
 8 that there wouldn't be the same impacts here for women.  
 9 Q. Thank you.  
 10 I now want to turn, if I may, to a separate topic,  
 11 which is that in relation to public funding cuts since  
 12 2010 that you raise in your report, and you explain in  
 13 relation to that that significant cuts had been made to  
 14 healthcare, by 2015 over a billion, 6.3 billion from  
 15 social care, 13 billion from education, and indeed,  
 16 by 2020, £37 billion had been cut from welfare payments.  
 17 Can you, in headline summary form, for us, please  
 18 help the Inquiry with how that specifically, in your  
 19 view, exacerbates gender inequality?  
 20 A. Sure. So the two headline messages from  
 21 the austerity-related cuts in the UK for women are this.  
 22 The first one being that women are more likely to use  
 23 public services, they're more likely to need  
 24 interaction, whether that's through benefit support,  
 25 whether that's through healthcare services, whether

121

1 services than others.  
 2 Q. Thank you.  
 3 A. Can I just say, my screen has gone blank.  
 4 Q. I don't believe we'll be needing it, Dr Wenham, so  
 5 please don't worry. If we do, I'll pause for a moment  
 6 so that can be rectified.  
 7 If I can focus in on one aspect of those public  
 8 sector cuts, we've just dealt with, very briefly, women  
 9 as part of the public sector workforce but also as users  
 10 effectively of public services.  
 11 Benefits. I'm looking at financial autonomy and  
 12 benefit cuts.  
 13 A. Yeah.  
 14 Q. You note within your report that in relation to  
 15 Universal Credit caps that came into force, those apply  
 16 predominantly to single parents, and 90% of those are  
 17 women, is that right?  
 18 LADY HALLETT: Sorry, Ms Cecil, I think we are straying  
 19 a bit here. I mean, the fact that there were  
 20 inequalities and that many witnesses have attributed  
 21 that to austerity is obviously relevant, but I think we  
 22 are going perhaps into a little detail away from  
 23 Module 2. Sorry.  
 24 MS CECIL: No, not at all, thank you.  
 25 I was going to move on in any event after this

123

1 that's through a range of different ways that we see  
 2 women engaging with these services, so they're more  
 3 likely to be users, but we also know that women are  
 4 disproportionate employed in the public sector as well,  
 5 as healthcare workers in the education sector,  
 6 for example.  
 7 Q. If I can ask you just to pause there for a moment.  
 8 Thank you.  
 9 You say that women form the majority?  
 10 A. Majority of the workforce in the public sector. So  
 11 women are both impacted by these cuts as users  
 12 of services and as staff and employees within public  
 13 services.  
 14 Q. I'm going to pick up on workforce in due course but it's  
 15 effectively women form almost two-thirds of the public  
 16 sector workforce. Just to follow on in terms of impact  
 17 there, you relate to other characteristics as being  
 18 important and that not all women are affected as  
 19 a homogenous group. Can you just explain the importance  
 20 of that in relation to public welfare cuts?  
 21 A. Absolutely. Well, we know that women are not  
 22 a homogeneous group, we know that particular groups of  
 23 women, whether they be particular ethnic groups, whether  
 24 they be different socio-demographic groups, whether they  
 25 be migrant groups, might be more likely to use these

122

1 question to gender inequality and health, if I may, and  
 2 looking at gender and interactions with healthcare  
 3 systems.  
 4 Now, you point out a number of structural  
 5 differences in the way in which women interact with  
 6 healthcare systems as opposed to men. Could you, again,  
 7 just set those out, please, in summary form.  
 8 A. Sure. So to start with, women are more likely to use  
 9 healthcare services in their lifetimes than men, mainly  
 10 because of the need for maternity and/or sexual  
 11 reproductive health services. But gender also  
 12 determines and influences health knowledge and health  
 13 behaviour and how you might listen to advice given, and  
 14 also how you might access services and when you might  
 15 access health services. And this then has a knock-on  
 16 effect on outcomes, depending on when you might have  
 17 a visit -- visit a practitioner or whether you might  
 18 follow advice or not. But it's on the supply side as  
 19 well: the gender of a patient might impact on how  
 20 a medical professional interacts and gives guidance in  
 21 a consultation. So --  
 22 Q. If I can pause you there just for a moment. Just to  
 23 pick up on that final point, if I may, is it correct  
 24 that women, and in particular black women, are less  
 25 likely to have pain-related symptoms believed?

124

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

125

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

127

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

126

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

128



1 Q. Thank you.  
 2 That's different in Scotland, where abortion  
 3 provision is by the NHS. Northern Ireland, is it  
 4 correct that specific challenges still remain in terms  
 5 of travel and geographic availability?  
 6 A. Absolutely. So although the repeal of criminalisation  
 7 of abortion took place in 2019, there remain  
 8 a significant number of physical and structural barriers  
 9 for women being able to access that particularly in  
 10 terms of geographical proximity to services.  
 11 Q. Thank you.  
 12 And you note key developments during the pandemic,  
 13 which of course will no doubt be covered by a later  
 14 module.  
 15 If I may turn now to the labour market, and of  
 16 specific relevance to this module is women as healthcare  
 17 workers. What proportion of healthcare workers are  
 18 women?  
 19 A. So the data from England shows that 77% of those in the  
 20 NHS workforce are women, and that's a similar number  
 21 across the devolved administrations.  
 22 Q. Thank you.  
 23 To break further workforces down, in terms of health  
 24 and social care, education and early years, that's  
 25 predominantly, is that correct, staffed by women?

129

1 director, managerial, senior roles within organisations?  
 2 A. **(Witness nods)**  
 3 Q. That leads me on, if I may, to the gender pay gap, very  
 4 briefly. What is the gender pay gap?  
 5 A. So the gender pay gap is now a statutory requirement  
 6 across the UK for companies to report the difference in  
 7 average hourly wages between men and women.  
 8 Q. As at 2019, just to place this in context, the gap at  
 9 that point was 17.3%, as a median figure; is that  
 10 correct?  
 11 A. Between --  
 12 Q. In 2019. It's at paragraph 39 of your report, if that  
 13 assists.  
 14 A. Well, 8.6% across all full-time workers and up to 17.9%  
 15 when including part-time workforce.  
 16 Q. That's what I thought. You then talk about feminised  
 17 sectors in relation to the pay gap and look at various  
 18 professions. Can you just set out the differences there  
 19 in relation to early years, doctors and clinical  
 20 academics so that we get a broad picture?  
 21 A. Sure. So the feminised sectors such as early years care  
 22 and a lot of healthcare activity is devalued in  
 23 the labour market. That means that people are earning  
 24 less in those industries than in other industries. So  
 25 we know, for example, that, you know, there are much

131

1 A. Absolutely, yes, those are all sectors predominantly  
 2 staffed by women.  
 3 Q. Up to 96% in early years care, 75% in education, and 58%  
 4 of social care?  
 5 A. Yes.  
 6 Q. You describe that as occupational segregation?  
 7 A. Yes.  
 8 Q. What do you mean by that?  
 9 A. There are differences in who works in different labour  
 10 sectors and different industries across the UK and  
 11 across the globe and we know that healthcare, health and  
 12 social care, education and early years are predominantly  
 13 staffed and worked in by women compared to men.  
 14 Q. Thank you.  
 15 You then, just if I may, look at industries and role  
 16 types. Do you see any similar patterns there in terms  
 17 of occupational segregation?  
 18 A. We know that women are more likely to be in the lower  
 19 paid jobs and men are more likely to be in the higher  
 20 paid and/or managerial positions within those industries  
 21 as well.  
 22 Q. You point out engineering, finance, those sorts of  
 23 occupations.  
 24 A. Yes.  
 25 Q. Then, in terms of roles, men typically occupying

130

1 lower wages amongst early years and nursing professions  
 2 compared to hospital doctors or other clinical higher  
 3 grades.  
 4 Q. To what extent can any of the pay gap be attributed to  
 5 part-time work, and choice?  
 6 A. I think that's a really hard question because I think we  
 7 have to look at the structural factors of why people are  
 8 in part-time work, and it tends to be because of the  
 9 burden of unpaid care within the households and  
 10 childcare. And the lack of affordable childcare  
 11 provision across this country is a key reason why people  
 12 have to take part-time work. So it's unfair to say that  
 13 women always have a choice to -- you know, want to work  
 14 part-time compared to full-time. That completely misses  
 15 the drivers of why people have to work and the need to  
 16 be able to afford to live, to feed your children and the  
 17 vast cost of childcare.  
 18 Q. Thank you.  
 19 That brings me in to the issue of childcare and  
 20 other caring responsibilities, including unpaid work.  
 21 You speak within your report at paragraph 44 of the  
 22 "motherhood penalty", and I'm going to ask you just to  
 23 explain what that is, because it has some impact in  
 24 relation to unpaid work later.  
 25 A. Sure. So the motherhood penalty is the phenomenon which

132

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

13 **Q.** Thank you.

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

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

19 **Q.** Yes?

20 **A.** Falls disproportionately on women.

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

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

133

1 you mean by that expression?

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

8 **Q.** Thank you.

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

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

19 **Q.** Thank you.

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

135

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

5 **Q.** Thank you.

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

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

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

18 **A.** Sure.

19 **Q.** Please continue.

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

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

134

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

4 **A.** As I understand it, yes.

5 **Q.** Thank you.

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

11 **A.** Absolutely.

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

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

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

136

1 services and antenatal provision.

2 **A.** Yeah.

3 **Q.** Turning to the next aspect --

4 **A.** Sure.

5 **Q.** -- does that relate to health and social care workers?

6 **A.** Absolutely.

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

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

19 **Q.** Thank you.

20 Then if I may just pull together two aspects: in  
21 relation to unpaid care, obviously you say that aspect  
22 ought to be something that should be accommodated and  
23 considered in decision-making?

24 **A.** Absolutely. So if you know that women are the people  
25 who are going to do the childcare, if you are going to

137

1 of society, and women differently to that of men, and  
2 what could have been -- how these could have looked  
3 different, had the question been asked: how will this  
4 affect women? How will this affect a particular social  
5 group?

6 **MS CECIL:** Thank you, so looking at gender as part and  
7 parcel of decision-making and of course, as I said at  
8 the outset, your report really deals with the  
9 pre-pandemic looking forward position -- or looking  
10 backwards, rather, position and then looking at  
11 potential missed opportunities.

12 Chair, you've granted permission for a number of  
13 Rule 10 questions to be asked by Ms Davies on behalf of  
14 Solace Women's Aid and Southall Black Sisters.

15 **LADY HALLETT:** Thank you very much.

16 Yes, Ms Davies.

#### 17 Questions from MS DAVIES KC

18 **MS DAVIES:** Thank you, my Lady.

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

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

139

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

8 **Q.** Thank you.

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

15 In relation to moving forwards and general  
16 recommendations, with regard to gender and sex being  
17 taken into account, do you have any specific  
18 recommendation there?

19 **A.** I do. The first -- mainly being that, you know, we  
20 don't know to what extent equality impact assessments  
21 were undertaken, they weren't made public in the initial  
22 months of the pandemic, or gender advisory and how this  
23 was considered and whether government considered the  
24 downstream secondary effects of the policies they were  
25 bringing in and how they might affect different sectors

138

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

6 That's pre-pandemic. Looking at pandemic and  
7 specifically lockdown, rather than the health side of  
8 the pandemic, can you comment on whether the pressures  
9 of lockdown could produce a similar pressure on those  
10 locked down, thus exacerbating the possibility of an  
11 increase in domestic abuse?

12 **A.** Yes, absolutely, this is what we've seen in previous  
13 epidemics that, you know, these effects, lockdown, being  
14 put under some sort of restriction of mobility, has that  
15 effect and has in previous epidemics as well.

16 **Q.** That's restriction on mobility being in the same house  
17 together?

18 **A.** Yes.

19 **Q.** What about the point that you directly make in the  
20 paragraph, the financial costs of lockdown and indeed  
21 anticipated financial costs and worries about future  
22 finances, loss of employment, what's going to happen to  
23 welfare benefits and so forth; can that produce  
24 a similar pressure exacerbating the possibility of  
25 domestic abuse?

140

1 A. Yes, I would believe so.

2 Q. Yes. And in the specific sector of those working in  
3 healthcare and in social care, they were under a great  
4 deal of very specific pressure in lockdown. Again,  
5 would that pressure on those workers increase the  
6 possibility of domestic abuse?

7 A. I would imagine so, yes.

8 Q. Thank you.

9 The second topic is about migrant women, and it's  
10 paragraph 51 of your report, and you talk about  
11 asylum-seeking women, migrant women and refugee women,  
12 and I just want to break those three statuses down,  
13 because they have slightly different eligibility for  
14 welfare benefits, so that we're clear.

15 So the first status is asylum-seeking women, and all  
16 asylum seekers -- men or women -- don't have access to  
17 mainstream public funds, welfare benefits and so forth;  
18 they have a specific arm of the welfare state which is  
19 accommodation and support provided by the Home Office,  
20 it tends to be referred to as NASS accommodation.

21 So that's one status, and you say in relation to  
22 asylum-seeking women that they're particularly  
23 vulnerable to violence and abuse due to their precarity,  
24 so that's waiting on the decision on their asylum  
25 application. Then you also say many of these women had

141

1 Q. Moving on to the third group of migrant women that you  
2 talk about in this paragraph, and those are women who  
3 are here and they have leave to remain but their leave  
4 to remain is subject to a "no recourse to public funds"  
5 condition, and that means that they cannot claim welfare  
6 benefits and are therefore financially dependent on  
7 their sponsor, who sponsored their leave to remain.

8 Are those the women that you are talking about when  
9 you say, "Perpetrators use women's precarious  
10 immigration status, poor access to alternative housing",  
11 and then just in the preceding sentence, "risk of  
12 destitution to threaten them"?

13 A. Well, yes. I mean, the research shows that those women  
14 with no access to -- with no recourse to public funds  
15 have fear around accessing support services, therefore  
16 they are more vulnerable to the impacts of domestic  
17 violence.

18 Q. So the fear is a fear of being reported to the  
19 Home Office and therefore their leave being cancelled,  
20 a fear about that?

21 A. I would imagine, I'm --

22 Q. You don't know.

23 A. I don't know.

24 Q. That's fine. And a fear that, because they have no  
25 recourse to public funds, if they leave their abuser, if

143

1 already been subjected to violence prior to coming to  
2 the UK, so that's again likely to be asylum-seeking  
3 women?

4 A. Yes.

5 Q. Then refugee women. They were asylum-seeking women,  
6 their claim for asylum has been successful and they are  
7 given various forms of leave to remain, sometimes  
8 indefinite, sometimes finite, but it is a more stable  
9 immigration position, and they do have access to  
10 mainstream welfare benefits, the right to work and so  
11 forth, as any British citizen does.

12 So although they, like any woman, might be subject  
13 to domestic abuse, there isn't an additional aspect of  
14 precarity hanging over them?

15 A. Well --

16 Q. Those who have refugee status and the right to live in  
17 the UK.

18 A. So I am not able to comment on that --

19 Q. That's perfectly all right, yes.

20 A. -- but I think it's fair to say that we know that risk  
21 of domestic abuse is intersectional and there are  
22 varying different vulnerabilities that women face.  
23 Asylum seekers, migrant status might be one of  
24 a multiple variety of different risk factors that any  
25 particular woman might face.

142

1 their abuser is also their sponsor, that they will be  
2 destitute. That's where you say "risk of destitution",  
3 that's their fear. And so that is both the real thing  
4 that they worry about and also something that  
5 a perpetrator of abuse can threaten them with; yes?

6 A. I would imagine so, yes.

7 Q. So that puts them in an even more vulnerable position  
8 than women who are British citizens who are subject to  
9 domestic abuse, because they have that additional fear  
10 and threat hanging over them?

11 A. I would imagine so, yes, but I don't think I'm the right  
12 person to comment on that particular detail. But  
13 I would say that there are multiple different layers of  
14 risk, both of domestic violence and how -- what you  
15 would do in that situation and where you would turn for  
16 help, if indeed you feel you can turn for help.

17 Q. Thank you.

18 Then the third and final topic, which you deal with  
19 at paragraph 47, and Ms Cecil asked you a bit about:  
20 "At the same time that domestic violence has  
21 increased ..."

22 And you're talking pre-pandemic, you're talking in  
23 the years since the financial crash in 2008. You say:  
24 "... funding for women's shelters and other  
25 programmes to support victims have been cut which, along

144

1 with differences in commissioning practices in local  
 2 councils, has created a geographic lottery for women  
 3 survivors of domestic abuse."  
 4 So you make the point that, on one hand, in the  
 5 years leading up to the pandemic, domestic abuse had  
 6 increased and, on the other hand, funding to support the  
 7 resources had decreased.  
 8 So given that that was the state of the violence  
 9 against women and girls sector on the eve of the  
 10 pandemic, and given that they then saw an escalation in  
 11 domestic abuse and an increase in demand for their  
 12 services, are you able to comment on how that left the  
 13 violence against women and girls sector in an attempt to  
 14 meet that demand for their services?  
 15 **A.** I imagine your next speaker is better qualified to  
 16 answer that, but my assessment would be that, you know,  
 17 they would be struggling to manage the demand that they  
 18 are given.  
 19 **MS DAVIES:** Thank you very much, Dr Wenham.  
 20 Thank you, my Lady.  
 21 **LADY HALLETT:** Thank you, Ms Davies.  
 22 **MS CECIL:** Thank you, my Lady. Do you have any questions?  
 23 **LADY HALLETT:** No, I don't.  
 24 Thank you very much, Dr Wenham.  
 25 **THE WITNESS:** You're very welcome.

145

1 Ms Goshawk, you have provided a statement to  
 2 the Inquiry; is that correct?  
 3 **A.** Yes.  
 4 **Q.** Just to, for the assistance of others, if I can, it can  
 5 be found at INQ000280726. Thank you. That statement is  
 6 dated 20 September of 2023; is that right?  
 7 **A.** Yes.  
 8 **Q.** You explain within that statement that at the very end,  
 9 at page 63, you provide a declaration and statement of  
 10 truth; is that correct?  
 11 **A.** Yes.  
 12 **Q.** Thank you.  
 13 Ms Goshawk, is it correct that you are the head of  
 14 public affairs and partnerships at Solace Women's Aid?  
 15 **A.** Yes.  
 16 **Q.** I'm going to ask you now, if I may, some questions about  
 17 Solace Women's Aid.  
 18 Can you provide a brief overview of the organisation  
 19 for us?  
 20 **A.** Yes, we are a violence against women and girls charity,  
 21 we have been established for over 48 years, and in  
 22 2020/21 we supported just under 11,000 women and  
 23 children.  
 24 **Q.** Thank you.  
 25 Solace provides, it's fair to say, a broad and

147

1 **LADY HALLETT:** Thank you for all your help.  
 2 **(The witness withdrew)**  
 3 **MS CECIL:** My Lady, I understand that the plan now is to  
 4 have a very short five-minute break.  
 5 **LADY HALLETT:** I'm not even sure, do we need a five-minute  
 6 break?  
 7 **MS CECIL:** It's perhaps a matter for -- yes.  
 8 **LADY HALLETT:** Is that a yes?  
 9 **MS CECIL:** Yes.  
 10 **LADY HALLETT:** Five-minute break.  
 11 **(2.32 pm)**  
 12 **(A short break)**  
 13 **(2.38 pm)**  
 14 **LADY HALLETT:** Ms Cecil.  
 15 **MS CECIL:** Indeed. My Lady, may I call Ms Goshawk, please.  
 16 **MS REBECCA GOSHAWK (affirmed)**  
 17 **Questions from COUNSEL TO THE INQUIRY**  
 18 **MS CECIL:** Thank you, Ms Goshawk. If you could state your  
 19 name, please.  
 20 **A.** Sure. Rebecca Jane Goshawk.  
 21 **Q.** As you will be aware, there's a stenographer taking  
 22 a note and so, as a consequence, I'm going to ask you to  
 23 go at a slow pace. And it's my fault if you don't, not  
 24 yours, so it may be that I ask you to slow down or pause  
 25 at various points.

146

1 impressive array of services in relation to gender-based  
 2 violence, and reflective perhaps of many in your sector,  
 3 but in terms of those services you provide refuges?  
 4 **A.** Yes.  
 5 **Q.** Therapeutic services, community-based interventions and  
 6 programmes?  
 7 **A.** Yes.  
 8 **Q.** Advice lines, and other aspects including training?  
 9 **A.** Yes, we do.  
 10 **Q.** Indeed, you've referred to a snapshot of your work in  
 11 2020 providing that support to nearly 11,000 survivors  
 12 of domestic abuse, and in 2020 you accommodated 920  
 13 women and children in refuges; is that right?  
 14 **A.** We did.  
 15 **Q.** Thank you.  
 16 If I can turn, then, to the pre-pandemic position  
 17 and the sector, the violence against women and girls  
 18 sector, going into the pandemic, you describe that  
 19 sector -- at paragraph 25 -- as being woefully  
 20 underfunded and struggling.  
 21 What was the impact of that position in terms of the  
 22 services that you could provide at that time, and how  
 23 you could serve that client base of women and children?  
 24 **A.** Yes. So, as mentioned, there had been a reduction of  
 25 funding whilst also seeing an increase in demand for our

148

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

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

8 **Q.** Thank you.

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

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

18 **Q.** If we can just get a sense of what that means in real  
19 terms with regard to women and children facing  
20 gender-based violence, and you set it out very helpfully  
21 at paragraph 31 of your report, and you explain that in  
22 2019, in a research report involving 100 women, 30% of  
23 women had been turned away six times or more, from local  
24 authority services, that were coming to you; is that  
25 correct?

149

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

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

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

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

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

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

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

151

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

6 **Q.** Thank you.

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

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

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

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

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

150

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

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

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

10 **LADY HALLETT:** Sorry to interrupt, Ms Cecil.

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

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

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

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

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

152

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

153

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

155

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

154

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

156

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

5 **Q.** Thank you.

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

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

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

20 **A.** In schools specifically?

21 **Q.** In schools and early learning establishments.

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

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

157

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

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

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

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

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

159

1 **A.** We definitely saw that women were coming to us with that  
2 one chance, I think, to leave, in real emergency states.

3 We also saw that women came with higher mental health  
4 needs, that could be self-harming or suicidal ideation.

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

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

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

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

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

21 **A.** Yes, in those first few weeks.

22 **Q.** Thank you.

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

158

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

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

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

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

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

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

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

25 **A.** Service users.

160



1 **LADY HALLETT:** Service users. Oh, I don't like "service  
2 users". Can I --  
3 **A.** Victims or survivors as well.  
4 **LADY HALLETT:** Okay. The problems that they were facing,  
5 what steps did the sector take to bring this to the  
6 attention of the government?

7 **A.** Yeah, I can absolutely cover that.  
8 So we took a number of steps to write to government  
9 to alert them to some of the challenges. There was  
10 a quite broad sector letter sent to the Prime Minister  
11 and a number of the key Cabinet positions on 3 April  
12 which outlined for us what were four key priorities for  
13 protecting victims of domestic abuse.

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

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

22 **LADY HALLETT:** Did you detect any movement as a result of  
23 your representations?

24 **A.** We did see some, yes. I think those early  
25 representations meant that we saw public statements  
161

1 messaging?

2 **A.** It was one, we would have seen it as a positive  
3 development, but that message was coming directly from  
4 the Home Secretary and from government, it's certainly  
5 not enough to ensure that all the women at risk were  
6 aware that there was an exemption.

7 **Q.** And the government did institute a "You Are Not Alone"  
8 campaign from 11 April. What are your views on that?

9 **A.** We were pleased when the campaign was launched. Again,  
10 I think it was a positive step, but we saw on our own  
11 advice line that that wasn't cutting through to all  
12 women who needed our support. We were getting women  
13 saying they didn't know they could leave, when they  
14 called us, and we actually had that across all three  
15 lockdowns.

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

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

24 I also think an online campaign is one tool to reach  
25 people, but there are many people where a campaign like  
163

1 about the ability to leave and domestic abuse being  
2 an exemption from that --

3 **LADY HALLETT:** They changed, didn't they, I think?

4 **A.** They did. I know the first announcement did not have  
5 any mention of domestic abuse, and actually no  
6 announcement of a lockdown had a mention of domestic  
7 abuse until January 2021, which is a real concern that  
8 those large platforms that many of us were watching  
9 didn't reference the exemption. It was sort of hidden  
10 in guidance and regulations, which was a real concern to  
11 us.

12 **MS CECIL:** Perhaps, my Lady, if I pick up on public  
13 messaging at this point.

14 **LADY HALLETT:** Yes, do, please. I'm so sorry to have taken  
15 over.

16 **MS CECIL:** No, no, not at all, please feel free.

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

21 There was, subsequently to that, an article in the  
22 Daily Mail by the Home Secretary on 28 March of 2020.  
23 Is that a source of messaging that the women you see  
24 facing domestic abuse and gender-based violence were  
25 likely to see or access? How effective was that  
162

1 that will not be effective, whether that's those with  
2 communication barriers, for example, so ...

3 **Q.** You pick up on that within your statement. I don't  
4 intend to take you through it in detail, but the  
5 communication, language barriers and accessibility  
6 barriers in short?

7 **A.** Yes.

8 **Q.** Thank you.

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

15 What do you mean by that?

16 **A.** So we talked about the pandemic as being sort of a dual  
17 pandemic, that is the restrictions, the risk of -- to  
18 health that the Covid-19 brought to women, the threat of  
19 violence and abuse that they would experience in their  
20 own home, and then I think for migrant women we saw that  
21 threat of immigration enforcement and destitution.

22 **Q.** Picking up on the theme and the questions you've just  
23 been asked, what did you, as an organisation, do in  
24 respect to that?

25 **A.** So this was highlighted to government on 31 March 2020,  
164

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

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

13 **A.** Yes.

14 **Q.** And the exclusion, the refusal of the government to  
 15 extend measures to migrant women with insecure status  
 16 and women with no recourse to public funds.  
 17 What could the government have done, in your view?

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

165

1 that was referred to by the previous witness.

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

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

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

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

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

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

25 We -- there were schemes like Rail to Refuge which

167

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

3 Yeah, it's just --

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

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

10 **Q.** Thank you.

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

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

17 **Q.** And specifically where do you see those failings?

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

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

166

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

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

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

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

20 **A.** Yeah, I think --

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

23 **MS CECIL:** Exactly. Yes, not general.

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

168

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

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

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

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

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

INDEX	PAGE
PROFESSOR DAVID TAYLOR-ROBINSON (affirmed) .....	1
Questions from COUNSEL TO THE INQUIRY .....	1
Questions from MS TWITE .....	23
MS ANNE LONGFIELD (affirmed) .....	27
Questions from COUNSEL TO THE INQUIRY .....	27
Questions from THE CHAIR .....	44
Questions from MS TWITE .....	45
Summary of questionnaire responses .....	51
Summary of questionnaire responses .....	55
MS KATE BELL (affirmed) .....	60
Questions from COUNSEL TO THE INQUIRY .....	60

1 MS CECIL: Thank you very much.

2 My Lady, those are all the questions that I have.

3 There are no Rule 10 requests that have been granted, or  
 4 indeed made. Does your Ladyship have any questions?

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

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

10 THE WITNESS: Unfortunately not.

11 LADY HALLETT: Anyway, thank you very much indeed.

12 THE WITNESS: Thank you.

(The witness withdrew)

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

15 LADY HALLETT: Thank you, Ms Cecil.

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

18 (3.08 pm)

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

MR ADE ADEYEMI (sworn) .....	85
Questions from COUNSEL TO THE INQUIRY .....	85
DR CLARE WENHAM (affirmed) .....	111
Questions from COUNSEL TO THE INQUIRY .....	111
Questions from MS DAVIES KC .....	139
MS REBECCA GOSHAWK (affirmed) .....	146
Questions from COUNSEL TO THE INQUIRY .....	146

<b>LADY HALLETT:</b> <b>[55]</b> 1/4 22/19 22/21 23/5 23/11 26/20 44/4 44/11 45/9 50/22 51/2 51/5 51/8 54/9 54/15 54/24 55/4 77/8 77/12 77/16 82/18 82/21 84/10 85/2 85/4 85/9 85/11 110/22 111/3 111/5 111/9 114/17 123/18 139/15 145/21 145/23 146/1 146/5 146/8 146/10 146/14 151/23 152/10 160/17 160/21 161/1 161/4 161/22 162/3 162/14 168/21 168/24 170/5 170/11 170/15 <b>MR KEATING: [10]</b> 1/3 1/5 1/8 22/14 27/4 27/6 27/9 43/24 51/6 51/10 <b>MR O'CONNOR: [15]</b> 54/16 55/3 55/8 60/15 77/11 77/14 77/17 82/20 82/23 84/19 84/25 85/3 85/7 85/17 110/16 <b>MR WEATHERBY:</b> <b>[1]</b> 23/8 <b>MS CECIL: [18]</b> 111/10 111/13 115/1 123/24 139/6 145/22 146/3 146/7 146/9 146/15 146/18 152/11 160/20 162/12 162/16 168/23 170/1 170/14 <b>MS DAVIES: [2]</b> 139/18 145/19 <b>MS TWITE: [8]</b> 22/20 22/25 23/7 23/13 23/15 26/17 45/16 50/20 <b>THE WITNESS: [10]</b> 27/3 51/1 84/24 85/5 85/10 85/13 111/2 145/25 170/10 170/12	<b>10.30 [1]</b> 170/16 <b>100 [1]</b> 149/22 <b>11 [3]</b> 8/18 17/21 95/21 <b>11 April [1]</b> 163/8 <b>11 March 2020 [1]</b> 72/23 <b>11,000 [2]</b> 147/22 148/11 <b>11.16 am [1]</b> 54/12 <b>11.30 [1]</b> 54/10 <b>11.30 am [1]</b> 54/14 <b>117 [2]</b> 150/13 150/22 <b>12 [5]</b> 33/17 36/14 41/8 105/18 133/8 <b>12 May [2]</b> 155/11 167/19 <b>12.48 pm [1]</b> 111/6 <b>120 [2]</b> 71/6 73/3 <b>126 [1]</b> 18/13 <b>13 [1]</b> 9/7 <b>13 billion [1]</b> 121/15 <b>131 [1]</b> 20/10 <b>14 [3]</b> 17/14 17/20 100/2 <b>14 years [2]</b> 85/21 85/23 <b>147 [2]</b> 69/7 69/7 <b>15 billion [1]</b> 47/14 <b>15,000 [1]</b> 64/4 <b>15-year [1]</b> 13/13 <b>16 [2]</b> 15/16 71/20 <b>17 [1]</b> 9/16 <b>17.3 [1]</b> 131/9 <b>17.9 [1]</b> 131/14 <b>18 [1]</b> 27/23 <b>184 [1]</b> 164/14 <b>187 [1]</b> 164/14 <b>19 [8]</b> 9/11 56/10 57/6 58/2 58/11 81/12 164/18 166/13 <b>19 March 2020 [1]</b> 57/18 <b>1999 [1]</b> 13/14 <b>1s [1]</b> 38/24	140/3 144/23 <b>2008/9 [1]</b> 20/21 <b>2010 [4]</b> 8/10 116/1 121/12 149/17 <b>2015 [3]</b> 6/17 28/16 121/14 <b>2016 [2]</b> 60/25 117/18 <b>2017 [3]</b> 13/15 15/3 18/2 <b>2018 [1]</b> 127/13 <b>2018/19 [1]</b> 9/11 <b>2019 [11]</b> 16/24 119/18 129/7 131/8 131/12 134/9 134/16 134/21 135/11 135/22 149/22 <b>2019/20 [2]</b> 6/6 9/11 <b>2020 [48]</b> 2/20 6/17 8/3 9/16 13/16 21/17 39/5 40/7 46/2 47/2 56/11 57/7 57/18 58/17 58/19 70/4 70/6 72/23 75/1 75/2 76/17 78/11 78/16 80/11 81/4 83/3 90/24 95/24 100/4 100/13 108/22 115/8 120/22 121/16 148/11 148/12 150/13 150/22 152/9 154/11 154/14 154/16 155/7 155/11 155/21 155/23 162/22 164/25 <b>2020/21 [1]</b> 147/22 <b>2021 [5]</b> 28/16 39/5 126/4 134/20 162/7 <b>2023 [3]</b> 1/1 147/6 170/20 <b>208 [2]</b> 154/20 158/13 <b>21 [2]</b> 12/3 147/22 <b>21 September [1]</b> 1/19 <b>212 [1]</b> 168/11 <b>22 [2]</b> 13/4 87/9 <b>22 April [1]</b> 102/20 <b>22 September [2]</b> 86/8 111/17 <b>23 [4]</b> 15/7 30/22 154/15 155/7 <b>24 [2]</b> 71/20 126/5 <b>24 May [1]</b> 61/5 <b>25 [6]</b> 8/15 8/16 10/7 12/7 46/10 148/19 <b>25 years [1]</b> 59/23 <b>258 [2]</b> 78/2 78/3 <b>26 [1]</b> 12/15 <b>265 [1]</b> 78/13 <b>27 [1]</b> 81/18 <b>27 September [1]</b> 61/20 <b>271 [1]</b> 80/7 <b>275 [1]</b> 80/9 <b>28 March [1]</b> 162/22	<b>28 September [1]</b> 74/24 <b>280 [1]</b> 81/7 <b>29 [1]</b> 95/21	<b>3</b> <b>3 April [2]</b> 161/11 165/5 <b>3 March 2020 [2]</b> 70/4 70/6 <b>3,200,000 [1]</b> 81/11 <b>3,400 [1]</b> 80/13 <b>3.08 pm [1]</b> 170/18 <b>30 [2]</b> 97/11 149/22 <b>31 [3]</b> 6/7 17/15 149/21 <b>31 March 2020 [1]</b> 164/25 <b>320 [1]</b> 73/13 <b>33 [4]</b> 105/19 105/20 108/20 133/9 <b>34 [1]</b> 71/18 <b>35 [2]</b> 60/3 108/15 <b>36 [1]</b> 165/11 <b>37 [1]</b> 12/4 <b>37 billion [1]</b> 121/16 <b>39 [3]</b> 81/17 100/1 131/12	<b>64 [1]</b> 108/18 <b>65 [3]</b> 71/21 100/15 154/10 <b>67 [1]</b> 39/24	<b>7</b> <b>7 April [1]</b> 102/19 <b>7 April 2020 [1]</b> 90/24 <b>70 [5]</b> 10/12 46/22 75/9 81/14 167/20 <b>70-bed [2]</b> 155/10 155/16 <b>71 [1]</b> 160/15 <b>73 [1]</b> 15/3 <b>75 [1]</b> 130/3 <b>76 [1]</b> 15/18 <b>77 [3]</b> 81/12 81/13 129/19 <b>78 [1]</b> 77/24	<b>8</b> <b>8.6 [1]</b> 131/14 <b>80 [1]</b> 36/24 <b>83 [1]</b> 81/13	<b>9</b> <b>9 October 2023 [1]</b> 170/20 <b>9.7 [1]</b> 13/14 <b>90 [2]</b> 73/19 123/16 <b>920 [1]</b> 148/12 <b>94.25 [1]</b> 73/24 <b>96 [1]</b> 130/3	<b>A</b> <b>ability [8]</b> 16/2 24/21 65/13 162/1 165/3 165/9 168/1 168/6 <b>able [30]</b> 30/1 32/10 32/13 32/17 32/19 34/12 34/16 34/20 36/20 41/4 43/8 47/8 70/19 74/5 100/25 101/8 108/7 113/25 128/18 129/9 132/16 142/18 145/12 150/17 153/2 157/13 159/24 160/1 168/16 168/24 <b>abolition [1]</b> 73/9 <b>abortion [5]</b> 128/9 128/15 128/21 129/2 129/7 <b>about [130]</b> 3/13 3/14 3/16 3/16 4/16 4/22 10/7 10/14 11/1 12/10 15/10 16/1 16/20 16/21 16/22 17/4 18/1 18/7 20/19 20/21 21/21 21/21 22/9 23/20 23/25 25/20 25/22 29/7 29/18 30/13 30/20 31/20 31/22 33/4 33/17 34/9
<b>1</b> <b>1,200 [1]</b> 78/18 <b>1.1 [1]</b> 9/17 <b>1.45 [1]</b> 111/5 <b>1.45 pm [1]</b> 111/8 <b>1.8 million [2]</b> 9/17 34/19 <b>10 [6]</b> 17/21 18/5 31/17 33/17 139/13 170/3 <b>10 am [1]</b> 170/19 <b>10 May [1]</b> 152/17 <b>10.00 am [1]</b> 1/2 <b>10.1 [1]</b> 13/14	<b>2</b> <b>2 million [2]</b> 70/10 71/1 <b>2.2 million [1]</b> 39/14 <b>2.3 million [1]</b> 40/3 <b>2.32 pm [1]</b> 146/11 <b>2.38 [1]</b> 146/13 <b>20 [4]</b> 6/6 9/11 14/5 155/18 <b>20 September [1]</b> 147/6 <b>20 years [2]</b> 3/10 31/17 <b>2004 [2]</b> 13/14 29/11 <b>2005 [1]</b> 29/17 <b>2006 [1]</b> 18/2 <b>2008 [3]</b> 134/12	<b>23 [4]</b> 15/7 30/22 154/15 155/7 <b>24 [2]</b> 71/20 126/5 <b>24 May [1]</b> 61/5 <b>25 [6]</b> 8/15 8/16 10/7 12/7 46/10 148/19 <b>25 years [1]</b> 59/23 <b>258 [2]</b> 78/2 78/3 <b>26 [1]</b> 12/15 <b>265 [1]</b> 78/13 <b>27 [1]</b> 81/18 <b>27 September [1]</b> 61/20 <b>271 [1]</b> 80/7 <b>275 [1]</b> 80/9 <b>28 March [1]</b> 162/22	<b>5</b> <b>5.5 million [1]</b> 62/14 <b>50 [2]</b> 38/17 149/16 <b>50 million [1]</b> 76/10 <b>50,000 [1]</b> 88/4 <b>500 [3]</b> 73/18 75/2 75/19 <b>51 [1]</b> 141/10 <b>53 [1]</b> 135/20 <b>55 [2]</b> 23/19 25/17 <b>55,000 [2]</b> 86/23 135/21 <b>58 [2]</b> 13/5 130/3	<b>6</b> <b>6 October 2023 [1]</b> 1/1 <b>6,000 [1]</b> 135/23 <b>6.3 billion [1]</b> 121/14 <b>6.8 [1]</b> 15/14 <b>62 [1]</b> 38/5 <b>63 [2]</b> 38/20 147/9					

A				
<p><b>about...</b> [94] 35/11 35/12 36/14 36/16 38/8 38/25 40/20 44/11 46/1 46/7 46/22 47/24 48/16 49/7 49/10 49/16 52/5 53/20 53/23 55/10 58/9 59/2 59/13 60/7 60/8 63/21 65/8 65/9 65/19 66/5 67/13 68/17 68/25 69/19 75/17 77/14 78/8 79/6 81/4 81/8 83/18 84/3 84/15 84/15 86/17 93/12 93/25 94/10 94/13 94/14 95/12 95/22 96/13 98/10 99/10 101/24 103/3 104/2 104/15 105/5 107/19 108/6 112/15 115/2 115/6 120/13 126/16 126/19 131/16 133/18 134/23 134/25 136/13 138/9 139/25 140/19 140/21 141/9 141/10 143/2 143/8 143/20 144/4 144/19 147/16 154/24 159/22 161/14 162/1 164/16 165/2 168/5 168/21 169/19</p>	<p>159/16 159/18 160/10 161/13 161/17 162/1 162/5 162/7 162/24 164/19 165/12 165/22 166/5 166/12 166/18 166/24 167/10 169/5 169/15 169/22 <b>abuser</b> [2] 143/25 144/1 <b>abusers</b> [1] 134/22 <b>abusive</b> [1] 159/2 <b>academic</b> [1] 48/7 <b>academics</b> [1] 131/20 <b>accepted</b> [1] 119/22 <b>access</b> [29] 9/18 9/20 9/20 9/24 9/25 10/1 10/3 19/2 24/6 26/9 30/19 40/16 55/21 56/2 79/7 120/15 124/14 124/15 128/13 128/19 129/9 135/5 141/16 142/9 143/10 143/14 157/13 162/25 165/25 <b>accessibility</b> [2] 75/21 164/5 <b>accessing</b> [2] 128/21 143/15 <b>accommodated</b> [2] 137/22 148/12 <b>accommodation</b> [16] 32/7 40/20 40/21 141/19 141/20 150/2 150/2 150/4 155/10 155/16 156/5 156/6 156/9 161/21 167/18 169/11 <b>accorded</b> [1] 56/7 <b>according</b> [1] 15/11 <b>account</b> [3] 33/6 97/22 138/17 <b>accurate</b> [1] 15/23 <b>achieve</b> [2] 86/18 89/13 <b>acknowledged</b> [1] 59/16 <b>acknowledgement</b> [1] 57/16 <b>across</b> [40] 4/10 8/6 11/17 11/20 19/19 46/6 57/14 62/20 66/19 68/13 87/2 89/6 92/8 98/3 101/22 102/4 102/10 102/24 106/25 106/25 113/6 115/20 115/22 116/1 116/5 120/9 127/13 128/10 128/22 129/21 130/10 130/11 131/6 131/14 132/11 133/17 136/24 153/8 154/2 163/14 <b>act</b> [3] 85/24 165/12</p>	<p>166/5 <b>acted</b> [1] 97/5 <b>action</b> [6] 25/9 30/16 52/6 52/12 53/23 161/19 <b>actions</b> [1] 57/21 <b>active</b> [4] 66/5 90/10 90/13 91/7 <b>activity</b> [3] 92/5 92/17 131/22 <b>actors</b> [1] 135/16 <b>acts</b> [1] 29/20 <b>actually</b> [26] 10/18 37/9 37/13 40/3 44/22 45/1 46/14 47/6 75/16 85/13 88/16 88/21 93/9 98/9 104/11 104/15 106/10 108/4 149/14 150/16 150/16 151/7 155/7 160/1 162/5 163/14 <b>acute</b> [1] 39/8 <b>addiction</b> [2] 32/8 39/17 <b>addition</b> [1] 119/12 <b>additional</b> [5] 67/20 74/18 142/13 144/9 149/11 <b>address</b> [9] 4/1 4/2 73/14 74/22 77/23 90/4 90/7 90/11 92/6 <b>addressed</b> [4] 11/6 60/5 72/22 90/5 <b>addressing</b> [1] 58/12 <b>ADE</b> [3] 85/15 85/18 172/1 <b>adequacy</b> [1] 57/23 <b>adequate</b> [11] 52/9 57/14 67/25 69/11 69/13 69/21 76/5 77/3 105/23 106/2 169/8 <b>adequately</b> [2] 166/12 169/9 <b>Adeyemi</b> [13] 54/19 55/1 85/8 85/15 85/18 85/19 86/16 89/15 91/1 102/13 105/20 110/17 172/1 <b>adjourned</b> [1] 170/19 <b>adjournment</b> [1] 111/7 <b>administered</b> [1] 75/4 <b>administration</b> [1] 115/18 <b>administrations</b> [2] 116/10 129/21 <b>administrative</b> [1] 36/6 <b>adolescent</b> [1] 13/3 <b>adopted</b> [1] 29/11 <b>adoption</b> [1] 49/19 <b>adult</b> [7] 3/22 4/2 14/9 21/22 24/25</p>	<p>25/13 46/9 <b>adulthood</b> [3] 4/6 4/8 14/6 <b>adults</b> [5] 12/12 35/19 40/25 93/3 134/23 <b>adverse</b> [2] 5/17 58/2 <b>adversely</b> [1] 31/24 <b>adversity</b> [1] 20/4 <b>advice</b> [12] 30/12 33/5 33/7 87/23 112/1 124/13 124/18 148/8 150/11 150/21 157/9 163/11 <b>advisory</b> [1] 138/22 <b>advocate</b> [3] 30/7 50/24 156/13 <b>affairs</b> [1] 147/14 <b>affect</b> [10] 3/18 5/24 14/2 87/24 105/11 126/9 135/3 138/25 139/4 139/4 <b>affected</b> [9] 21/5 28/24 29/2 30/9 31/24 59/21 119/3 122/18 149/15 <b>affecting</b> [3] 4/3 4/9 13/20 <b>affects</b> [4] 5/19 20/5 20/5 20/6 <b>affiliates</b> [1] 81/3 <b>affirmed</b> [11] 1/6 27/7 60/12 60/13 111/11 146/16 171/3 171/9 171/21 172/5 172/11 <b>affluent</b> [3] 18/7 34/14 120/6 <b>afford</b> [5] 55/24 56/13 73/21 74/3 132/16 <b>affordable</b> [1] 132/10 <b>afraid</b> [4] 23/2 60/11 160/17 170/8 <b>Africa</b> [2] 117/4 117/13 <b>African</b> [1] 88/22 <b>after</b> [13] 6/11 53/25 59/24 72/24 76/18 91/10 94/15 100/16 114/20 114/20 119/7 123/25 134/3 <b>afternoon</b> [1] 55/2 <b>afternoons</b> [1] 44/15 <b>again</b> [50] 4/16 9/22 12/8 16/23 17/4 24/24 25/6 25/9 26/7 29/15 40/13 40/17 42/25 50/24 53/19 61/20 64/9 64/14 66/4 69/5 80/12 88/8 88/9 93/1 93/17 95/10 98/8 98/16 99/3 99/12 101/6 101/17 103/7</p>	<p>103/16 106/16 107/24 109/3 110/4 110/10 112/5 116/14 117/13 124/6 128/9 141/4 142/2 152/8 159/14 163/9 170/16 <b>against</b> [8] 145/9 145/13 147/20 148/17 159/6 166/19 169/2 169/4 <b>age</b> [10] 14/5 18/5 18/20 18/20 19/5 64/3 64/4 79/24 103/14 125/11 <b>age 10</b> [1] 18/5 <b>age 2</b> [1] 18/20 <b>age 5</b> [2] 18/20 19/5 <b>aged</b> [6] 17/21 18/19 40/9 71/20 71/21 79/13 <b>agencies</b> [1] 30/13 <b>agency</b> [1] 95/5 <b>agree</b> [2] 23/24 24/1 <b>agreed</b> [1] 134/21 <b>agreement</b> [1] 22/8 <b>Aid</b> [4] 139/14 139/20 147/14 147/17 <b>aim</b> [2] 89/9 89/12 <b>aims</b> [1] 62/6 <b>air</b> [1] 44/20 <b>akin</b> [1] 169/12 <b>alarmingly</b> [1] 117/17 <b>Alder</b> [1] 2/10 <b>Alder Hey</b> [1] 2/10 <b>alert</b> [2] 152/16 161/9 <b>alive</b> [1] 104/9 <b>all</b> [75] 2/22 5/15 5/25 6/7 7/15 8/3 18/19 19/19 25/14 27/1 36/5 36/18 37/4 44/1 49/1 55/13 56/6 57/24 61/4 62/12 62/17 63/16 64/18 70/15 71/9 71/16 72/15 77/24 84/25 87/15 88/10 88/12 89/20 89/21 91/1 91/8 93/4 93/12 93/14 94/7 94/11 97/13 97/15 98/16 99/9 102/4 103/10 103/13 108/25 112/17 113/24 120/5 120/9 120/20 122/18 123/24 126/23 130/1 131/14 141/15 142/19 146/1 152/11 152/11 153/9 155/7 156/16 162/16 163/5 163/11 163/14 163/16 166/4 170/2 170/17 <b>alleviate</b> [1] 53/8 <b>Alliance</b> [3] 23/18 45/23 53/14 <b>allied</b> [1] 94/21</p>

<b>A</b>	39/7 64/11 68/21 84/1 118/1 127/15 132/1	<b>apparent [2]</b> 90/6 94/6	73/18 79/2 80/23 87/4 87/17 101/2 104/16	<b>assisting [2]</b> 1/13 29/4
<b>allocated [2]</b> 74/14 74/21	<b>amount [7]</b> 28/22 71/5 73/12 73/15 74/21 76/7 117/19	<b>appear [2]</b> 14/20 93/3	107/14 108/11 110/14 120/22 143/15 149/16 159/3	<b>assists [1]</b> 131/13
<b>allow [1]</b> 45/10	<b>amounts [1]</b> 34/24	<b>appears [1]</b> 166/22		<b>associate [1]</b> 112/8
<b>allowances [1]</b> 41/3	<b>analyses [1]</b> 21/3	<b>appendages [1]</b> 108/11	<b>array [1]</b> 148/1	<b>Association [5]</b> 57/20 91/2 96/8 96/20 103/8
<b>allowed [1]</b> 17/11	<b>analysis [1]</b> 52/23	<b>application [3]</b> 30/11 76/1 141/25	<b>article [2]</b> 68/19 162/21	<b>associations [1]</b> 134/3
<b>allowing [1]</b> 45/17	<b>anchor [1]</b> 35/16	<b>applications [1]</b> 75/10	<b>as [203]</b>	<b>asthma [2]</b> 4/12 16/22
<b>almost [8]</b> 5/12 11/15 16/11 34/16 41/16 77/6 79/14 122/15	<b>anecdotaly [1]</b> 116/11	<b>apply [4]</b> 75/7 115/20 115/22 123/15	<b>as: [1]</b> 128/16	<b>asylum [9]</b> 141/11 141/15 141/16 141/22 141/24 142/2 142/5 142/6 142/23
<b>alone [4]</b> 50/16 56/13 159/23 163/7	<b>Anne [4]</b> 27/6 27/7 27/12 171/9	<b>applying [2]</b> 59/11 76/3	<b>as: how [1]</b> 128/16	<b>asylum-seeking [5]</b> 141/11 141/15 141/22 142/2 142/5
<b>along [2]</b> 144/25 161/18	<b>Anne Elizabeth [1]</b> 27/12	<b>appreciate [2]</b> 22/21 160/20	<b>Asian [4]</b> 104/6 106/7 106/19 107/5	<b>asymmetrical [1]</b> 95/6
<b>alongside [3]</b> 36/15 43/7 90/14	<b>Anne Longfield [1]</b> 27/6	<b>appreciation [1]</b> 99/4	<b>ask [34]</b> 16/20 22/15 22/17 23/15 27/20 42/6 44/2 44/4 45/11 45/19 45/21 45/25 46/2 47/23 54/21 60/11 78/8 82/8 82/14 94/9 95/20 112/17 122/7 132/22 134/17 139/21 146/22 146/24 147/16 149/9 150/19 154/24 156/14 160/14	<b>at [232]</b>
<b>already [23]</b> 15/19 24/4 25/7 26/12 32/22 33/2 34/16 36/8 39/15 41/18 45/12 45/24 46/7 48/23 57/5 66/3 103/11 127/7 138/12 142/1 167/7 167/14 170/6	<b>annex [1]</b> 91/4	<b>approach [4]</b> 25/7 49/17 49/18 169/14	<b>asked [14]</b> 21/16 50/13 59/6 59/12 79/16 94/4 120/3 125/23 136/6 139/3 139/13 139/24 144/19 164/23	<b>attainment [10]</b> 2/21 18/10 18/14 18/24 19/8 19/12 19/16 19/20 20/1 20/6
<b>also [74]</b> 2/6 7/9 9/1 11/16 14/3 16/1 16/12 19/22 20/15 21/5 22/12 26/25 30/17 35/14 36/1 38/25 41/18 42/13 42/20 43/6 44/20 47/18 49/22 50/5 50/10 56/1 57/23 62/7 63/5 63/23 63/25 64/9 64/13 66/2 71/24 77/2 79/6 80/21 81/24 83/25 89/23 95/5 95/6 98/14 98/22 103/20 104/2 109/16 119/8 119/25 122/3 123/9 124/11 124/14 125/10 126/3 133/22 133/24 134/2 135/13 137/15 141/25 144/1 144/4 148/25 158/3 158/13 159/5 160/21 161/18 163/24 165/21 167/8 167/15	<b>announced [1]</b> 91/11	<b>approaches [4]</b> 49/9 49/11 49/23 52/21	<b>asking [4]</b> 23/9 93/11 103/8 115/6	<b>attempt [1]</b> 145/13
<b>alternative [2]</b> 37/5 143/10	<b>announcement [5]</b> 150/24 152/15 152/16 162/4 162/6	<b>appropriate [3]</b> 79/10 82/4 107/17	<b>aspect [7]</b> 123/7 127/11 127/21 137/3 137/21 142/13 154/19	<b>attempts [1]</b> 65/1
<b>although [5]</b> 38/1 56/20 116/10 129/6 142/12	<b>announcements [1]</b> 151/8	<b>approximately [3]</b> 128/7 128/8 155/24	<b>aspects [7]</b> 7/10 137/20 138/9 148/8 166/5 167/14 168/12	<b>attend [3]</b> 33/20 36/12 38/2
<b>always [7]</b> 43/14 45/7 108/10 120/13 120/13 120/15 132/13	<b>another [18]</b> 3/21 12/2 12/9 18/10 44/15 47/20 53/1 56/20 77/9 80/4 95/12 98/2 98/22 101/20 101/20 104/12 104/16 134/6	<b>April [19]</b> 28/16 40/7 56/11 90/24 95/24 100/4 102/19 102/20 151/11 151/13 151/14 152/13 154/4 154/10 155/7 155/22 161/11 163/8 165/5	<b>asking [4]</b> 23/9 93/11 103/8 115/6	<b>attendance [1]</b> 38/3
<b>am [11]</b> 1/2 17/10 54/12 54/14 60/19 61/10 86/13 110/24 125/23 142/18 170/19	<b>answer [6]</b> 3/3 47/1 104/19 145/16 153/4 153/6	<b>April 2015 [1]</b> 28/16	<b>aspect [7]</b> 123/7 127/11 127/21 137/3 137/21 142/13 154/19	<b>attending [4]</b> 1/12 27/14 34/15 36/10
<b>ambitious [1]</b> 45/3	<b>answered [2]</b> 25/15 45/24	<b>April 2020 [4]</b> 56/11 95/24 100/4 155/7	<b>assertion [1]</b> 69/9	<b>attention [5]</b> 90/17 91/16 99/15 161/6 168/19
<b>ameliorate [1]</b> 113/5	<b>answering [1]</b> 153/3	<b>April and [1]</b> 40/7	<b>asserts [2]</b> 18/19 21/17	<b>attributed [2]</b> 123/20 132/4
<b>America [1]</b> 117/6	<b>antenatal [4]</b> 127/9 127/23 136/16 137/1	<b>architecture [1]</b> 24/8	<b>aspects [7]</b> 7/10 137/20 138/9 148/8 166/5 167/14 168/12	<b>August [1]</b> 153/11
<b>amongst [8]</b> 7/24	<b>anticipated [1]</b> 140/21	<b>are [183]</b>	<b>assertion [1]</b> 69/9	<b>August/September</b> [1] 153/11
	<b>anxiety [2]</b> 59/17 105/11	<b>area [15]</b> 12/2 16/7 54/22 55/12 56/20 67/14 68/11 69/23 88/25 92/15 92/15 112/10 118/6 121/2 164/10	<b>assess [2]</b> 18/19 21/17	<b>austerity [6]</b> 46/19 121/21 123/21 134/14 135/6 140/4
	<b>any [37]</b> 6/20 15/15 17/5 26/17 27/20 37/18 59/6 71/12 79/25 85/1 85/2 100/9 115/21 116/7 120/18 123/25 130/16 132/4 138/11 138/17 142/11 142/12 142/24 145/22 153/12 156/22 157/9 157/18 157/24 158/7 159/2 161/22 162/5 167/15 168/17 168/18 170/4	<b>areas [22]</b> 2/18 6/21 7/13 13/22 16/20 18/4 18/8 18/9 22/1 30/2 34/5 37/2 41/23 49/10 54/23 67/15 80/4 96/14 106/18 115/3 117/9 127/19	<b>assessed [2]</b> 100/11 103/14	<b>authorities [6]</b> 39/4 75/5 75/11 76/3 150/4 156/11
	<b>anybody [2]</b> 44/5 44/11	<b>aren't [3]</b> 70/10 105/11 108/3	<b>assessment [9]</b> 31/5 93/16 93/19 100/10 100/17 100/25 101/1 101/3 145/16	<b>authority [2]</b> 135/15 149/24
	<b>anything [1]</b> 49/10	<b>arise [1]</b> 18/14	<b>assessments [26]</b> 48/16 49/21 52/22 65/18 65/19 67/8 67/17 79/8 80/1 99/10 99/10 99/17 99/22 100/6 100/14 100/22 101/22 101/25 102/2 102/8 103/11 116/3 116/5 116/10 116/15 138/20	<b>autonomy [1]</b> 123/11
	<b>anything's [1]</b> 47/1	<b>arises [1]</b> 27/22	<b>assist [3]</b> 1/18 27/14 74/8	<b>autumn [1]</b> 83/3
	<b>anyway [2]</b> 99/1 170/11	<b>arising [1]</b> 100/11	<b>assistant [1]</b> 60/17	<b>availability [3]</b> 57/14 69/11 129/5
	<b>apologise [2]</b> 22/25 23/3	<b>arm [1]</b> 141/18	<b>assistants [1]</b> 66/12	<b>available [7]</b> 75/24 76/8 115/13 135/16 154/25 156/3 156/17
		<b>arose [3]</b> 90/8 90/11 106/4	<b>assisted [1]</b> 59/9	<b>average [4]</b> 73/17 74/1 114/15 131/7
		<b>around [28]</b> 3/23 8/10 20/21 28/11 35/4 35/24 39/14 39/22 46/19 46/22 65/10 65/18 65/23 66/13		<b>avoid [2]</b> 42/25 160/17
				<b>aware [10]</b> 42/7 42/10 42/14 77/21 91/21 146/21 157/19 157/22 163/6 166/18
				<b>away [9]</b> 29/23 30/1

<b>A</b>	79/17 80/22 81/16 93/3 93/24 93/25 94/5 95/9 95/25 97/16 97/17 97/25 99/22 99/24 102/2 104/7 104/12 104/16 104/17 105/15 109/5 109/9 111/17 114/19 115/5 118/7 119/4 120/3 120/10 120/18 121/8 122/3 122/23 122/24 122/25 122/25 123/4 123/6 126/10 128/16 129/13 130/18 130/19 132/4 132/8 132/16 133/9 133/24 134/1 134/2 135/4 135/24 136/6 137/22 137/22 139/13 139/22 141/20 142/2 142/12 142/23 144/1 145/16 145/17 146/21 146/24 147/5 149/16 151/19 155/16 158/4 159/24 160/15 163/23 164/1 170/8	74/11 74/12 75/20 76/11 78/25 79/2 80/21 84/17 84/22 85/20 88/19 89/19 90/1 90/4 94/7 98/24 98/24 98/25 99/1 100/6 100/17 101/11 103/5 104/13 108/22 110/22 110/25 115/17 121/13 121/16 126/15 134/21 135/13 136/23 137/9 137/14 137/16 138/2 138/5 139/2 139/3 142/1 142/6 144/25 147/21 148/24 149/23 151/24 156/25 157/2 157/15 158/10 158/13 158/18 163/19 164/23 165/18 165/20 165/23 166/1 170/3	148/19 152/17 154/15 157/12 160/5 160/5 160/7 162/1 162/20 164/16 165/8 166/9 166/19 168/24 <b>belief [7]</b> 31/13 61/15 61/16 62/1 62/2 86/14 106/16 <b>believe [7]</b> 36/21 85/1 85/2 96/13 123/4 141/1 152/12 <b>believed [10]</b> 31/9 95/3 95/16 107/1 108/12 110/7 110/14 124/25 125/3 160/11 <b>believes [1]</b> 89/16 <b>belittled [1]</b> 160/10 <b>Bell [22]</b> 54/18 54/20 58/23 60/11 60/13 60/16 60/17 61/2 61/8 62/4 66/15 69/25 70/3 77/17 78/15 80/4 82/6 82/25 84/20 85/1 85/4 171/21 <b>belong [1]</b> 110/24 <b>belonging [1]</b> 86/23 <b>beloved [1]</b> 109/7 <b>below [4]</b> 8/16 74/1 93/1 93/23 <b>benefit [4]</b> 48/1 68/8 121/24 123/12 <b>benefited [1]</b> 68/13 <b>benefits [7]</b> 48/24 123/11 140/23 141/14 141/17 142/10 143/6 <b>best [14]</b> 13/9 29/20 30/15 43/9 43/11 43/19 48/14 48/19 48/25 61/14 61/16 62/1 62/2 86/14 <b>better [11]</b> 23/4 44/20 47/18 67/21 67/23 67/24 110/23 134/21 136/22 137/17 145/15 <b>between [26]</b> 4/5 8/1 9/11 9/17 16/13 18/2 24/25 27/17 28/16 32/16 39/5 40/7 46/9 54/16 58/14 65/6 99/7 113/2 116/9 118/2 118/17 127/3 131/7 131/11 134/13 140/2 <b>beyond [3]</b> 16/5 54/2 96/16 <b>big [5]</b> 18/22 19/4 19/5 89/12 104/24 <b>biggest [2]</b> 16/25 22/6 <b>Bill [3]</b> 134/16 134/20 166/9 <b>billion [5]</b> 47/14 121/14 121/14 121/15 121/16	<b>bills [1]</b> 84/17 <b>bin [1]</b> 109/2 <b>biological [2]</b> 57/6 104/12 <b>bit [20]</b> 35/9 49/7 62/22 69/19 72/7 72/22 74/13 80/15 86/25 88/3 92/18 94/13 97/21 98/2 104/22 106/10 123/19 144/19 150/15 166/15 <b>black [25]</b> 67/9 72/3 72/6 79/13 87/21 89/6 95/15 101/14 102/11 104/6 106/7 106/18 107/5 124/24 125/2 127/15 139/14 139/20 149/10 149/13 154/8 160/12 161/18 164/11 167/5 <b>blank [1]</b> 123/3 <b>blast [1]</b> 92/8 <b>bleary [1]</b> 85/12 <b>block [1]</b> 74/14 <b>blocks [1]</b> 32/6 <b>blood [1]</b> 109/16 <b>blue [1]</b> 18/1 <b>BME [3]</b> 78/5 78/23 94/3 <b>BMJ [1]</b> 15/24 <b>board [2]</b> 8/6 119/18 <b>bodies [1]</b> 137/17 <b>body [4]</b> 5/13 59/4 63/12 116/6 <b>bones [1]</b> 86/25 <b>books [1]</b> 19/2 <b>born [2]</b> 3/8 4/24 <b>both [23]</b> 21/21 28/12 30/17 35/4 52/20 61/3 63/7 66/11 66/13 77/8 87/24 89/22 89/24 105/23 109/15 117/20 122/11 135/14 138/5 144/3 144/14 159/4 164/10 <b>bottom [5]</b> 1/21 6/5 7/18 17/23 64/23 <b>bounce [2]</b> 47/18 54/4 <b>bouncing [1]</b> 110/3 <b>box [1]</b> 54/20 <b>boys [1]</b> 125/19 <b>brain [6]</b> 24/8 24/9 25/21 25/22 25/24 25/24 <b>brave [1]</b> 108/8 <b>Brazil [2]</b> 118/9 120/10 <b>break [12]</b> 35/8 51/11 54/10 54/13 54/17 115/14 129/23 141/12 146/4 146/6 146/10 146/12 <b>breed [1]</b> 159/14
<b>B</b>	<b>back [26]</b> 8/3 18/16 25/9 25/16 40/19 45/6 47/18 49/2 54/4 66/16 68/16 82/9 87/6 88/7 91/5 94/4 95/20 98/20 105/17 107/13 110/3 151/23 152/8 153/12 158/23 167/8 <b>backed [1]</b> 45/5 <b>background [4]</b> 2/2 28/6 79/4 112/6 <b>backgrounds [1]</b> 58/4 <b>backwards [2]</b> 21/25 139/10 <b>baffling [1]</b> 5/11 <b>bags [2]</b> 59/4 109/2 <b>bakers [1]</b> 79/12 <b>BAME [7]</b> 58/11 58/20 91/18 93/2 103/20 107/15 108/18 <b>banks [1]</b> 9/10 <b>barely [1]</b> 59/16 <b>barriers [7]</b> 128/16 128/21 129/8 164/2 164/5 164/6 167/9 <b>base [2]</b> 148/23 156/22 <b>based [9]</b> 114/21 118/6 118/14 126/17 134/7 148/1 148/5 149/20 162/24 <b>basic [2]</b> 74/6 119/23 <b>basing [1]</b> 55/23 <b>basis [4]</b> 4/25 19/14 19/17 59/11 <b>be [139]</b> 5/22 11/15 11/16 11/25 18/4 21/2 25/18 25/19 25/20 26/22 29/2 29/8 29/9 30/3 30/5 30/17 32/10 32/17 32/19 34/20 35/15 36/20 39/1 39/16 39/20 40/16 40/25 41/4 41/14 42/19 43/3 43/8 46/5 47/5 47/10 47/23 48/13 48/15 48/19 48/24 49/2 50/9 51/10 51/17 52/20 54/17 55/24 60/12 60/21 62/4 67/2 67/2 68/21 68/21 70/18 70/19 72/3 73/18 73/20 73/21 74/5 77/5 77/9	26/11 26/12 26/13 26/14 26/15 26/16 26/17 26/18 26/19 26/20 26/21 26/22 26/23 26/24 26/25 26/26 26/27 26/28 26/29 26/30 26/31 26/32 26/33 26/34 26/35 26/36 26/37 26/38 26/39 26/40 26/41 26/42 26/43 26/44 26/45 26/46 26/47 26/48 26/49 26/50 26/51 26/52 26/53 26/54 26/55 26/56 26/57 26/58 26/59 26/60 26/61 26/62 26/63 26/64 26/65 26/66 26/67 26/68 26/69 26/70 26/71 26/72 26/73 26/74 26/75 26/76 26/77 26/78 26/79 26/80 26/81 26/82 26/83 26/84 26/85 26/86 26/87 26/88 26/89 26/90 26/91 26/92 26/93 26/94 26/95 26/96 26/97 26/98 26/99 26/100 26/101 26/102 26/103 26/104 26/105 26/106 26/107 26/108 26/109 26/110 26/111 26/112 26/113 26/114 26/115 26/116 26/117 26/118 26/119 26/120 26/121 26/122 26/123 26/124 26/125 26/126 26/127 26/128 26/129 26/130 26/131 26/132 26/133 26/134 26/135 26/136 26/137 26/138 26/139 26/140 26/141 26/142 26/143 26/144 26/145 26/146 26/147 26/148 26/149 26/150 26/151 26/152 26/153 26/154 26/155 26/156 26/157 26/158 26/159 26/160 26/161 26/162 26/163 26/164 26/165 26/166 26/167 26/168 26/169 26/170 26/171 26/172 26/173 26/174 26/175 26/176 26/177 26/178 26/179 26/180 26/181 26/182 26/183 26/184 26/185 26/186 26/187 26/188 26/189 26/190 26/191 26/192 26/193 26/194 26/195 26/196 26/197 26/198 26/199 26/200 26/201 26/202 26/203 26/204 26/205 26/206 26/207 26/208 26/209 26/210 26/211 26/212 26/213 26/214 26/215 26/216 26/217 26/218 26/219 26/220 26/221 26/222 26/223 26/224 26/225 26/226 26/227 26/228 26/229 26/230 26/231 26/232 26/233 26/234 26/235 26/236 26/237 26/238 26/239 26/240 26/241 26/242 26/243 26/244 26/245 26/246 26/247 26/248 26/249 26/250 26/251 26/252 26/253 26/254 26/255 26/256 26/257 26/258 26/259 26/260 26/261 26/262 26/263 26/264 26/265 26/266 26/267 26/268 26/269 26/270 26/271 26/272 26/273 26/274 26/275 26/276 26/277 26/278 26/279 26/280 26/281 26/282 26/283 26/284 26/285 26/286 26/287 26/288 26/289 26/290 26/291 26/292 26/293 26/294 26/295 26/296 26/297 26/298 26/299 26/300 26/301 26/302 26/303 26/304 26/305 26/306 26/307 26/308 26/309 26/310 26/311 26/312 26/313 26/314 26/315 26/316 26/317 26/318 26/319 26/320 26/321 26/322 26/323 26/324 26/325 26/326 26/327 26/328 26/329 26/330 26/331 26/332 26/333 26/334 26/335 26/336 26/337 26/338 26/339 26/340 26/341 26/342 26/343 26/344 26/345 26/346 26/347 26/348 26/349 26/350 26/351 26/352 26/353 26/354 26/355 26/356 26/357 26/358 26/359 26/360 26/361 26/362 26/363 26/364 26/365 26/366 26/367 26/368 26/369 26/370 26/371 26/372 26/373 26/374 26/375 26/376 26/377 26/378 26/379 26/380 26/381 26/382 26/383 26/384 26/385 26/386 26/387 26/388 26/389 26/390 26/391 26/392 26/393 26/394 26/395 26/396 26/397 26/398 26/399 26/400 26/401 26/402 26/403 26/404 26/405 26/406 26/407 26/408 26/409 26/410 26/411 26/412 26/413 26/414 26/415 26/416 26/417 26/418 26/419 26/420 26/421 26/422 26/423 26/424 26/425 26/426 26/427 26/428 26/429 26/430 26/431 26/432 26/433 26/434 26/435 26/436 26/437 26/438 26/439 26/440 26/441 26/442 26/443 26/444 26/445 26/446 26/447 26/448 26/449 26/450 26/451 26/452 26/453 26/454 26/455 26/456 26/457 26/458 26/459 26/460 26/461 26/462 26/463 26/464 26/465 26/466 26/467 26/468 26/469 26/470 26/471 26/472 26/473 26/474 26/475 26/476 26/477 26/478 26/479 26/480 26/481 26/482 26/483 26/484 26/485 26/486 26/487 26/488 26/489 26/490 26/491 26/492 26/493 26/494 26/495 26/496 26/497 26/498 26/499 26/500 26/501 26/502 26/503 26/504 26/505 26/506 26/507 26/508 26/509 26/510 26/511 26/512 26/513 26/514 26/515 26/516 26/517 26/518 26/519 26/520 26/521 26/522 26/523 26/524 26/525 26/526 26/527 26/528 26/529 26/530 26/531 26/532 26/533 26/534 26/535 26/536 26/537 26/538 26/539 26/540 26/541 26/542 26/543 26/544 26/545 26/546 26/547 26/548 26/549 26/550 26/551 26/552 26/553 26/554 26/555 26/556 26/557 26/558 26/559 26/560 26/561 26/562 26/563 26/564 26/565 26/566 26/567 26/568 26/569 26/570 26/571 26/572 26/573 26/574 26/575 26/576 26/577 26/578 26/579 26/580 26/581 26/582 26/583 26/584 26/585 26/586 26/587 26/588 26/589 26/590 26/591 26/592 26/593 26/594 26/595 26/596 26/597 26/598 26/599 26/600 26/601 26/602 26/603 26/604 26/605 26/606 26/607 26/608 26/609 26/610 26/611 26/612 26/613 26/614 26/615 26/616 26/617 26/618 26/619 26/620 26/621 26/622 26/623 26/624 26/625 26/626 26/627 26/628 26/629 26/630 26/631 26/632 26/633 26/634 26/635 26/636 26/637 26/638 26/639 26/640 26/641 26/642 26/643 26/644 26/645 26/646 26/647 26/648 26/649 26/650 26/651 26/652 26/653 26/654 26/655 26/656 26/657 26/658 26/659 26/660 26/661 26/662 26/663 26/664 26/665 26/666 26/667 26/668 26/669 26/670 26/671 26/672 26/673 26/674 26/675 26/676 26/677 26/678 26/679 26/680 26/681 26/682 26/683 26/684 26/685 26/686 26/687 26/688 26/689 26/690 26/691 26/692 26/693 26/694 26/695 26/696 26/697 26/698 26/699 26/700 26/701 26/702 26/703 26/704 26/705 26/706 26/707 26/708 26/709 26/710 26/711 26/712 26/713 26/714 26/715 26/716 26/717 26/718 26/719 26/720 26/721 26/722 26/723 26/724 26/725 26/726 26/727 26/728 26/729 26/730 26/731 26/732 26/733 26/734 26/735 26/736 26/737 26/738 26/739 26/740 26/741 26/742 26/743 26/744 26/745 26/746 26/747 26/748 26/749 26/750 26/751 26/752 26/753 26/754 26/755 26/756 26/757 26/758 26/759 26/760 26/761 26/762 26/763 26/764 26/765 26/766 26/767 26/768 26/769 26/770 26/771 26/772 26/773 26/774 26/775 26/776 26/777 26/778 26/779 26/780 26/781 26/782 26/783 26/784 26/785 26/786 26/787 26/788 26/789 26/790 26/791 26/792 26/793 26/794 26/795 26/796 26/797 26/798 26/799 26/800 26/801 26/802 26/803 26/804 26/805 26/806 26/807 26/808 26/809 26/810 26/811 26/812 26/813 26/814 26/815 26/816 26/817 26/818 26/819 26/820 26/821 26/822 26/823 26/824 26/825 26/826 26/827 26/828 26/829 26/830 26/831 26/832 26/833 26/834 26/835 26/836 26/837 26/838 26/839 26/840 26/841 26/842 26/843 26/844 26/845 26/846 26/847 26/848 26/849 26/850 26/851 26/852 26/853 26/854 26/855 26/856 26/857 26/858 26/859 26/860 26/861 26/862 26/863 26/864 26/865 26/866 26/867 26/868 26/869 26/870 26/871 26/872 26/873 26/874 26/875 26/876 26/877 26/878 26/879 26/880 26/881 26/882 26/883 26/884 26/885 26/886 26/887 26/888 26/889 26/890 26/891 26/892 26/893 26/894 26/895 26/896 26/897 26/898 26/899 26/900 26/901 26/902 26/903 26/904 26/905 26/906 26/907 26/908 26/909 26/910 26/911 26/912 26/913 26/914 26/915 26/916 26/917 26/918 26/919 26/920 26/921 26/922 26/923 26/924 26/925 26/926 26/927 26/928 26/929 26/930 26/931 26/932 26/933 26/934 26/935 26/936 26/937 26/938 26/939 26/940 26/941 26/942 26/943 26/944 26/945 26/946 26/947 26/948 26/949 26/950 26/951 26/952 26/953 26/954 26/955 26/956 26/957 26/958 26/959 26/960 26/961 26/962 26/963 26/964 26/965 26/966 26/967 26/968 26/969 26/970 26/971 26/972 26/973 26/974 26/975 26/976 26/977 26/978 26/979 26/980 26/981 26/982 26/983 26/984 26/985 26/986 26/987 26/988 26/989 26/990 26/991 26/992 26/993 26/994 26/995 26/996 26/997 26/998 26/999 26/1000	<b>bear [4]</b> 23/12 27/1 38/23 59/25 <b>beards [1]</b> 107/18 <b>became [5]</b> 37/8 37/12 42/7 77/20 151/17 <b>because [49]</b> 3/19 11/6 14/2 16/4 19/15 25/5 25/21 36/11 46/16 49/18 50/3 59/3 62/6 64/13 70/23 72/8 75/13 79/1 79/3 80/9 80/23 80/24 82/25 87/23 90/4 97/4 99/13 103/6 103/22 104/5 104/17 108/1 110/3 113/13 117/24 120/9 124/10 128/4 132/6 132/8 132/23 134/13 141/13 143/24 144/9 150/25 151/16 164/10 165/24 <b>become [2]</b> 42/14 47/2 <b>becoming [1]</b> 19/12 <b>bed [4]</b> 155/10 155/16 155/23 167/20 <b>beds [1]</b> 156/2 <b>been [98]</b> 7/16 13/25 16/7 16/7 17/4 20/23 25/11 28/11 28/23 31/15 36/16 36/21 37/3 37/11 38/13 38/14 38/15 38/15 39/13 40/14 41/16 43/14 45/18 48/2 48/6 48/9 48/10 50/1 51/12 52/19 53/25 55/1 55/9 61/11 63/22 64/9 74/2	<b>before [35]</b> 14/5 21/15 23/8 32/12 32/22 39/16 44/4 53/18 54/21 54/25 56/14 57/18 64/2 65/13 68/4 68/19 70/6 78/2 81/18 82/2 82/11 84/15 88/23 89/2 98/4 100

<b>B</b>	45/25 46/1 46/11 46/18 47/18 47/25 49/3 49/17 49/22 50/5 50/18 51/11 51/18 53/13 54/20 57/7 59/6 61/11 61/21 63/11 63/23 66/3 66/4 66/17 67/6 69/2 69/19 70/24 73/7 73/23 74/12 74/22 75/20 75/25 76/24 78/24 80/14 82/12 82/24 84/7 85/24 86/11 87/10 87/11 88/3 88/10 89/4 89/13 90/8 91/5 93/2 93/5 93/11 95/9 95/15 97/5 101/25 102/8 102/21 104/13 104/19 105/7 106/18 106/23 108/9 109/8 109/13 109/16 112/1 112/8 112/21 115/4 118/12 118/16 118/20 119/5 119/16 122/3 122/14 123/9 123/21 124/11 124/18 125/13 126/3 126/11 137/15 142/8 142/20 143/3 144/11 144/12 145/16 148/3 152/6 152/8 152/24 153/9 157/13 159/5 160/9 163/3 163/10 163/25 164/4 165/21 166/7 168/3 169/2 169/24 170/8 <b>buy [2]</b> 52/10 106/22	153/3 153/13 153/23 154/7 154/20 154/21 <b>came [16]</b> 29/11 29/16 33/16 36/14 39/12 45/8 46/19 50/2 74/22 82/4 100/19 100/20 123/15 134/20 150/25 158/3 <b>cameras [1]</b> 22/24 <b>Cameron [1]</b> 46/15 <b>campaign [7]</b> 76/19 163/8 163/9 163/24 163/25 165/1 165/1 <b>campaigned [3]</b> 64/19 69/15 81/21 <b>campaigning [1]</b> 66/5 <b>campaigns [1]</b> 63/17 <b>can [106]</b> 3/3 3/12 3/16 3/16 4/24 18/3 18/12 19/16 23/24 25/19 25/21 26/8 28/2 35/7 40/17 42/2 43/21 44/4 44/12 45/16 45/25 46/1 47/1 47/10 47/25 48/17 49/2 49/10 51/6 52/20 54/20 64/21 66/17 69/25 70/5 70/23 72/7 73/18 77/8 77/24 78/1 78/5 78/12 80/8 80/14 82/24 83/10 83/11 84/3 86/19 86/25 87/10 87/11 88/7 91/1 91/8 91/12 92/19 93/8 93/11 95/12 95/20 97/10 99/25 103/6 106/3 106/17 108/11 108/25 111/17 112/1 112/17 114/3 114/12 121/17 122/7 122/19 123/3 123/6 123/7 124/22 126/12 131/18 132/4 134/8 134/17 135/7 136/14 140/8 140/23 144/5 144/16 147/4 147/4 147/18 148/16 149/18 151/23 152/1 156/14 160/4 160/14 161/2 161/7 167/16 169/10 <b>can't [8]</b> 22/19 25/4 25/19 98/12 98/12 104/8 104/17 168/25 <b>cancelled [1]</b> 143/19 <b>cancelling [1]</b> 165/19 <b>cannot [3]</b> 25/18 143/5 151/4 <b>capacity [1]</b> 89/25 <b>caps [1]</b> 123/15 <b>care [52]</b> 7/15 20/10 20/13 20/20 20/22 21/2 21/4 21/9 22/4 29/25 51/25 58/12	64/8 68/20 81/14 82/14 83/2 83/4 83/14 84/1 88/4 89/23 90/15 98/10 98/17 100/21 106/8 114/18 119/20 120/13 121/15 127/17 127/21 127/23 127/24 128/2 128/2 129/24 130/3 130/4 130/12 131/21 132/9 133/21 133/25 136/16 136/22 137/5 137/8 137/21 138/6 141/3 <b>care home [1]</b> 83/4 <b>care homes [1]</b> 68/20 <b>care sector [2]</b> 82/14 83/2 <b>career [1]</b> 105/12 <b>caregiving [1]</b> 119/12 <b>carers [1]</b> 133/25 <b>caring [2]</b> 132/20 133/15 <b>Carlton [1]</b> 1/11 <b>carried [2]</b> 100/7 100/10 <b>carry [2]</b> 59/13 93/18 <b>case [3]</b> 14/19 38/14 52/19 <b>caseloads [1]</b> 149/5 <b>cases [3]</b> 157/23 157/25 158/12 <b>cast [1]</b> 87/10 <b>catch [1]</b> 16/3 <b>category [3]</b> 54/18 71/14 157/12 <b>caught [3]</b> 25/19 64/10 80/2 <b>caused [2]</b> 83/18 135/4 <b>Cecil [8]</b> 111/9 123/18 139/24 144/19 146/14 152/10 160/17 170/15 <b>central [1]</b> 5/1 <b>centre [1]</b> 102/7 <b>centres [1]</b> 95/2 <b>CEO [1]</b> 91/13 <b>certain [12]</b> 8/11 8/11 14/15 31/21 57/25 63/2 71/5 101/19 106/11 110/11 113/20 165/25 <b>certainly [13]</b> 16/14 28/10 42/10 44/14 48/9 71/22 106/4 106/23 125/24 163/4 163/16 167/22 168/3 <b>cetera [10]</b> 3/24 4/13 5/18 5/23 14/11 20/7 21/7 26/3 107/22 108/12 <b>chair [5]</b> 43/16 44/3 111/10 139/12 171/13	<b>challenge [2]</b> 32/25 57/1 <b>challenges [10]</b> 16/25 22/6 116/16 129/4 150/3 156/7 159/17 159/17 161/9 161/14 <b>challenging [1]</b> 120/15 <b>chance [3]</b> 151/21 153/17 158/2 <b>chances [1]</b> 135/3 <b>change [8]</b> 16/11 43/17 47/6 59/6 59/9 104/8 157/24 168/24 <b>changed [3]</b> 47/2 64/16 162/3 <b>changes [1]</b> 135/14 <b>chanting [1]</b> 84/18 <b>characteristics [1]</b> 122/17 <b>charging [3]</b> 127/21 127/25 128/4 <b>charities [1]</b> 28/12 <b>charity [2]</b> 136/2 147/20 <b>charting [1]</b> 6/17 <b>cheaper [1]</b> 47/20 <b>chief [7]</b> 91/13 96/21 99/6 99/14 101/16 102/22 103/9 <b>child [51]</b> 1/19 2/6 2/13 2/19 3/6 3/8 4/16 4/18 5/2 5/5 5/8 5/8 5/10 5/11 5/14 5/16 7/1 7/1 7/14 7/19 8/2 8/5 8/8 8/12 8/19 10/25 11/8 12/16 12/18 12/23 13/3 13/6 15/11 15/19 15/24 16/8 16/22 17/7 21/5 21/21 22/11 24/3 25/2 29/15 40/18 42/7 49/20 133/1 133/5 133/6 133/8 <b>child's [1]</b> 15/12 <b>childcare [9]</b> 128/19 132/10 132/10 132/17 132/19 133/14 133/18 133/18 137/25 <b>childhood [8]</b> 3/20 4/5 4/7 4/12 13/22 13/25 14/7 22/5 <b>children [218]</b> <b>children's [51]</b> 2/10 3/21 3/25 4/20 5/4 5/14 6/1 7/6 7/19 11/20 16/16 18/17 18/19 18/22 19/24 20/1 20/5 22/1 22/10 23/16 23/17 24/5 24/8 25/6 25/10 26/11 26/15 28/15 28/19 29/7 29/16 30/4 30/10
<b>brief [6]</b> 62/5 62/6 62/11 86/16 139/22 147/18 <b>briefing [1]</b> 50/13 <b>briefly [15]</b> 2/4 7/17 11/5 18/12 26/8 28/7 29/9 40/17 61/17 118/22 119/17 123/8 125/22 131/4 167/14 <b>bring [5]</b> 17/18 44/20 160/23 161/5 168/18 <b>bringing [2]</b> 66/25 138/25 <b>brings [2]</b> 63/13 132/19 <b>Britain [1]</b> 57/3 <b>British [8]</b> 57/20 79/13 91/2 101/7 103/7 106/1 142/11 144/8 <b>broad [6]</b> 52/2 117/9 131/20 147/25 161/10 165/20 <b>broadening [1]</b> 169/19 <b>broader [3]</b> 53/10 90/7 112/11 <b>broadly [1]</b> 118/16 <b>broke [1]</b> 28/18 <b>broken [1]</b> 32/16 <b>brought [7]</b> 55/1 65/12 118/19 118/25 160/15 164/18 165/8 <b>budget [2]</b> 46/12 72/22 <b>build [1]</b> 43/18 <b>building [3]</b> 24/21 24/24 116/14 <b>buildings [1]</b> 44/18 <b>bullet [9]</b> 65/21 66/4 70/9 71/18 71/22 72/22 73/7 74/7 80/15 <b>bullied [1]</b> 105/4 <b>burden [4]</b> 114/16 114/18 132/9 133/17 <b>bus [1]</b> 67/11 <b>business [4]</b> 67/1 68/12 77/2 170/8 <b>busy [1]</b> 79/19 <b>but [153]</b> 2/23 4/8 6/12 8/3 8/15 9/1 11/12 11/23 13/17 14/3 14/19 15/2 16/1 16/22 18/8 19/22 20/24 22/21 23/9 25/11 25/15 25/23 26/8 29/8 30/17 31/9 33/10 33/16 33/24 34/6 36/1 36/4 36/25 37/8 37/11 38/25 41/17 42/19 42/25 44/16 45/1 45/19	<b>C</b> <b>Cabinet [5]</b> 43/11 121/3 121/4 161/11 165/5 <b>Cabinet Office [2]</b> 121/3 121/4 <b>calculation [1]</b> 41/11 <b>call [20]</b> 1/5 27/6 54/17 67/12 69/25 70/13 70/13 70/17 74/8 78/15 78/24 111/10 146/15 153/4 153/17 153/25 159/22 159/24 159/25 160/24 <b>called [15]</b> 46/15 56/4 62/23 63/13 67/11 67/15 67/20 68/10 71/11 73/20 93/10 98/5 150/17 151/25 163/14 <b>calling [6]</b> 72/8 72/13 73/8 73/11 75/20 92/14 <b>calls [16]</b> 36/25 39/22 66/24 150/12 150/14 151/9 151/24 152/2 152/18 152/25	<b>can [106]</b> 3/3 3/12 3/16 3/16 4/24 18/3 18/12 19/16 23/24 25/19 25/21 26/8 28/2 35/7 40/17 42/2 43/21 44/4 44/12 45/16 45/25 46/1 47/1 47/10 47/25 48/17 49/2 49/10 51/6 52/20 54/20 64/21 66/17 69/25 70/5 70/23 72/7 73/18 77/8 77/24 78/1 78/5 78/12 80/8 80/14 82/24 83/10 83/11 84/3 86/19 86/25 87/10 87/11 88/7 91/1 91/8 91/12 92/19 93/8 93/11 95/12 95/20 97/10 99/25 103/6 106/3 106/17 108/11 108/25 111/17 112/1 112/17 114/3 114/12 121/17 122/7 122/19 123/3 123/6 123/7 124/22 126/12 131/18 132/4 134/8 134/17 135/7 136/14 140/8 140/23 144/5 144/16 147/4 147/4 147/18 148/16 149/18 151/23 152/1 156/14 160/4 160/14 161/2 161/7 167/16 169/10 <b>can't [8]</b> 22/19 25/4 25/19 98/12 98/12 104/8 104/17 168/25 <b>cancelled [1]</b> 143/19 <b>cancelling [1]</b> 165/19 <b>cannot [3]</b> 25/18 143/5 151/4 <b>capacity [1]</b> 89/25 <b>caps [1]</b> 123/15 <b>care [52]</b> 7/15 20/10 20/13 20/20 20/22 21/2 21/4 21/9 22/4 29/25 51/25 58/12		
			<b>(48) brief - children's</b>	



<b>C</b>			
<b>children's... [18]</b> 33/3 34/3 37/23 38/16 40/14 43/11 45/22 45/23 46/8 47/17 48/10 49/21 49/24 50/9 51/19 52/17 52/22 53/14	<b>climbed [1]</b> 36/14 <b>Climbié [1]</b> 29/13 <b>clinical [7]</b> 16/4 126/7 126/11 126/12 126/14 131/19 132/2	28/15 28/19 29/7 29/16 33/3 40/15 42/8 48/10 49/21 50/9 161/17	<b>comprises [1]</b> 62/14 <b>comprising [1]</b> 86/23 <b>computer [2]</b> 9/18 9/24
<b>Children's</b> <b>Commissioner [2]</b> 48/10 50/9	<b>close [11]</b> 21/15 37/11 48/13 48/21 48/21 53/7 57/17 84/1 119/10 128/16 138/1	<b>Commissioner for [4]</b> 28/15 29/7 33/3 40/15	<b>computers [1]</b> 10/1 <b>concentration [1]</b> 9/1 <b>concept [1]</b> 47/7 <b>concern [21]</b> 14/1 14/13 20/19 21/20 22/9 38/5 38/24 56/20 63/14 73/14 80/5 83/6 92/21 94/23 95/12 103/3 105/21 120/17 162/7 162/10 168/7
<b>Children's</b> <b>Commissioners [1]</b> 49/24	<b>closed [7]</b> 36/4 37/4 37/6 37/19 49/14 49/14 119/5	<b>Commissioners [1]</b> 49/24	<b>concerned [5]</b> 33/4 34/9 62/21 65/10 165/2
<b>choice [2]</b> 132/5 132/13	<b>closely [2]</b> 63/11 63/12	<b>commitment [2]</b> 30/25 116/1	<b>concerns [17]</b> 16/1 31/8 33/7 39/6 49/15 65/9 66/13 74/12 79/20 81/4 84/14 94/25 95/7 95/9 105/5 106/4 108/8
<b>cholera [1]</b> 117/6	<b>closure [4]</b> 34/10 36/3 37/7 119/2	<b>Committee [1]</b> 108/17	<b>concerted [1]</b> 54/1
<b>chose [1]</b> 41/19	<b>closures [1]</b> 159/9	<b>common [2]</b> 17/9 63/14	<b>concession [1]</b> 166/1
<b>Chris [3]</b> 91/13 93/11 102/21	<b>clubs [1]</b> 53/13	<b>commonality [1]</b> 51/15	<b>concludes [2]</b> 54/8 170/14
<b>Chris Whitty [3]</b> 91/13 93/11 102/21	<b>clustering [1]</b> 5/25	<b>commonalties [1]</b> 49/13	<b>conclusions [1]</b> 78/19
<b>circulation [1]</b> 102/24	<b>clusters [1]</b> 90/2	<b>commonly [1]</b> 58/5	<b>conclusively [1]</b> 125/9
<b>circumstances [6]</b> 4/15 4/17 4/23 4/25 7/9 19/24	<b>coalescing [1]</b> 88/19	<b>communication [2]</b> 164/2 164/5	<b>condition [3]</b> 58/8 143/5 165/20
<b>cite [1]</b> 9/16	<b>cognitive [1]</b> 19/25	<b>communities [6]</b> 31/1 35/17 72/6 92/22 96/17 134/4	<b>conditions [16]</b> 4/20 5/2 5/17 7/8 14/21 64/16 84/16 103/15 105/5 125/8 126/9 126/17 126/20 127/4 159/1 159/15
<b>cited [1]</b> 56/9	<b>coin [1]</b> 166/4	<b>community [2]</b> 148/5 149/4	<b>conductive [1]</b> 159/1
<b>citizen [1]</b> 142/11	<b>coinciding [1]</b> 150/23	<b>community-based [1]</b> 148/5	<b>confidence [1]</b> 67/16
<b>citizens [1]</b> 144/8	<b>collate [1]</b> 97/2	<b>comorbidities [1]</b> 94/23	<b>confident [1]</b> 77/6
<b>city [1]</b> 3/6	<b>colleague's [1]</b> 60/2	<b>comorbidity [1]</b> 14/10	<b>confirm [2]</b> 28/2 112/1
<b>civil [1]</b> 77/7	<b>colleagues [7]</b> 59/15 59/17 59/21 79/5 104/4 106/1 106/8	<b>companies [1]</b> 131/6	<b>confirms [1]</b> 111/23
<b>claim [4]</b> 56/11 70/20 142/6 143/5	<b>collected [4]</b> 19/15 57/9 97/4 98/12	<b>comparable [1]</b> 25/14	<b>confusing [1]</b> 99/18
<b>clapping [1]</b> 84/2	<b>collecting [2]</b> 96/20 98/8	<b>compare [2]</b> 25/5 76/10	<b>Congo [2]</b> 117/5 117/14
<b>claps [2]</b> 84/16 84/17	<b>collection [1]</b> 97/23	<b>compared [13]</b> 12/7 14/25 15/15 19/18 23/22 81/18 108/19 125/6 130/13 132/2 132/14 154/11 158/19	<b>congregate [1]</b> 87/22
<b>Clare [3]</b> 111/10 111/11 172/5	<b>College [1]</b> 81/2	<b>comparisons [1]</b> 163/21	<b>Congress [1]</b> 63/6
<b>clarify [1]</b> 65/17	<b>Collins [1]</b> 47/14	<b>compassion [1]</b> 80/1	<b>connect [1]</b> 151/15
<b>clarity [2]</b> 84/13 127/2	<b>colour [1]</b> 104/7	<b>compensation [1]</b> 69/21	<b>connected [1]</b> 118/20
<b>class [1]</b> 44/9	<b>combination [1]</b> 128/11	<b>completely [5]</b> 10/14 25/4 25/12 132/14 136/20	<b>connection [1]</b> 134/13
<b>classroom [2]</b> 33/22 66/12	<b>combine [1]</b> 88/13	<b>complex [1]</b> 114/8	<b>conscious [1]</b> 51/11
<b>cleaner [1]</b> 56/10	<b>combined [2]</b> 134/14 140/4	<b>complexity [2]</b> 33/19 157/24	<b>consequence [6]</b> 3/15 117/1 126/23 136/8 146/22 155/11
<b>cleaners [1]</b> 56/24	<b>come [15]</b> 35/22 59/22 66/16 68/2 68/16 70/22 73/22 84/4 87/4 87/17 88/24 89/14 94/4 105/12 105/15	<b>compliance [1]</b> 1/22	<b>consequences [4]</b> 12/14 97/23 98/1 128/13
<b>clear [22]</b> 21/20 37/8 37/12 39/13 43/10 43/15 49/4 67/18 76/14 81/4 83/20 89/15 89/19 89/22 93/1 106/21 125/24 141/14 157/14 166/8 166/8 169/16	<b>coming [8]</b> 19/10 45/7 99/9 99/25 142/1 149/24 158/1 163/3	<b>complicated [3]</b> 11/11 76/1 156/4	<b>consider [8]</b> 2/18
<b>clearer [1]</b> 67/6	<b>comment [6]</b> 53/14 97/18 140/8 142/18 144/12 145/12	<b>complications [1]</b> 117/19	
<b>clearly [10]</b> 13/10 16/1 22/1 31/14 37/7 49/5 66/2 67/6 78/22 100/23	<b>commented [1]</b> 52/16	<b>comprehensive [1]</b>	
<b>client [2]</b> 148/23 156/22	<b>comments [3]</b> 40/19 120/22 138/11		
<b>clients [1]</b> 160/24	<b>Commission [1]</b> 127/17		
	<b>commissioner [11]</b>		

<p><b>C</b></p> <p><b>cooker [1]</b> 158/11</p> <p><b>Copenhagen [1]</b> 2/6</p> <p><b>core [4]</b> 21/16 52/16 85/3 125/23</p> <p><b>core participants [1]</b> 21/16</p> <p><b>corner [1]</b> 3/9</p> <p><b>coronavirus [2]</b> 73/6 79/3</p> <p><b>correct [48]</b> 1/25 2/1 2/15 6/15 6/16 6/22 6/23 7/23 8/6 8/12 8/13 8/25 9/19 9/21 9/22 10/5 10/6 13/2 15/7 17/1 21/14 40/10 40/11 61/24 64/6 70/4 98/21 111/15 111/16 112/12 115/12 124/23 125/20 125/21 125/25 126/1 127/5 127/20 129/4 129/25 131/10 136/3 147/2 147/10 147/13 149/25 154/21 156/2</p> <p><b>correlation [1]</b> 118/2</p> <p><b>Correspondence [1]</b> 65/3</p> <p><b>cost [3]</b> 41/16 74/9 132/17</p> <p><b>costly [1]</b> 26/3</p> <p><b>costs [8]</b> 6/11 8/24 55/23 74/6 74/16 128/17 140/20 140/21</p> <p><b>could [69]</b> 1/5 1/9 2/16 11/5 22/23 23/1 23/2 27/6 27/11 27/16 27/20 29/9 30/16 31/13 37/14 41/5 44/8 44/19 44/19 44/21 46/5 50/9 55/23 60/15 61/6 67/15 73/21 74/3 74/12 79/10 84/8 85/17 97/2 98/24 104/7 109/4 109/5 124/6 136/23 136/23 137/9 137/14 137/16 138/2 138/4 139/2 139/2 140/9 146/18 148/22 148/23 156/23 156/25 157/2 158/4 159/6 159/13 159/25 160/2 161/16 163/13 163/19 165/17 165/18 165/21 165/23 165/25 166/1 170/8</p> <p><b>couldn't [5]</b> 41/6 41/13 41/13 56/13 59/25</p> <p><b>council [3]</b> 63/13 120/1 156/25</p> <p><b>councils [1]</b> 145/2</p> <p><b>COUNSEL [12]</b> 1/7</p>	<p>27/8 60/14 85/16 111/12 146/17 171/5 171/11 171/23 172/3 172/7 172/13</p> <p><b>counselling [2]</b> 136/2 149/7</p> <p><b>counterparts [5]</b> 90/1 95/10 114/23 125/16 127/16</p> <p><b>countries [7]</b> 8/11 19/20 44/16 50/15 120/6 151/3 169/14</p> <p><b>country [17]</b> 4/11 5/13 11/17 16/25 41/9 41/19 43/7 57/19 87/19 101/22 102/10 102/25 106/25 113/6 120/8 128/22 132/11</p> <p><b>counts [1]</b> 49/1</p> <p><b>couple [8]</b> 45/12 45/19 63/20 90/21 91/10 102/16 103/5 109/12</p> <p><b>couriers [2]</b> 57/4 57/8</p> <p><b>course [44]</b> 3/21 4/1 14/11 18/16 20/17 25/7 32/1 32/25 35/22 35/25 46/24 49/1 49/12 49/16 51/8 52/4 53/3 54/7 57/18 61/3 62/7 62/9 63/20 63/24 63/25 66/15 67/22 68/6 68/17 69/22 75/16 75/23 84/14 87/2 104/23 115/4 119/16 120/22 122/14 126/14 129/13 136/6 139/7 169/1</p> <p><b>cover [8]</b> 2/22 55/22 59/5 62/10 74/9 77/19 78/6 161/7</p> <p><b>coverage [1]</b> 72/15</p> <p><b>covered [6]</b> 45/12 45/18 47/22 66/3 105/17 129/13</p> <p><b>covers [2]</b> 103/2 115/11</p> <p><b>Covid [34]</b> 30/23 31/18 34/3 42/4 42/5 42/6 47/5 56/10 57/6 58/2 58/11 58/20 59/2 59/21 60/3 63/21 63/24 64/3 64/10 64/12 79/15 79/18 79/24 80/3 80/24 81/12 82/2 82/3 83/5 103/25 107/22 109/17 164/18 166/13</p> <p><b>Covid Inquiry [1]</b> 82/2</p> <p><b>Covid-19 [7]</b> 56/10 57/6 58/2 58/11 81/12 164/18 166/13</p>	<p><b>cramped [2]</b> 32/7 40/20</p> <p><b>crash [1]</b> 144/23</p> <p><b>create [1]</b> 95/6</p> <p><b>created [3]</b> 113/14 145/2 159/13</p> <p><b>creates [5]</b> 95/11 98/8 101/18 107/2 135/6</p> <p><b>creative [1]</b> 45/3</p> <p><b>Credit [1]</b> 123/15</p> <p><b>cried [1]</b> 60/1</p> <p><b>crime [2]</b> 135/11 140/2</p> <p><b>crimes [1]</b> 101/11</p> <p><b>criminalisation [1]</b> 129/6</p> <p><b>crises [4]</b> 117/2 117/11 118/15 118/16</p> <p><b>crisis [19]</b> 15/20 15/25 20/21 22/3 30/23 32/20 32/22 39/8 46/25 81/18 118/9 118/10 118/18 118/20 120/12 134/12 135/23 136/2 140/3</p> <p><b>criteria [1]</b> 157/17</p> <p><b>critical [5]</b> 14/12 25/5 26/5 37/3 120/3</p> <p><b>cross [1]</b> 51/15</p> <p><b>cross-section [1]</b> 51/15</p> <p><b>cultural [2]</b> 113/6 113/21</p> <p><b>culturally [1]</b> 107/16</p> <p><b>culture [3]</b> 98/9 101/6 101/18</p> <p><b>cupboard [1]</b> 47/9</p> <p><b>current [1]</b> 53/17</p> <p><b>currently [3]</b> 70/25 71/1 74/9</p> <p><b>cut [2]</b> 121/16 144/25</p> <p><b>cutbacks [1]</b> 21/5</p> <p><b>cuts [10]</b> 22/12 121/11 121/13 121/21 122/11 122/20 123/8 123/12 135/6 135/13</p> <p><b>cutting [1]</b> 163/11</p> <p><b>cycle [1]</b> 110/14</p>	<p>97/23 97/24 98/5 98/8 98/24 115/13 115/14 115/15 116/7 116/8 126/1 126/4 126/18 129/19 133/7</p> <p><b>date [2]</b> 70/5 76/19</p> <p><b>dated [10]</b> 1/19 27/23 61/5 61/20 86/8 90/24 102/16 108/22 111/17 147/6</p> <p><b>dates [1]</b> 78/6</p> <p><b>daughter [1]</b> 60/3</p> <p><b>DAVID [4]</b> 1/6 1/11 46/15 171/3</p> <p><b>David Cameron [1]</b> 46/15</p> <p><b>Davies [5]</b> 139/13 139/16 139/17 145/21 172/9</p> <p><b>day [12]</b> 35/3 35/23 59/15 59/24 70/15 72/15 72/18 72/21 73/3 73/5 90/14 96/11</p> <p><b>day one [1]</b> 70/15</p> <p><b>days [14]</b> 25/11 57/18 60/1 63/21 69/16 72/12 72/20 83/3 91/9 91/23 92/25 93/5 106/5 133/6</p> <p><b>DDVC [2]</b> 165/22 169/19</p> <p><b>de [1]</b> 59/10</p> <p><b>de-gloving [1]</b> 59/10</p> <p><b>deal [15]</b> 18/10 20/8 20/10 40/12 62/8 89/17 89/19 94/11 94/12 111/19 112/13 113/17 138/10 141/4 144/18</p> <p><b>dealing [11]</b> 2/4 16/5 26/23 28/23 29/1 83/5 115/4 115/10 127/11 128/6 128/9</p> <p><b>deals [1]</b> 139/8</p> <p><b>dealt [5]</b> 11/4 16/19 94/5 123/8 164/12</p> <p><b>death [2]</b> 29/12 56/15</p> <p><b>deaths [2]</b> 59/5 94/1</p> <p><b>debate [1]</b> 42/19</p> <p><b>debunked [1]</b> 104/13</p> <p><b>decades [1]</b> 28/12</p> <p><b>December [1]</b> 155/23</p> <p><b>decent [1]</b> 170/17</p> <p><b>decision [18]</b> 29/20 30/8 37/3 41/10 44/17 45/8 50/1 50/4 52/18 52/25 53/6 53/15 88/25 90/17 137/23 139/7 141/24 150/24</p> <p><b>decision-makers [4]</b> 29/20 52/18 88/25 90/17</p> <p><b>decision-making [5]</b> 52/25 53/6 53/15</p>	<p>137/23 139/7</p> <p><b>decisions [14]</b> 30/9 30/14 30/20 30/21 42/20 43/12 46/6 46/14 46/19 50/3 51/22 52/14 53/6 57/21</p> <p><b>declaration [2]</b> 1/22 147/9</p> <p><b>decrease [4]</b> 8/8 8/8 149/14 155/5</p> <p><b>decreased [4]</b> 7/21 145/7 151/10 154/22</p> <p><b>dedication [3]</b> 30/25 36/5 153/10</p> <p><b>deep [1]</b> 99/4</p> <p><b>deficiency [1]</b> 103/21</p> <p><b>define [2]</b> 107/10 112/25</p> <p><b>definitely [6]</b> 101/5 101/5 156/24 158/1 158/9 166/7</p> <p><b>delay [6]</b> 100/18 100/19 101/1 101/24 101/25 102/9</p> <p><b>Delays [1]</b> 58/12</p> <p><b>demand [12]</b> 145/11 145/14 145/17 148/25 153/1 153/2 154/5 154/25 155/4 155/12 167/24 168/8</p> <p><b>Democratic [2]</b> 117/5 117/13</p> <p><b>demographic [1]</b> 122/24</p> <p><b>demonstrate [1]</b> 116/8</p> <p><b>demonstrated [1]</b> 50/8</p> <p><b>demonstrating [1]</b> 114/25</p> <p><b>denied [1]</b> 79/6</p> <p><b>department [3]</b> 60/24 85/24 110/6</p> <p><b>departments [1]</b> 165/7</p> <p><b>dependent [1]</b> 143/6</p> <p><b>depending [1]</b> 124/16</p> <p><b>deployment [1]</b> 99/17</p> <p><b>deprived [7]</b> 6/14 6/21 17/23 17/25 18/4 21/12 127/19</p> <p><b>descending [1]</b> 62/22</p> <p><b>describe [28]</b> 5/7 9/4 12/24 18/1 30/22 38/8 56/5 63/1 72/11 77/20 78/15 80/2 80/5 86/20 92/1 126/8 126/23 128/11 130/6 135/12 148/18 151/9 151/13 152/15 155/1 164/13 165/10 168/13</p>
--	---	--	--	---

<b>D</b>	76/7 76/10 76/19 79/25 86/1 100/9 106/24 108/8 110/9 117/20 148/14 151/14 153/12 155/5 156/22 158/6 158/16 159/24 161/5 161/22 161/24 162/4 162/4 163/7 164/23	13/9 16/10 32/9 34/16 34/20 35/12 52/12 <b>dimension [1]</b> 9/15 <b>dimensions [1]</b> 9/4 <b>direct [1]</b> 118/2 <b>directing [1]</b> 99/5 <b>direction [1]</b> 94/18 <b>directive [1]</b> 100/20 <b>directives [1]</b> 99/16 <b>directly [5]</b> 57/12 92/23 140/19 161/15 163/3 <b>directness [1]</b> 99/11 <b>director [1]</b> 131/1 <b>disabilities [2]</b> 12/8 52/1 <b>disability [4]</b> 12/2 12/21 13/23 58/7 <b>disabled [4]</b> 12/6 12/12 12/14 167/6 <b>disadvantage [4]</b> 12/11 43/6 46/24 48/8 <b>disadvantaged [16]</b> 7/13 10/2 14/18 14/25 15/16 16/17 17/10 18/8 19/18 20/25 21/1 21/25 33/1 34/12 35/13 35/14 <b>disadvantages [2]</b> 41/17 48/23 <b>disaggregate [1]</b> 118/17 <b>disaggregated [1]</b> 97/14 <b>disappear [1]</b> 29/13 <b>disappointed [1]</b> 92/10 <b>disappointing [1]</b> 111/1 <b>disaster [2]</b> 5/8 33/1 <b>disbelieved [1]</b> 160/8 <b>disciplinary [1]</b> 86/22 <b>disclose [1]</b> 157/4 <b>disclosed [1]</b> 157/3 <b>discover [1]</b> 76/7 <b>discretion [1]</b> 83/23 <b>discretionary [1]</b> 76/1 <b>discrimination [1]</b> 80/18 <b>discuss [3]</b> 63/14 67/1 67/22 <b>discussed [2]</b> 47/10 103/11 <b>discussion [1]</b> 91/23 <b>discussions [2]</b> 43/16 44/13 <b>disease [1]</b> 93/20 <b>disorder [2]</b> 15/15 59/17 <b>disorders [1]</b> 13/13 <b>disparate [1]</b> 65/21 <b>disparities [2]</b> 100/11 103/4	<b>disparity [1]</b> 46/8 <b>disproportionate [11]</b> 58/10 63/21 72/1 72/5 78/23 81/24 91/18 92/23 94/1 96/1 122/4 <b>disproportionately</b> <b>[5]</b> 105/22 119/3 133/20 133/21 137/11 <b>disregarded [1]</b> 80/20 <b>disruption [2]</b> 106/17 106/18 <b>distance [1]</b> 44/19 <b>distancing [1]</b> 65/14 <b>distribution [1]</b> 106/22 <b>diversion [2]</b> 117/14 118/3 <b>divide [2]</b> 10/4 35/12 <b>division [1]</b> 133/16 <b>do [68]</b> 1/8 1/17 3/16 3/16 15/2 16/22 23/23 34/20 34/23 36/21 41/20 44/19 47/1 48/1 50/13 54/25 63/11 64/14 68/5 77/8 79/5 79/6 79/8 79/9 79/11 80/15 82/25 84/13 89/17 94/12 95/16 96/13 96/16 96/20 100/22 103/9 109/7 112/25 113/18 115/17 115/20 116/16 118/12 123/5 126/2 130/8 130/16 133/15 134/25 137/25 138/7 138/17 138/19 142/9 144/15 145/22 146/5 148/9 154/9 159/9 160/2 160/5 160/24 162/14 164/15 164/23 166/2 166/17 <b>doctor [1]</b> 5/10 <b>doctors [14]</b> 58/4 58/7 88/11 94/3 94/3 94/13 94/20 95/18 100/15 103/17 108/18 108/20 131/19 132/2 <b>document [7]</b> 6/6 64/15 69/18 69/25 70/2 87/8 93/8 <b>documents [1]</b> 52/24 <b>does [12]</b> 11/8 73/14 84/4 91/16 108/22 112/19 114/12 133/22 137/5 142/11 152/24 170/4 <b>doesn't [3]</b> 110/2 110/11 112/22 <b>doing [8]</b> 27/19 67/19 90/14 96/24 97/7 99/20 99/20 153/6 <b>domestic [58]</b> 32/8	39/4 39/6 39/18 39/22 39/22 57/22 118/11 119/16 134/7 134/11 134/16 134/20 134/24 135/3 136/7 138/12 140/5 140/11 140/25 141/6 142/13 142/21 143/16 144/9 144/14 144/20 145/3 145/5 145/11 148/12 150/9 154/9 157/11 157/15 157/16 158/6 158/14 158/18 158/25 159/3 159/16 161/13 161/17 162/1 162/5 162/6 162/24 165/12 165/22 166/5 166/12 166/18 166/24 167/10 169/5 169/15 169/22 <b>Domestic Abuse Bill</b> <b>[1]</b> 134/20 <b>don't [51]</b> 4/7 6/12 15/7 24/1 25/4 26/1 26/17 36/15 41/1 48/12 48/14 61/11 62/10 71/2 71/12 71/12 73/22 84/17 85/1 85/2 89/20 94/11 97/24 97/25 98/9 98/13 98/17 99/1 100/6 107/22 108/10 112/7 113/5 123/4 123/5 126/18 133/10 133/11 138/13 138/20 141/16 143/22 143/23 144/11 145/23 146/23 161/1 164/3 167/8 167/13 167/22 <b>done [12]</b> 2/12 49/2 95/14 96/14 96/15 108/2 110/1 115/16 115/17 126/15 165/17 167/19 <b>double [2]</b> 14/23 14/24 <b>doubling [2]</b> 16/11 16/12 <b>doubt [3]</b> 63/11 64/11 129/13 <b>down [28]</b> 1/8 24/7 35/8 44/14 45/5 47/12 47/19 48/21 48/21 50/2 74/7 76/16 87/11 92/18 97/21 104/21 115/14 129/23 134/17 140/10 141/12 146/24 150/15 150/24 150/24 152/8 156/14 160/7 <b>download [1]</b> 34/19 <b>downstream [1]</b> 138/24 <b>downward [1]</b> 134/15 <b>downwards [2]</b>
----------	--	--	---	---

<b>D</b>	111/25	<b>eerily [1]</b> 151/10	93/14 93/18	34/22 93/15 158/11
<b>downwards... [2]</b> 134/25 139/25	<b>dwell [1]</b> 103/2	<b>effect [8]</b> 7/3 12/22 31/21 118/11 118/13 124/16 128/4 140/15	<b>employment [8]</b> 10/15 45/1 55/15 57/1 63/3 63/23 138/2 140/22	<b>environments [5]</b> 32/21 40/5 56/22 58/6 106/2
<b>Dr [12]</b> 93/10 111/10 111/11 111/13 114/2 118/23 123/4 134/17 139/19 145/19 145/24 172/5	<b>dying [5]</b> 4/11 7/12 59/3 78/9 83/5	<b>effective [3]</b> 36/9 162/25 164/1	<b>empted [1]</b> 163/19	<b>envisaged [1]</b> 96/4
<b>Dr Clare Wenham [1]</b> 111/10	<b>E</b>	<b>effectively [5]</b> 113/10 122/15 123/10 152/15 153/11	<b>empty [1]</b> 43/16	<b>epidemic [3]</b> 117/15 119/7 136/14
<b>Dr Mehta [1]</b> 93/10	<b>each [5]</b> 6/14 59/9 59/15 92/14 115/11	<b>effectiveness [1]</b> 69/10	<b>enable [1]</b> 70/19	<b>epidemics [7]</b> 13/25 112/11 116/20 117/1 118/15 140/13 140/15
<b>Dr Wenham [8]</b> 111/13 114/2 118/23 123/4 134/17 139/19 145/19 145/24	<b>earlier [6]</b> 90/13 103/5 108/6 136/13 139/25 167/19	<b>effects [6]</b> 12/25 42/13 53/22 118/19 138/24 140/13	<b>encourage [1]</b> 33/21	<b>epilepsy [1]</b> 16/21
<b>dramatic [2]</b> 13/18 13/21	<b>earliest [1]</b> 69/15	<b>effort [1]</b> 54/1	<b>encouraged [1]</b> 108/4	<b>Equalities [1]</b> 108/17
<b>dramatically [1]</b> 64/16	<b>early [46]</b> 3/19 4/2 5/3 5/18 9/16 16/15 18/25 19/3 20/4 24/5 24/7 24/9 25/12 25/18 25/25 46/22 48/3 57/6 57/17 67/11 72/10 72/10 83/3 91/9 91/17 91/23 92/25 93/5 103/23 106/5 120/21 129/24 130/3 130/12 131/19 131/21 132/1 151/11 154/16 157/6 157/21 158/17 158/20 161/24 169/3 169/25	<b>efforts [4]</b> 3/17 31/4 137/8 137/14	<b>endeavour [1]</b> 44/25	<b>equality [3]</b> 98/5 116/2 138/20
<b>draw [2]</b> 2/23 80/14	<b>earn [6]</b> 70/16 71/2 71/12 72/16 73/8 114/15	<b>eight [3]</b> 8/9 59/24 125/6	<b>ending [1]</b> 152/15	<b>equally [1]</b> 89/15
<b>drawing [4]</b> 12/15 21/15 31/11 42/22	<b>earned [1]</b> 71/5	<b>eight years [1]</b> 8/9	<b>energy [1]</b> 98/20	<b>equation [1]</b> 41/6
<b>drawn [2]</b> 62/17 78/19	<b>earning [3]</b> 74/2 131/23 133/11	<b>either [4]</b> 97/3 103/21 119/10 156/7	<b>enforcement [2]</b> 67/21 164/21	<b>equipment [3]</b> 52/10 57/9 79/7
<b>draws [2]</b> 15/10 91/16	<b>earnings [3]</b> 71/11 73/17 77/4	<b>elaborate [1]</b> 126/12	<b>engage [1]</b> 66/23	<b>equivalent [1]</b> 73/13
<b>DRC [1]</b> 117/22	<b>ears [1]</b> 30/18	<b>elderly [3]</b> 63/22 63/25 134/1	<b>engaged [2]</b> 64/25 134/2	<b>escalation [1]</b> 145/10
<b>dreadful [1]</b> 29/12	<b>easiest [1]</b> 20/15	<b>element [3]</b> 35/2 101/5 166/7	<b>engagement [8]</b> 51/21 65/5 66/19 67/4 68/11 68/12 119/21 127/8	<b>especially [4]</b> 38/24 43/22 49/25 50/14
<b>driven [1]</b> 21/4	<b>easily [1]</b> 32/14	<b>eligibility [1]</b> 141/13	<b>engaging [2]</b> 65/1 122/2	<b>essential [1]</b> 53/12
<b>drivers [1]</b> 132/15	<b>easy [1]</b> 113/15	<b>eligible [3]</b> 19/17 70/10 74/9	<b>engineering [1]</b> 130/22	<b>essentially [6]</b> 40/5 97/24 120/7 150/23 151/6 153/20
<b>driving [1]</b> 153/22	<b>Eat [2]</b> 37/21 76/12	<b>eliminate [1]</b> 89/10	<b>England [26]</b> 6/21 8/14 8/18 13/10 17/22 23/18 28/15 28/19 29/7 29/11 33/3 40/15 45/23 53/14 58/20 62/18 94/18 99/6 99/17 100/21 101/16 102/6 128/11 129/19 134/23 135/23	<b>established [3]</b> 52/6 93/5 147/21
<b>drop [2]</b> 73/19 152/22	<b>Ebola [9]</b> 117/4 117/12 117/20 117/21 117/25 118/8 118/25 120/1 136/16	<b>Elizabeth [1]</b> 27/12	<b>enquire [2]</b> 30/2 149/2	<b>establishments [1]</b> 157/21
<b>dropped [2]</b> 38/17 151/10	<b>eclectic [1]</b> 89/4	<b>eloquent [1]</b> 50/23	<b>enquiries [2]</b> 30/2 149/2	<b>estimate [1]</b> 39/14
<b>drove [1]</b> 46/23	<b>economic [10]</b> 4/15 4/17 4/19 7/7 12/23 14/14 19/24 55/14 118/22 120/13	<b>elsewhere [1]</b> 6/5	<b>enrolled [1]</b> 126/11	<b>estimated [1]</b> 134/22
<b>dual [1]</b> 164/16	<b>economics [2]</b> 60/24 112/10	<b>emails [1]</b> 37/1	<b>enshrined [1]</b> 24/2	<b>et [10]</b> 3/24 4/13 5/18 5/23 14/11 20/7 21/7 26/3 107/22 108/12
<b>duck [3]</b> 107/11 107/11 107/12	<b>economy [1]</b> 56/2	<b>emerge [2]</b> 20/2 52/2	<b>ensure [4]</b> 56/6 72/14 119/22 163/5	<b>et cetera [8]</b> 3/24 5/18 5/23 14/11 20/7 21/7 26/3 108/12
<b>due [11]</b> 8/24 51/23 65/15 113/3 115/4 119/16 122/14 136/6 141/23 153/10 156/10	<b>ecosystem [4]</b> 89/1 89/7 92/7 110/12	<b>emergencies [4]</b> 163/22 166/25 169/10 169/12	<b>ensures [1]</b> 119/21	<b>ethnic [29]</b> 11/14 11/18 12/21 12/23 58/4 58/6 67/9 79/4 86/4 87/5 87/14 87/21 89/6 94/22 95/15 98/6 98/18 99/18 100/12 100/14 101/3 101/15 102/12 104/6 105/21 106/7 106/19 107/5 122/23
<b>during [60]</b> 2/13 9/14 10/3 28/18 28/24 29/5 30/8 30/11 31/3 31/19 32/1 34/3 37/4 39/11 39/18 42/7 42/10 42/12 47/5 47/25 60/21 64/16 64/20 65/1 66/20 69/22 72/11 74/15 76/13 77/22 78/4 79/1 81/9 81/21 83/9 84/2 88/17 90/8 90/10 98/4 99/2 117/12 117/13 117/18 119/24 127/22 129/12 150/10 151/25 152/6 152/25 155/4 158/7 158/10 158/14 164/12 165/3 169/8 169/11 169/24	<b>editorial [1]</b> 15/24	<b>emergency [20]</b> 43/23 52/6 52/10 70/14 72/14 74/8 74/13 74/19 100/23 101/13 101/13 150/2 155/10 155/23 156/5 158/2 166/20 167/18 169/3 169/8	<b>enter [3]</b> 18/21 19/5 19/23	<b>ethnicity [12]</b> 11/4 11/8 11/10 58/17 79/1 79/24 92/22 97/14 97/15 97/16 103/14 125/11
<b>duty [3]</b> 1/22 29/17	<b>education [13]</b> 4/22 9/20 14/11 19/13 43/15 51/2 66/11 81/15 121/15 122/5 129/24 130/3 130/12	<b>emerging [1]</b> 158/7	<b>entering [6]</b> 7/15 20/20 20/22 21/4 21/8 21/9	<b>even [19]</b> 18/18 34/1 59/22 60/7 68/22 70/6 72/10 72/18 73/14 82/2 91/17 92/11 102/1 105/6 128/14 128/20 144/7 146/5 156/12
	<b>educational [5]</b> 2/21 4/13 18/10 18/14 18/24	<b>emotional [2]</b> 19/25 83/12	<b>entitled [9]</b> 71/8 72/18 72/19 73/15 73/24 80/11 111/14 112/14 150/5	<b>evenings [1]</b> 50/14
	<b>edrie [2]</b> 150/17 152/1	<b>employed [1]</b> 122/4	<b>entry [1]</b> 20/6	
		<b>employee [2]</b> 58/25 105/4	<b>environment [8]</b> 5/20 18/25 19/2 19/3 24/11	
		<b>employees [1]</b> 122/12		
		<b>employer [5]</b> 57/2 67/18 79/14 79/17 80/1		
		<b>employers [7]</b> 57/9 58/15 65/6 74/8 74/16		

<b>E</b>	162/20	5/19 5/22 43/4	87/14 116/4 116/23	<b>felt [6]</b> 34/2 37/10
<b>event [4]</b> 100/24	<b>exclusion [3]</b> 52/12	<b>exposing [2]</b> 56/19	142/20 147/25 166/6	44/24 66/18 136/21
118/18 119/7 123/25	72/4 165/14	105/10	<b>fairly [1]</b> 88/17	163/18
<b>events [4]</b> 118/9	<b>executive [1]</b> 99/6	<b>exposure [8]</b> 5/11	<b>falling [2]</b> 70/20	<b>female [1]</b> 126/25
118/10 120/12 136/14	<b>executives [3]</b> 99/15	5/15 5/22 6/1 58/1	133/21	<b>FEMHO [1]</b> 91/6
<b>ever [6]</b> 29/15 44/5	102/22 103/9	79/3 81/12 134/8	<b>falls [2]</b> 66/2 133/20	<b>feminised [3]</b> 131/16
69/20 73/9 105/7	<b>exempt [3]</b> 41/8	<b>exposures [1]</b> 5/25	<b>familiar [5]</b> 29/8 61/8	131/21 138/9
167/15	41/19 50/4	<b>expressed [4]</b> 79/20	70/2 83/1 86/11	<b>few [15]</b> 1/14 23/15
<b>every [6]</b> 11/22 18/24	<b>exemption [3]</b> 162/2	120/20 120/21 121/6	<b>families [31]</b> 4/23	25/13 27/16 32/4
77/6 153/4 155/2	162/9 163/6	<b>expressing [1]</b> 97/9	9/13 10/13 10/16	33/16 56/14 57/12
155/6	<b>exercise [2]</b> 41/1	<b>expression [1]</b> 135/1	10/23 10/23 10/23	72/12 78/8 82/15 94/9
<b>everyday [1]</b> 113/11	41/1	<b>extend [1]</b> 165/15	12/20 12/20 21/8	104/1 155/13 158/21
<b>everyone [3]</b> 91/3	<b>exhausting [1]</b> 96/11	<b>extended [1]</b> 165/24	34/12 34/15 34/21	<b>few weeks [1]</b>
159/14 169/12	<b>exhibits [1]</b> 28/21	<b>extensive [2]</b> 2/17	35/13 36/18 36/18	158/21
<b>Everyone In [1]</b>	<b>exist [4]</b> 112/22	28/22	36/19 36/20 36/24	<b>field [1]</b> 2/12
169/12	113/21 113/25 159/25	<b>extent [3]</b> 115/13	41/3 41/6 42/4 42/15	<b>fifth [3]</b> 15/13 71/20
<b>evidence [48]</b> 2/23	<b>existed [1]</b> 115/7	132/4 138/20	42/17 42/18 46/16	75/15
5/14 7/17 11/3 15/20	<b>existence [1]</b> 114/25	<b>extra [2]</b> 23/15	50/6 50/7 50/11 52/7	<b>figure [12]</b> 6/4 7/25
16/23 21/15 27/14	<b>existing [5]</b> 16/6 90/1	108/11	52/10	11/7 14/23 15/1 15/2
29/22 31/13 31/19	97/16 103/14 115/6	<b>extraordinary [1]</b>	<b>family [12]</b> 4/21	17/13 17/14 17/20
35/8 39/13 42/22	<b>exists [5]</b> 112/24	30/23	10/21 24/6 32/17	64/4 76/9 131/9
43/25 48/6 48/7 53/3	114/14 114/21 133/1	<b>extreme [1]</b> 32/12	32/19 39/8 39/15	<b>figure 1 [1]</b> 6/4
53/19 54/21 54/23	134/11	<b>extremely [1]</b> 110/23	46/16 59/14 83/7	<b>figure 2 [1]</b> 7/25
55/6 61/25 64/2 65/12	<b>expand [1]</b> 104/1	<b>eye [1]</b> 87/11	83/15 83/16	<b>figure 3 [1]</b> 11/7
65/23 66/16 78/15	<b>expanded [1]</b> 103/12	<b>eyed [1]</b> 85/12	<b>fantastic [1]</b> 44/25	<b>figure 9 [2]</b> 14/23
78/20 78/24 82/11	<b>expect [2]</b> 32/4 93/14	<b>eyes [1]</b> 30/18	<b>far [7]</b> 46/18 47/1	15/1
89/19 89/21 96/9	<b>expectancy [5]</b> 3/8	<b>F</b>	62/20 66/8 74/1 90/4	<b>figures [1]</b> 6/3
96/17 108/16 109/9	3/10 3/11 21/24 21/24	<b>face [13]</b> 3/23 22/6	110/23	<b>Filipino [2]</b> 96/7
110/18 116/7 125/1	<b>expectants [1]</b> 80/12	75/19 107/20 108/2	<b>fare [1]</b> 112/19	96/19
126/17 126/19 127/8	<b>expectation [1]</b>	119/9 119/9 142/22	<b>fatalistic [1]</b> 25/20	<b>filled [2]</b> 155/17
136/15 154/23 168/14	93/18	142/25 156/20 156/20	<b>fathers [1]</b> 81/17	155/18
168/14 170/14	<b>expected [1]</b> 102/3	156/25 156/25	<b>fault [3]</b> 23/5 114/6	<b>final [5]</b> 26/7 42/1
<b>evidenced [1]</b> 52/20	<b>experience [24]</b>	<b>faced [2]</b> 33/5 89/10	146/23	124/23 144/18 169/21
<b>evident [1]</b> 40/1	10/24 31/18 32/1 32/5	<b>faces [1]</b> 16/25	<b>fear [10]</b> 79/20	<b>Finally [4]</b> 49/7 53/19
<b>ex [1]</b> 44/21	34/3 37/2 37/24 46/3	<b>facet [1]</b> 160/3	105/10 105/14 143/15	58/22 94/2
<b>ex-teachers [1]</b>	58/25 83/2 83/6 99/1	<b>facets [1]</b> 156/17	143/18 143/18 143/20	<b>finance [2]</b> 130/22
44/21	100/7 100/7 105/9	<b>facilitate [2]</b> 105/23	143/24 144/3 144/9	135/17
<b>exacerbates [1]</b>	109/20 134/24 160/7	134/21	<b>fearful [2]</b> 58/9 151/1	<b>finances [1]</b> 140/22
121/19	160/9 160/10 163/17	<b>facilities [4]</b> 59/7	<b>feature [3]</b> 9/5 12/9	<b>financial [21]</b> 7/21
<b>exacerbating [3]</b>	164/19 166/23 166/25	59/8 117/23 118/3	98/22	20/21 67/24 69/3
140/1 140/10 140/24	<b>experienced [6]</b>	<b>facing [12]</b> 149/11	<b>features [1]</b> 38/8	69/11 69/21 70/21
<b>exactly [5]</b> 55/8	32/12 39/11 58/5	149/19 150/3 156/18	<b>February [1]</b> 28/16	74/19 75/23 76/5
62/25 63/4 86/1	80/17 105/8 150/8	157/10 159/18 160/24	<b>February 2021 [1]</b>	76/16 120/14 123/11
168/23	<b>experiences [6]</b>	161/4 162/24 164/13	28/16	134/12 134/13 135/4
<b>examination [1]</b>	80/12 82/13 83/8	166/11 167/10	<b>Federation [1]</b> 86/4	138/6 140/3 140/20
95/25	113/2 160/14 160/18	<b>fact [20]</b> 24/15 36/4	<b>feed [1]</b> 132/16	140/21 144/23
<b>examining [2]</b> 10/8	<b>experiencing [7]</b>	36/22 42/5 46/24	<b>feeds [1]</b> 12/9	<b>financially [4]</b> 41/17
11/1	39/20 64/12 81/1 83/4	59/16 68/17 69/20	<b>feel [9]</b> 60/8 94/16	55/18 55/24 143/6
<b>example [27]</b> 19/20	84/9 84/12 157/15	70/9 72/24 74/5 76/2	101/5 105/4 107/25	<b>find [5]</b> 36/22 76/22
33/13 67/16 72/3	<b>expert [2]</b> 1/23	80/8 91/2 96/18 97/21	108/7 110/15 144/16	106/1 106/14 160/22
76/12 79/9 80/18 82/1	111/25	102/15 102/16 119/8	162/16	<b>finding [1]</b> 69/3
92/4 92/17 96/7 101/9	<b>expertise [4]</b> 2/3 4/19	123/19	<b>feeling [11]</b> 58/8	<b>fine [1]</b> 143/24
107/17 114/14 117/18	112/5 112/10	<b>factor [1]</b> 24/5	80/20 83/21 83/25	<b>fingers [1]</b> 109/15
120/24 122/6 128/18	<b>explain [12]</b> 23/24	<b>factors [9]</b> 14/14	84/7 92/12 101/6	<b>finite [1]</b> 142/8
131/25 133/7 134/1	25/19 26/8 29/9	19/1 29/1 93/4 125/10	106/9 108/18 110/4	<b>firm [2]</b> 26/2 41/9
135/5 136/15 149/15	121/12 122/19 128/7	126/24 132/7 135/2	136/18	<b>first [51]</b> 7/12 25/10
152/14 156/24 164/2	132/23 135/21 147/8	142/24	<b>feels [3]</b> 110/13	26/6 29/16 32/4 32/10
<b>examples [7]</b> 96/23	149/21 155/9	<b>facts [1]</b> 111/24	110/13 110/13	35/6 36/13 37/7 37/11
97/6 107/24 112/23	<b>explained [3]</b> 55/9	<b>failed [2]</b> 23/2 45/2	<b>FEHMO [15]</b> 54/19	37/14 42/24 46/2 48/4
114/13 114/24 167/15	76/17 150/22	<b>failings [1]</b> 166/17	58/10 85/25 86/5	48/5 55/13 61/4 62/11
<b>exams [1]</b> 49/14	<b>explore [4]</b> 31/19	<b>failure [1]</b> 105/23	86/20 87/6 88/1 88/14	64/21 70/5 70/7 72/11
<b>except [1]</b> 22/19	31/22 34/4 104/22	<b>fair [12]</b> 8/15 14/16	88/16 89/9 90/9 91/22	72/13 72/15 72/17
<b>exception [2]</b> 120/4	<b>explored [1]</b> 29/2	22/7 28/9 30/12 35/15	97/22 101/7 104/4	72/20 75/12 77/24
	<b>exposed [4]</b> 5/17		<b>fell [1]</b> 102/2	80/22 90/23 91/1 91/8

<b>F</b>	<b>forced [4]</b> 56/12 56/18 79/5 80/21	85/17 87/5 131/14 132/14 155/8	134/7 148/1 149/20 162/24	61/11 61/20 67/22 69/25 73/19 74/3
<b>first... [19]</b> 91/10 93/12 94/11 102/19 103/2 103/10 103/12 111/20 112/17 117/9 119/10 121/22 133/8 136/12 138/19 139/23 141/15 158/21 162/4	<b>forces [1]</b> 138/10	<b>full-time [2]</b> 131/14 132/14	<b>gendered [1]</b> 112/11	77/24 78/1 78/12 80/9
<b>forecasting [1]</b> 68/20	<b>foreseeable [1]</b> 158/25	<b>fund [8]</b> 23/18 45/24 52/6 52/10 68/6 74/8 74/13 77/3	<b>gender [2]</b> 106/13 113/3	81/6 82/7 82/9 83/6 87/8 88/7 91/5 93/8 95/20 96/8 96/16 97/10 98/19 101/25 105/17 108/11 112/7 112/15 115/3 117/8 117/22 136/19 138/13 146/23 151/23 155/14 160/16 167/8 167/13
<b>firstly [7]</b> 1/14 23/19 27/13 52/2 112/14 150/9 165/18	<b>forged [1]</b> 89/3	<b>funded [1]</b> 169/9	<b>general [16]</b> 11/13 57/25 60/17 66/17 68/4 69/19 85/25 86/2 101/2 105/21 106/3 115/19 115/22 125/24 138/15 168/23	146/23 151/23 155/14 160/16 167/8 167/13
<b>fit [6]</b> 57/23 106/11 107/20 108/2 108/10 137/17	<b>forgive [1]</b> 2/3	<b>fundings [11]</b> 76/11 121/11 135/9 144/24 145/6 148/25 149/15 167/21 168/7 168/12 169/8	<b>generality [1]</b> 23/10	<b>goes [3]</b> 18/16 80/2 151/4
<b>fit test [1]</b> 108/2	<b>forgot [1]</b> 47/11	<b>fund [12]</b> 47/13 75/21 76/2 135/5 141/17 143/4 143/14 143/25 155/18 165/16 165/19 169/18	<b>generally [10]</b> 11/19 37/4 41/1 81/6 101/7 149/13 152/5 154/1 163/22 169/9	<b>going [71]</b> 2/22 16/20 17/18 20/8 21/24 22/17 22/22 23/15 28/6 31/19 40/19 42/24 43/2 47/22 48/13 48/15 48/19 48/24 51/17 54/17 54/21 59/12 60/12 66/21 68/2 69/18 73/22 77/9 78/8 82/8 82/14 82/18 82/21 82/23 85/7 87/7 87/10 88/9 90/23 91/3 93/25 94/9 98/13 99/22 99/24 103/2 104/7 107/13 108/14 115/3 115/5 116/12 119/16 122/14 123/22 123/25 132/22 136/10 136/19 136/21 137/25 137/25 138/10 140/22 146/22 147/16 148/18 150/19 153/12 156/25 160/16
<b>fits [1]</b> 107/21	<b>form [10]</b> 35/16 76/5 87/6 88/12 88/13 90/2 121/17 122/9 122/15 124/7	<b>furlough [5]</b> 45/1 68/7 74/13 76/12 80/19	<b>generic [1]</b> 137/17	<b>Gomes [3]</b> 56/9 56/12 56/16
<b>fitted [1]</b> 107/16	<b>formal [1]</b> 63/12	<b>furloughed [1]</b> 32/4	<b>geographic [3]</b> 128/24 129/5 145/2	<b>gone [2]</b> 123/3 152/7
<b>fitting [2]</b> 107/14 108/4	<b>formalities [1]</b> 111/19	<b>further [12]</b> 24/24 26/17 41/12 56/24 72/7 97/21 101/23 129/23 138/14 149/14 156/3 167/20	<b>geographical [1]</b> 129/10	<b>good [7]</b> 1/3 1/4 27/9 33/14 36/23 68/11 167/15
<b>five [13]</b> 6/17 8/9 26/6 48/9 51/6 78/25 125/6 134/23 146/4 146/5 146/10 158/18 158/18	<b>formed [2]</b> 88/22 89/2	<b>future [4]</b> 30/17 37/18 140/21 168/9	<b>get [27]</b> 4/7 23/4 25/8 25/16 32/10 32/13 32/18 32/20 33/21 36/22 36/24 46/18 68/22 70/24 131/20 133/10 136/21 149/18 150/1 151/3 151/21 157/1 163/16 165/3 165/9 168/1 170/17	<b>goodbye [1]</b> 26/24
<b>five years [3]</b> 6/17 26/6 48/9	<b>former [1]</b> 28/15	<b>gadgets [1]</b> 109/14	<b>gets [1]</b> 133/2	<b>Goshawk [7]</b> 146/15 146/16 146/18 146/20 147/1 147/13 172/11
<b>five-minute [3]</b> 146/4 146/5 146/10	<b>forms [1]</b> 142/7	<b>galvanise [1]</b> 90/3	<b>getting [8]</b> 39/21 46/11 75/6 150/13 150/14 151/20 153/16 163/12	<b>got [10]</b> 6/10 50/18 71/15 84/22 86/8 110/18 152/24 153/4 160/18 167/12
<b>flashbacks [1]</b> 59/3	<b>forth [3]</b> 140/23 141/17 142/11	<b>gap [13]</b> 3/10 18/5 19/13 19/16 19/19 73/4 114/14 131/3 131/4 131/5 131/8 131/17 132/4	<b>girl [1]</b> 56/2	<b>governed [1]</b> 113/4
<b>flee [1]</b> 155/14	<b>forum [2]</b> 66/22 66/25	<b>gaps [3]</b> 4/3 19/5 126/25	<b>girls [8]</b> 119/23 145/9 145/13 147/20 148/17 166/19 169/2 169/4	<b>government [59]</b> 16/24 17/3 23/23 30/13 33/6 33/9 34/2 38/23 42/24 43/7 43/18 43/20 46/6 47/3 52/8 52/11 52/14 52/19 53/17 57/16 57/21 59/16 63/4 65/1 65/11 65/12 65/16 66/19 66/23 67/1 67/5 68/5 68/11 68/12 69/20 74/18 74/21
<b>fleeing [1]</b> 150/2	<b>forward [11]</b> 14/6 39/13 42/24 43/3 43/12 45/5 47/14 55/2 75/23 85/13 139/9	<b>gather [5]</b> 29/22 85/9 96/4 96/17 97/1	<b>give [13]</b> 1/9 27/11 60/15 66/18 85/17 97/22 106/3 107/17 108/15 114/12 134/9 166/1 167/20	
<b>flesh [1]</b> 86/25	<b>forwards [2]</b> 29/21 138/15	<b>gathered [4]</b> 93/24 95/25 98/25 98/25	<b>given [15]</b> 67/15 76/11 78/20 100/17 103/22 109/6 112/23 124/13 138/5 142/7 145/8 145/10 145/18 160/18 168/8	
<b>flights [1]</b> 110/24	<b>found [8]</b> 10/16 13/4 75/9 75/15 83/9 111/17 127/17 147/5	<b>gave [4]</b> 64/2 82/11 106/15 168/1	<b>givers [1]</b> 119/20	
<b>flow [1]</b> 79/18	<b>foundations [1]</b> 26/2	<b>GCSE [1]</b> 19/20	<b>gives [3]</b> 59/2 64/4 124/20	
<b>flowed [1]</b> 85/9	<b>founded [1]</b> 88/17	<b>GCSEs [1]</b> 19/8	<b>glad [1]</b> 109/9	
<b>focus [3]</b> 51/2 123/7 160/18	<b>four [6]</b> 7/24 57/18 80/16 127/15 155/6 161/12	<b>geared [1]</b> 40/25	<b>global [3]</b> 112/9 119/18 120/6	
<b>focused [2]</b> 21/12 33/4	<b>four days [1]</b> 57/18	<b>gender [32]</b> 111/15 112/15 112/16 112/17 112/20 112/21 112/24 112/25 113/1 113/6 113/7 113/11 114/14 114/21 118/6 118/14 121/19 124/1 124/2 124/11 124/19 131/3 131/4 131/5 133/16 134/7 138/16 138/22 139/6 148/1 149/20 162/24	<b>globally [4]</b> 13/23 112/19 117/10 120/17	
<b>focuses [1]</b> 65/4	<b>four nations [1]</b> 7/24	<b>gender-based [7]</b> 114/21 118/6 118/14	<b>globe [1]</b> 130/11	
<b>focusing [2]</b> 2/19 71/23	<b>fourth [1]</b> 74/7		<b>gloving [1]</b> 59/10	
<b>follow [9]</b> 33/11 33/18 33/20 34/6 36/19 65/14 82/16 122/16 124/18	<b>framework [1]</b> 49/20		<b>go [45]</b> 29/15 36/15 36/20 40/21 44/4 47/8	
<b>follow-through [4]</b> 33/18 33/20 34/6 36/19	<b>framing [1]</b> 10/7			
<b>followed [1]</b> 29/12	<b>free [5]</b> 19/14 19/17 19/21 162/16 168/1			
<b>following [4]</b> 55/1 113/17 128/2 152/17	<b>freedom [2]</b> 75/12 76/17			
<b>follows [3]</b> 4/6 59/1 158/5	<b>frequency [3]</b> 38/19 128/3 158/6			
<b>food [6]</b> 7/8 9/4 9/8 9/10 47/8 64/9	<b>frequently [1]</b> 48/11			
<b>food processing [1]</b> 64/9	<b>Friday [1]</b> 1/1			
<b>footnote [1]</b> 108/21	<b>friends [5]</b> 24/6 25/1 25/3 40/22 133/23			
<b>footnote there [1]</b> 108/21	<b>frightening [1]</b> 60/4			
<b>force [2]</b> 123/15 133/2	<b>frivolous [1]</b> 24/19			
	<b>front [4]</b> 8/14 17/19 50/11 59/3			
	<b>frontline [9]</b> 54/18 56/23 64/7 79/5 93/19 94/21 95/13 103/13 106/8			
	<b>fuelled [1]</b> 46/24			
	<b>full [10]</b> 1/9 27/11 55/21 59/4 60/15			

<p><b>G</b></p> <p><b>government...</b> [22] 74/25 75/2 77/3 77/10 120/20 121/1 121/2 138/23 160/22 161/6 161/8 161/16 163/4 163/7 164/25 165/2 165/14 165/17 166/8 166/12 166/20 167/21</p> <p><b>governmental</b> [1] 135/16</p> <p><b>governments</b> [2] 44/17 116/12</p> <p><b>GP</b> [1] 157/2</p> <p><b>grades</b> [1] 132/3</p> <p><b>gradients</b> [1] 14/17</p> <p><b>grandparents</b> [1] 41/7</p> <p><b>granted</b> [2] 139/12 170/3</p> <p><b>grants</b> [1] 135/15</p> <p><b>graph</b> [8] 6/13 14/22 17/12 17/23 17/25 20/15 20/24 21/10</p> <p><b>graphs</b> [2] 6/15 17/11</p> <p><b>grateful</b> [7] 2/18 43/24 45/16 45/19 54/6 84/21 110/20</p> <p><b>grave</b> [1] 63/24</p> <p><b>great</b> [10] 23/6 49/12 55/19 57/3 68/8 89/17 89/19 101/8 125/19 141/3</p> <p><b>Great Britain</b> [1] 57/3</p> <p><b>greater</b> [9] 47/3 58/1 67/15 93/3 94/24 103/24 125/15 125/24 138/11</p> <p><b>green</b> [2] 6/13 26/10</p> <p><b>grief</b> [2] 79/20 79/24</p> <p><b>ground</b> [1] 92/12</p> <p><b>group</b> [8] 6/14 11/18 38/9 122/19 122/22 139/5 143/1 165/8</p> <p><b>grouping</b> [1] 88/21</p> <p><b>groups</b> [22] 11/14 14/15 16/14 31/21 31/23 34/9 41/5 42/15 51/15 57/25 58/20 65/20 65/22 77/19 87/14 96/23 122/22 122/23 122/24 122/25 161/15 167/4</p> <p><b>grow</b> [4] 4/24 5/4 5/20 30/24</p> <p><b>growing</b> [1] 5/16</p> <p><b>guess</b> [6] 4/19 5/1 11/23 13/24 18/16 24/13</p> <p><b>guest</b> [1] 26/25</p> <p><b>guidance</b> [16] 53/12 57/23 58/16 65/10</p>	<p>65/13 65/16 65/17 65/24 66/1 67/6 67/7 81/5 83/20 84/13 124/20 162/10</p> <p><b>guidelines</b> [3] 58/13 126/12 128/3</p> <hr/> <p><b>H</b></p> <p><b>had</b> [119] 8/23 9/14 9/18 9/25 10/2 10/9 13/14 16/16 16/16 17/7 20/23 22/8 22/9 22/10 22/25 31/21 32/2 32/11 32/19 33/4 34/19 36/23 37/16 37/20 37/20 37/20 37/21 38/14 38/15 38/15 40/25 41/18 41/18 42/5 42/11 42/14 43/1 44/24 44/25 47/16 48/2 48/6 49/21 49/22 51/14 53/22 54/5 55/17 55/20 56/2 59/4 59/7 59/8 59/22 59/23 60/3 60/6 60/25 63/22 63/24 67/25 69/24 75/15 75/20 76/11 77/6 77/12 78/25 79/5 79/14 79/15 80/17 80/21 82/10 84/25 88/19 88/22 89/2 90/2 92/8 92/8 93/25 94/25 96/8 96/16 102/6 103/4 109/3 110/7 121/13 121/16 134/12 135/13 135/23 138/6 139/3 141/25 145/5 145/7 148/24 149/14 149/15 149/23 151/24 154/25 155/2 155/6 155/18 156/12 157/15 158/10 158/10 158/18 160/9 162/6 163/14 165/24 166/7 166/25</p> <p><b>hadn't</b> [2] 36/16 100/16</p> <p><b>half</b> [7] 18/19 18/20 19/6 61/4 64/23 128/7 128/9</p> <p><b>hampered</b> [1] 69/11</p> <p><b>hand</b> [4] 69/1 69/2 145/4 145/6</p> <p><b>handling</b> [1] 57/5</p> <p><b>hands</b> [2] 59/9 59/11</p> <p><b>hanging</b> [2] 142/14 144/10</p> <p><b>happen</b> [7] 49/5 49/15 73/9 109/4 109/8 140/22 151/1</p> <p><b>happened</b> [5] 26/13 33/15 37/15 60/9 73/10</p> <p><b>happening</b> [6] 92/14</p>	<p>92/15 98/19 106/25 109/11 151/2</p> <p><b>happens</b> [3] 5/3 23/5 25/10</p> <p><b>happy</b> [2] 23/8 23/10</p> <p><b>harass</b> [1] 105/13</p> <p><b>harassed</b> [1] 105/4</p> <p><b>hard</b> [7] 49/25 51/12 118/17 125/9 132/6 153/5 169/24</p> <p><b>hardship</b> [2] 52/3 70/21</p> <p><b>harm</b> [2] 40/6 40/8</p> <p><b>harm's</b> [1] 93/20</p> <p><b>harmed</b> [1] 38/24</p> <p><b>harmful</b> [2] 5/15 11/19</p> <p><b>harming</b> [1] 158/4</p> <p><b>harms</b> [2] 38/20 38/25</p> <p><b>Harper's</b> [1] 101/12</p> <p><b>Harper's Law</b> [1] 101/12</p> <p><b>has</b> [41] 9/5 16/7 16/7 25/22 28/7 28/11 29/17 29/22 29/23 31/15 42/17 51/12 52/19 53/24 55/1 55/3 55/9 59/21 60/4 60/6 63/2 64/9 72/5 89/19 101/11 123/3 124/15 126/15 126/24 127/14 128/4 132/23 133/1 133/7 140/2 140/14 140/15 142/6 144/20 145/2 158/13</p> <p><b>hasn't</b> [1] 90/4</p> <p><b>have</b> [204]</p> <p><b>haven't</b> [1] 66/7</p> <p><b>having</b> [22] 4/12 22/23 35/21 37/6 40/16 41/3 44/8 47/8 83/2 83/6 83/20 90/16 109/2 110/20 133/4 133/5 134/21 149/1 149/2 149/4 159/10 169/8</p> <p><b>hazardous</b> [1] 106/2</p> <p><b>he</b> [9] 43/15 46/15 46/16 46/18 55/3 56/13 56/18 93/11 107/9</p> <p><b>head</b> [3] 60/23 106/13 147/13</p> <p><b>headline</b> [5] 114/13 117/3 118/12 121/17 121/20</p> <p><b>headteachers</b> [1] 66/12</p> <p><b>health</b> [146] 2/5 2/6 2/9 2/19 2/21 3/1 3/6 3/7 3/12 3/22 3/24 3/25 4/1 4/2 4/3 4/16 4/18 4/20 5/8 5/10</p>	<p>5/16 5/19 5/24 6/2 7/2 7/6 7/11 7/20 11/9 11/11 11/20 12/14 12/23 13/3 13/7 13/10 13/12 13/13 13/18 13/19 13/21 13/24 14/5 14/8 14/9 14/12 14/18 14/19 14/20 14/24 15/6 15/19 15/21 15/25 16/7 16/8 16/12 16/17 16/18 16/18 16/25 17/4 17/5 17/6 17/8 21/21 21/21 21/22 22/1 22/2 22/6 22/10 25/7 26/12 26/16 31/8 32/9 39/7 39/17 39/17 41/15 41/22 41/22 42/11 44/25 46/8 46/9 49/16 51/20 53/21 53/25 55/20 56/18 58/2 58/7 58/11 58/19 60/5 64/8 85/23 85/24 87/2 87/20 89/1 90/15 92/2 92/7 94/21 94/22 95/12 97/3 98/4 99/10 99/13 102/5 104/3 109/6 110/6 110/6 110/9 112/9 112/11 117/1 117/16 119/23 119/24 120/16 124/1 124/11 124/12 124/12 124/15 125/5 125/7 125/15 125/18 126/15 126/25 129/23 130/11 137/5 137/11 140/7 158/3 164/18 169/23</p> <p><b>healthcare</b> [48] 57/13 57/15 57/24 57/25 81/13 85/19 85/20 86/4 87/13 87/24 88/12 89/6 92/6 95/1 95/5 99/18 99/19 100/12 100/14 100/21 101/3 101/13 101/15 102/12 105/22 107/15 107/23 117/10 117/14 117/16 117/23 117/24 120/15 121/14 121/25 122/5 124/2 124/6 124/9 127/9 129/16 129/17 130/11 131/22 137/7 137/12 141/3 157/4</p> <p><b>healthcare-related</b> [1] 88/12</p> <p><b>healthcare-wise</b> [1] 87/24</p> <p><b>healthy</b> [2] 3/11 19/2</p> <p><b>hear</b> [2] 58/23 84/23</p> <p><b>heard</b> [23] 11/2 31/11 35/12 41/21 46/7 48/6 52/4 53/3 53/19 54/23 63/20 64/1 64/7 64/15</p>	<p>65/8 68/17 68/24 75/16 106/19 120/19 120/21 120/22 139/19</p> <p><b>hearing</b> [5] 2/24 23/6 108/1 108/2 170/19</p> <p><b>hears</b> [1] 1/16</p> <p><b>heart</b> [2] 12/17 113/7</p> <p><b>heeded</b> [1] 67/12</p> <p><b>heightened</b> [1] 39/19</p> <p><b>held</b> [2] 60/25 95/9</p> <p><b>help</b> [18] 27/2 35/7 37/21 42/1 47/18 51/3 53/8 54/3 76/12 95/14 96/2 121/18 144/16 144/16 146/1 159/19 165/3 170/7</p> <p><b>helped</b> [1] 21/6</p> <p><b>helpful</b> [4] 27/1 88/9 110/23 160/22</p> <p><b>helpfully</b> [2] 86/7 149/20</p> <p><b>helpline</b> [4] 39/23 154/6 154/10 163/18</p> <p><b>helps</b> [4] 15/8 17/13 21/7 21/8</p> <p><b>her</b> [8] 22/19 28/7 54/21 54/21 58/23 79/14 79/15 133/8</p> <p><b>here</b> [18] 3/9 11/13 33/13 85/24 94/24 98/3 101/14 104/12 104/18 105/6 107/9 108/5 109/10 120/18 120/23 121/8 123/19 143/3</p> <p><b>Hey</b> [1] 2/10</p> <p><b>hidden</b> [1] 162/9</p> <p><b>high</b> [13] 6/14 6/25 8/23 15/5 29/4 32/6 46/7 47/7 79/8 114/13 114/24 152/25 159/13</p> <p><b>high-level</b> [1] 114/24</p> <p><b>high-rise</b> [1] 32/6</p> <p><b>high-risk</b> [1] 79/8</p> <p><b>higher</b> [9] 8/5 126/2 127/15 130/19 132/2 149/5 152/6 154/15 158/3</p> <p><b>highest</b> [4] 15/13 16/14 81/11 153/14</p> <p><b>highlight</b> [1] 76/25</p> <p><b>highlighted</b> [5] 51/18 58/10 72/2 80/16 164/25</p> <p><b>highly</b> [2] 112/20 140/2</p> <p><b>hijab</b> [1] 108/12</p> <p><b>hindsight</b> [3] 48/2 48/12 48/15</p> <p><b>his</b> [4] 55/5 56/12 56/15 56/17</p> <p><b>Historically</b> [1] 126/14</p> <p><b>hold</b> [1] 60/21</p>
---	--	--	--	--



<b>H</b>	94/5 94/14 98/13 99/4 99/6 106/5 107/10 112/18 112/25 114/12 116/15 121/18 124/13 124/14 124/19 126/9 126/16 126/19 126/20 128/16 133/15 135/11 136/14 138/22 138/25 139/2 139/3 139/4 144/14 145/12 148/22 159/9 162/25 169/5	<b>I felt [2]</b> 37/10 44/24 <b>I gather [1]</b> 85/9 <b>I guess [6]</b> 4/19 5/1 11/23 13/24 18/16 24/13 <b>I have [10]</b> 15/2 26/7 28/4 42/14 76/22 110/21 115/17 115/17 139/20 170/2 <b>I heard [2]</b> 120/21 120/22 <b>I hope [3]</b> 85/11 89/12 170/16 <b>I imagine [2]</b> 54/16 145/15 <b>I invite [2]</b> 3/3 27/16 <b>I just [12]</b> 45/25 68/24 76/21 112/1 117/8 123/3 125/22 135/24 141/12 151/23 152/13 154/24 <b>I know [9]</b> 48/20 60/20 70/2 82/25 153/5 153/7 161/15 162/4 165/6 <b>I listed [1]</b> 89/20 <b>I lost [1]</b> 59/14 <b>I may [25]</b> 77/25 86/16 104/1 111/19 112/5 112/13 116/19 117/8 118/22 121/10 124/1 124/23 125/5 125/22 129/15 130/15 131/3 134/6 134/8 136/9 137/20 147/16 149/9 150/7 154/24 <b>I mean [10]</b> 3/5 17/11 36/21 37/7 107/8 113/20 123/19 143/13 159/21 169/1 <b>I mentioned [1]</b> 165/6 <b>I might [1]</b> 69/7 <b>I momentarily [1]</b> 47/4 <b>I need [1]</b> 151/3 <b>I now [4]</b> 116/19 121/10 134/6 150/7 <b>I often [1]</b> 30/18 <b>I only [1]</b> 45/19 <b>I pause [1]</b> 77/8 <b>I pick [1]</b> 162/12 <b>I propose [1]</b> 22/15 <b>I read [2]</b> 64/2 82/11 <b>I referred [1]</b> 167/18 <b>I refused [1]</b> 79/19 <b>I represent [1]</b> 94/16 <b>I said [6]</b> 53/18 68/16 82/7 90/13 100/19 139/7 <b>I saw [1]</b> 33/8 <b>I say [5]</b> 26/1 45/24 62/6 81/20 167/12 <b>I shall [2]</b> 54/10	111/5 <b>I stick [1]</b> 45/11 <b>I support [1]</b> 37/7 <b>I suppose [5]</b> 44/24 68/4 152/24 156/8 169/21 <b>I suspect [1]</b> 50/24 <b>I talked [1]</b> 159/21 <b>I think [102]</b> 17/10 17/18 21/20 22/7 31/15 33/8 33/23 33/24 39/24 42/16 43/4 43/17 44/16 45/10 45/12 46/5 47/11 47/22 48/20 49/1 51/5 60/20 60/25 62/4 62/25 66/21 67/4 67/22 69/14 70/23 72/20 72/23 73/24 74/24 76/14 77/5 77/12 78/22 83/10 83/10 83/11 84/4 84/4 85/20 86/11 87/8 88/16 93/10 97/9 97/12 101/23 102/1 102/16 104/2 109/14 109/20 113/1 113/7 119/8 123/18 123/21 125/9 125/11 126/3 132/6 132/6 136/12 142/20 150/13 150/25 151/2 151/16 152/6 153/4 154/3 154/4 155/15 158/2 158/16 158/18 159/1 159/11 159/12 159/14 159/21 160/7 160/19 160/22 161/24 162/3 163/10 163/17 164/20 166/7 167/17 168/3 168/7 169/1 169/3 169/16 169/19 170/5 <b>I understand [2]</b> 62/25 136/4 <b>I want [12]</b> 2/23 13/3 37/25 38/7 40/12 62/4 82/7 82/9 82/12 86/16 102/14 104/21 <b>I wanted [3]</b> 23/19 42/5 90/21 <b>I was [15]</b> 15/10 28/20 33/14 39/18 42/10 59/15 60/2 60/23 77/14 79/17 79/21 87/7 91/3 99/25 123/25 <b>I will [4]</b> 23/3 26/25 45/10 45/10 <b>I won't [1]</b> 78/6 <b>I work [1]</b> 3/5 <b>I would [11]</b> 22/21 77/5 79/17 82/7 141/1 141/7 143/21 144/6 144/11 144/13 160/22	<b>I'd [7]</b> 39/13 42/1 48/9 48/10 81/6 89/21 136/8 <b>I'll [2]</b> 1/17 123/5 <b>I'm [55]</b> 2/22 15/2 16/20 20/8 22/20 23/1 23/8 23/10 23/15 26/22 28/6 43/24 45/16 45/19 51/11 54/21 55/10 60/11 60/11 61/8 63/16 68/2 69/18 78/1 78/8 80/7 82/8 82/14 82/20 85/13 85/23 85/24 87/10 88/9 94/9 103/2 108/21 109/14 115/5 119/15 122/14 123/11 132/22 143/21 144/11 146/5 146/22 147/16 150/19 157/22 160/16 160/17 160/17 162/14 170/8 <b>I'm afraid [2]</b> 60/11 160/17 <b>I've [17]</b> 7/5 14/1 25/6 26/12 43/12 43/13 45/10 56/21 63/15 84/20 85/22 96/9 112/1 112/23 115/18 169/16 170/5 <b>ICUs [1]</b> 106/8 <b>idea [1]</b> 66/18 <b>ideation [1]</b> 158/4 <b>identification [1]</b> 157/7 <b>identified [2]</b> 157/2 162/18 <b>identify [3]</b> 117/7 160/4 160/5 <b>if [116]</b> 1/16 2/16 2/25 3/7 4/1 4/7 6/4 6/12 6/24 9/7 12/15 14/6 14/7 15/2 15/7 17/13 20/15 22/22 25/3 26/1 27/20 27/20 27/21 38/14 40/17 42/1 43/1 43/22 45/6 47/7 48/12 48/15 48/21 50/9 55/5 60/11 65/5 65/20 68/22 69/5 71/11 71/14 72/7 72/17 73/2 74/6 76/21 79/10 80/8 80/14 86/16 86/19 87/9 88/7 88/8 89/9 89/20 91/12 92/3 92/18 93/8 95/20 96/2 97/10 97/24 103/6 104/1 105/18 107/11 108/14 110/25 111/19 112/5 112/13 114/3 114/12 116/19 117/8 118/22 121/10 122/7 123/5 123/7 124/1 124/22 124/23
----------	--	--	--	--



<b>I</b>	4/18 7/20 14/10 17/6 21/18 29/1 29/5 42/25 51/18 51/23 52/23 55/14 57/13 72/2 72/6 77/20 117/8 117/10 118/22 120/13 121/8 127/24 137/9 137/15 143/16 <b>imperative [1]</b> 4/9 <b>implementation [2]</b> 33/12 102/9 <b>implementing [1]</b> 58/18 <b>implications [2]</b> 69/24 133/4 <b>implore [1]</b> 90/17 <b>importance [3]</b> 5/2 26/6 122/19 <b>important [29]</b> 1/15 3/2 3/19 9/23 18/11 18/15 19/22 22/1 23/25 24/1 24/3 24/12 24/18 24/22 26/11 26/12 26/14 40/18 42/16 45/8 49/3 50/16 66/21 119/22 122/18 125/12 126/4 155/15 167/23 <b>impression [1]</b> 153/16 <b>impressive [1]</b> 148/1 <b>improve [1]</b> 43/2 <b>improving [1]</b> 28/11 <b>inability [2]</b> 156/4 156/11 <b>inadequate [5]</b> 47/24 55/22 76/14 105/24 108/19 <b>incidents [2]</b> 16/1 40/8 <b>include [1]</b> 97/15 <b>included [4]</b> 13/17 67/8 97/17 169/25 <b>includes [1]</b> 63/7 <b>including [10]</b> 36/18 43/21 58/17 70/11 80/18 116/3 119/23 131/15 132/20 148/8 <b>inclusive [1]</b> 89/5 <b>incoherent [1]</b> 33/25 <b>income [5]</b> 4/21 15/4 15/5 15/14 73/19 <b>inconsistencies [1]</b> 58/14 <b>inconsistent [1]</b> 128/23 <b>increase [36]</b> 7/12 8/2 8/12 9/9 9/10 21/11 21/11 38/19 39/24 40/7 59/19 73/12 118/14 126/5 140/5 140/11 141/5 145/11 148/25 149/14 150/9 150/14 150/23	151/14 151/24 152/3 152/5 153/13 153/22 154/5 154/7 154/10 155/5 158/14 159/2 166/23 <b>increased [15]</b> 7/19 9/5 12/25 38/22 38/25 39/5 52/3 73/20 117/25 134/12 136/17 140/3 144/21 145/6 158/10 <b>increases [3]</b> 12/13 41/23 150/12 <b>increasing [9]</b> 7/10 12/18 15/21 18/6 18/8 19/11 37/10 56/17 125/19 <b>incredible [2]</b> 24/13 25/22 <b>incredibly [3]</b> 24/17 153/5 169/24 <b>incrementally [1]</b> 13/12 <b>indeed [29]</b> 8/22 17/2 22/19 22/25 23/7 23/12 26/20 45/18 50/22 51/3 54/9 56/14 85/4 110/22 118/15 121/15 126/1 139/24 140/20 144/16 146/15 148/10 160/13 164/11 168/9 168/12 170/4 170/7 170/11 <b>indefinite [1]</b> 142/8 <b>independent [10]</b> 57/3 63/10 96/23 97/9 97/11 97/18 111/25 128/12 128/17 135/16 <b>Independent SAGE</b> <b>[3]</b> 97/9 97/11 97/18 <b>INDEX [1]</b> 170/21 <b>Indian [2]</b> 91/3 103/8 <b>indicated [1]</b> 56/22 <b>indifferent [1]</b> 34/2 <b>indirectly [1]</b> 92/23 <b>individual [4]</b> 58/24 86/23 160/14 160/18 <b>individuals [6]</b> 41/4 133/23 156/5 156/18 160/3 164/13 <b>industrial [2]</b> 106/12 109/24 <b>industrialised [1]</b> 120/8 <b>industries [5]</b> 130/10 130/15 130/20 131/24 131/24 <b>inequalities [39]</b> 1/19 2/13 2/19 3/1 3/7 3/12 3/18 3/20 3/22 3/25 4/2 4/8 7/10 7/14 7/14 9/25 11/4 12/23 13/19 14/3 15/22 16/6 17/4 18/6 18/13 19/11 20/4	20/24 21/22 21/23 22/5 89/10 89/17 111/15 112/15 113/3 115/7 115/7 123/20 <b>inequality [19]</b> 4/5 11/2 11/9 12/2 12/9 16/13 112/16 112/16 112/18 112/21 112/21 112/24 112/25 113/1 113/7 113/11 116/14 121/19 124/1 <b>infant [3]</b> 7/11 21/23 40/9 <b>infection [1]</b> 119/11 <b>Infections [1]</b> 79/25 <b>infectious [1]</b> 69/1 <b>influence [5]</b> 5/1 11/11 18/23 19/8 19/24 <b>influences [2]</b> 20/1 124/12 <b>inform [1]</b> 30/20 <b>informal [1]</b> 87/3 <b>information [6]</b> 75/12 76/18 97/2 98/3 103/3 126/16 <b>informed [2]</b> 79/17 79/21 <b>infrared [2]</b> 109/23 110/3 <b>infringing [1]</b> 30/3 <b>initial [2]</b> 101/24 138/21 <b>initially [1]</b> 53/11 <b>INQ000148476 [1]</b> 90/25 <b>INQ000192239 [1]</b> 70/1 <b>INQ000215036 [1]</b> 61/7 <b>INQ000273750 [1]</b> 27/24 <b>INQ0002800 [1]</b> 111/18 <b>INQ000280060 [1]</b> 1/20 <b>INQ000280726 [1]</b> 147/5 <b>inquiry [28]</b> 1/7 1/13 1/18 27/8 27/11 27/14 29/12 42/3 56/22 57/4 60/14 61/2 82/2 85/16 101/11 111/12 111/14 121/18 146/17 147/2 168/19 169/2 171/5 171/11 171/23 172/3 172/7 172/13 <b>Inquiry's [2]</b> 55/12 168/19 <b>insecure [3]</b> 9/8 72/5 165/15 <b>insecurity [1]</b> 135/4 <b>insofar [1]</b> 61/25 <b>inspection [1]</b> 67/21	<b>instance [3]</b> 35/6 36/13 96/15 <b>instances [2]</b> 94/25 113/16 <b>instead [4]</b> 37/19 37/19 37/21 44/5 <b>institute [1]</b> 163/7 <b>institution [1]</b> 110/8 <b>institutional [2]</b> 107/3 116/3 <b>institutions [4]</b> 100/23 101/7 113/23 157/10 <b>insufficiency [1]</b> 116/6 <b>insufficient [1]</b> 116/8 <b>insurance [1]</b> 71/10 <b>intend [1]</b> 164/4 <b>intensity [2]</b> 158/6 158/9 <b>intensive [1]</b> 106/8 <b>intent [1]</b> 99/8 <b>interact [2]</b> 124/5 136/14 <b>interaction [4]</b> 24/6 25/12 77/6 121/24 <b>interactions [7]</b> 24/10 26/14 64/25 113/12 119/1 124/2 150/20 <b>interacts [1]</b> 124/20 <b>interest [2]</b> 86/1 87/13 <b>interesting [2]</b> 98/2 110/25 <b>interests [13]</b> 29/20 30/15 34/7 43/9 43/11 43/20 48/14 48/20 48/25 63/18 64/20 87/18 87/23 <b>intergenerational [1]</b> 20/3 <b>international [9]</b> 60/24 116/22 116/24 118/15 119/15 119/17 163/21 166/23 166/25 <b>internationally [1]</b> 117/11 <b>internet [2]</b> 9/20 10/1 <b>interrupt [1]</b> 152/10 <b>intersect [1]</b> 11/10 <b>intersectional [1]</b> 142/21 <b>intervened [1]</b> 170/5 <b>intervention [2]</b> 46/22 75/18 <b>interventions [5]</b> 47/25 68/13 118/25 119/21 148/5 <b>into [40]</b> 2/13 4/6 4/23 6/21 12/9 14/6 21/2 22/4 23/4 29/16 30/2 33/6 33/21 36/20 36/22 62/22 66/21
----------	--	---	--	--

<b>I</b>	101/2 116/2 125/15 128/23 137/11 160/19 167/11 <b>it</b> [256] <b>it's</b> [127] 1/15 2/17 4/8 4/10 4/22 5/10 5/24 10/13 11/23 11/24 13/17 14/19 15/7 18/25 20/15 22/7 22/21 23/5 23/5 24/3 24/5 24/17 24/18 25/11 25/16 25/23 26/2 26/11 26/12 29/10 29/17 35/18 35/19 42/16 42/17 48/13 49/25 60/16 61/6 61/11 61/19 62/7 62/16 63/23 66/21 69/7 70/1 70/3 71/10 71/11 72/10 77/5 80/10 82/16 84/22 86/17 87/8 87/20 87/25 88/16 89/12 89/15 90/1 90/6 90/8 90/25 91/5 91/11 92/15 95/21 97/23 98/18 99/12 100/1 101/5 101/15 101/16 101/17 101/17 102/20 103/11 103/12 104/5 104/13 104/14 105/18 106/19 106/20 106/24 107/1 107/1 107/11 107/25 107/25 108/3 109/3 110/13 110/25 114/6 115/14 116/23 118/17 118/18 120/11 120/12 120/13 120/14 120/16 122/14 124/18 125/9 126/1 126/3 128/11 131/12 132/12 134/22 141/9 142/20 146/7 146/23 147/25 155/15 160/8 163/4 165/23 166/3 <b>its</b> [10] 62/5 65/17 74/2 75/19 86/11 96/21 102/9 102/9 113/7 166/13 <b>itself</b> [4] 18/11 102/7 118/18 140/4	96/11 130/19 137/13 138/4 <b>journal</b> [1] 92/7 <b>July</b> [4] 37/15 58/17 78/11 108/22 <b>July 2020</b> [3] 58/17 78/11 108/22 <b>June</b> [6] 37/15 58/19 78/16 80/11 100/13 154/11 <b>June 2020</b> [3] 58/19 78/16 80/11 <b>just</b> [134] 1/14 1/16 1/17 2/3 2/16 4/16 8/16 11/5 12/4 13/16 15/10 17/18 18/7 23/15 23/17 24/21 25/15 25/19 26/8 26/21 31/11 31/19 34/21 35/7 35/7 35/8 37/1 44/4 44/6 45/22 45/25 46/23 51/6 54/25 54/25 55/4 56/14 56/21 61/17 62/16 62/22 64/21 65/5 68/3 68/24 71/4 72/17 72/24 74/7 75/1 76/21 78/8 80/14 82/12 82/15 82/23 86/16 90/21 92/4 92/18 92/18 93/2 95/23 96/20 98/18 102/14 104/1 106/3 106/9 107/24 108/21 111/19 112/1 112/13 114/2 114/3 114/12 114/24 115/2 115/4 115/10 116/14 117/3 117/8 119/5 119/16 122/7 122/16 122/19 123/3 123/8 124/7 124/22 124/22 125/22 126/7 126/12 127/2 127/10 128/9 130/15 131/8 131/18 132/22 133/22 134/9 135/24 136/25 136/25 137/20 139/19 141/12 143/11 147/4 147/22 149/9 149/18 150/19 150/19 150/20 150/22 151/23 152/13 152/21 154/19 154/24 156/14 156/17 159/21 160/3 162/17 164/22 166/3 167/23 <b>justice</b> [2] 21/6 56/11	<b>KC</b> [3] 45/16 139/17 172/9 <b>Keating</b> [2] 1/4 54/9 <b>keep</b> [7] 1/14 27/17 36/6 37/3 41/10 48/22 59/12 <b>keeping</b> [2] 44/6 81/5 <b>Kensington</b> [2] 3/8 3/9 <b>kept</b> [1] 33/13 <b>Kevan</b> [1] 47/14 <b>key</b> [17] 24/5 36/7 44/7 52/24 78/19 78/19 81/16 81/18 81/23 88/25 120/3 129/12 132/11 161/11 161/12 167/11 169/21 <b>key worker</b> [2] 81/23 169/21 <b>key workers</b> [4] 36/7 44/7 81/16 81/18 <b>kids</b> [15] 4/24 5/12 5/16 9/25 11/15 14/18 14/25 15/14 19/6 21/2 23/17 24/12 24/12 45/22 48/22 <b>kind</b> [15] 23/11 30/18 40/23 41/13 47/10 66/24 83/11 87/4 87/23 98/8 104/13 104/15 108/5 152/24 169/14 <b>Kingdom</b> [2] 115/23 116/2 <b>kit</b> [1] 109/6 <b>knock</b> [2] 118/11 124/15 <b>know</b> [135] 3/19 5/13 7/5 14/5 14/17 14/22 15/7 15/16 15/25 16/2 17/14 18/16 18/17 18/25 19/4 19/6 22/7 23/9 24/4 24/7 24/7 24/13 25/9 25/11 25/21 25/24 26/5 26/22 32/11 35/23 40/21 40/24 41/12 44/8 44/12 44/17 44/20 44/22 44/24 45/4 46/10 47/9 47/16 48/12 48/15 48/19 48/20 48/20 48/21 48/23 49/8 49/14 49/15 50/16 50/17 55/4 60/20 63/16 64/18 67/5 67/13 70/2 75/24 76/4 82/25 83/17 84/16 88/24 94/17 94/19 95/3 95/5 95/17 96/9 97/25 98/11 98/12 98/14 99/5 99/6 99/20 104/10 106/10 106/13 106/21 106/22 107/20	107/21 108/5 109/7 110/11 114/14 114/15 114/21 114/22 118/24 120/17 122/3 122/21 122/22 128/14 128/20 130/11 130/18 131/25 131/25 132/13 133/5 133/6 133/7 133/17 133/24 134/11 134/11 134/13 135/2 136/21 137/7 137/10 137/24 138/19 138/20 140/13 142/20 143/22 143/23 145/16 153/5 153/7 160/22 161/15 162/4 163/13 165/6 169/23 <b>knowing</b> [4] 69/1 69/1 83/19 137/15 <b>knowledge</b> [16] 61/15 61/16 62/1 62/2 86/14 87/22 90/3 90/16 111/24 116/21 116/22 116/24 124/12 154/2 154/3 157/8 <b>known</b> [10] 18/18 62/7 63/15 75/17 91/24 92/9 92/9 100/11 100/16 118/8
<b>L</b>	<b>Jane</b> [1] 146/20 <b>January</b> [5] 21/17 57/7 115/8 154/11 162/7 <b>January 2020</b> [3] 21/17 57/7 115/8 <b>January 2021</b> [1] 162/7 <b>job</b> [4] 27/19 78/9 109/7 135/5 <b>jobs</b> [6] 84/14 90/14	<b>Kate</b> [4] 54/18 60/13 60/16 171/21 <b>Kate Bell</b> [2] 54/18 60/16 <b>Katrina</b> [2] 118/10 120/5	<b>labour</b> [6] 20/7 129/15 130/9 131/23 133/2 138/10 <b>lack</b> [16] 51/20 52/21 53/1 53/10 56/15 58/9 65/15 81/4 81/25 84/12 106/15 126/9 132/10 135/5 156/10 167/2 <b>Lady</b> [31] 1/3 21/17 22/16 22/20 22/25 26/19 27/3 27/6 28/25 44/1 45/20 50/21 51/6 51/13 54/5 54/16 60/10 77/15 84/25 85/7 85/10 110/21 139/18 145/20 145/22 146/3 146/15 160/20 162/12 170/2 170/14 <b>Ladyship</b> [1] 170/4 <b>Laming</b> [1] 29/14 <b>Laming's</b> [1] 29/12 <b>language</b> [1] 164/5 <b>large</b> [5] 10/23 76/13 88/2 88/3 162/8 <b>largely</b> [2] 8/19 8/23 <b>largest</b> [2] 126/5 126/25 <b>last</b> [15] 28/2 28/20 28/25 37/11 61/11 63/20 65/21 66/7 68/2 82/8 87/8 94/2 94/12 105/3 105/16 <b>lastly</b> [1] 27/20	

<b>L</b>	72/14 <b>length [1]</b> 62/10 <b>lengthened [1]</b> 166/1 <b>lengthy [2]</b> 61/5 64/22 <b>Leone [2]</b> 117/18 120/10 <b>less [13]</b> 10/2 113/15 117/15 120/6 124/24 125/2 126/10 131/24 135/17 135/17 149/16 155/15 156/20 <b>lessons [2]</b> 34/18 118/7 <b>let [7]</b> 5/11 55/4 76/8 82/25 94/10 95/20 160/7 <b>let's [17]</b> 5/5 6/3 31/22 34/8 40/2 61/17 68/16 69/25 70/22 72/9 77/17 80/4 86/19 87/7 103/6 105/15 105/17 <b>Letby [1]</b> 101/12 <b>letter [20]</b> 70/23 90/24 91/2 91/8 91/16 92/5 93/10 94/15 95/23 95/24 96/5 99/8 99/24 100/3 100/16 102/14 103/4 161/10 161/19 165/5 <b>letters [2]</b> 90/16 90/21 <b>level [17]</b> 18/24 19/20 29/4 65/7 66/17 70/18 73/20 73/23 75/19 95/1 95/8 114/24 133/3 133/9 135/15 152/25 154/6 <b>levels [12]</b> 7/16 8/14 8/15 13/18 19/9 22/11 43/6 46/8 85/22 102/4 109/16 152/6 <b>Liberia [2]</b> 120/23 121/7 <b>life [19]</b> 3/7 3/10 3/11 3/25 5/3 5/18 7/13 14/4 14/11 18/16 21/24 21/24 25/7 26/4 26/6 28/8 28/11 47/4 113/12 <b>lifetime [1]</b> 134/24 <b>lifetimes [1]</b> 124/9 <b>light [1]</b> 94/5 <b>like [27]</b> 17/8 42/1 44/21 47/7 50/9 62/14 74/13 79/4 81/6 81/25 83/21 101/7 104/4 104/10 107/11 107/11 110/13 136/8 142/12 149/6 159/22 159/25 161/1 163/25 167/25 169/12 169/15 <b>likely [37]</b> 5/20 5/22	10/24 11/14 11/15 11/16 12/12 13/11 14/8 14/18 15/5 18/4 21/2 31/10 58/8 72/3 81/16 105/25 114/19 119/4 121/22 121/23 122/3 122/25 124/8 124/25 125/2 126/10 130/18 130/19 133/24 134/2 136/21 136/22 142/2 159/14 162/25 <b>limit [4]</b> 71/11 77/4 105/12 119/1 <b>limited [3]</b> 52/13 69/12 76/2 <b>line [9]</b> 6/13 6/13 17/25 30/5 79/21 88/10 150/11 150/21 163/11 <b>lines [2]</b> 8/4 148/8 <b>linkage [1]</b> 4/5 <b>linked [4]</b> 7/16 56/20 87/12 92/22 <b>links [1]</b> 35/1 <b>list [9]</b> 65/4 76/22 78/3 81/7 87/5 88/9 89/5 104/21 135/23 <b>listed [2]</b> 88/2 89/20 <b>listen [1]</b> 124/13 <b>listened [6]</b> 95/7 95/10 95/13 95/16 108/9 108/12 <b>lists [1]</b> 149/6 <b>little [22]</b> 35/9 49/7 53/7 54/1 58/18 62/22 65/8 69/18 72/7 74/13 84/3 88/3 92/18 97/21 106/10 107/19 114/4 123/22 134/17 150/15 156/14 166/15 <b>live [7]</b> 12/12 29/23 30/24 56/13 113/24 132/16 142/16 <b>Liverpool [2]</b> 2/5 3/5 <b>lives [7]</b> 3/21 5/4 28/11 30/10 43/6 47/17 113/24 <b>living [19]</b> 6/8 10/17 12/5 12/6 15/4 15/5 18/3 30/1 32/2 32/6 33/2 39/15 43/5 47/7 55/23 73/13 74/6 151/17 151/17 <b>lobbying [1]</b> 165/10 <b>local [11]</b> 39/4 75/5 75/11 76/2 95/1 95/8 135/15 145/1 149/23 150/4 156/11 <b>locations [1]</b> 119/4 <b>lock [2]</b> 150/24 150/24 <b>lockdown [29]</b> 37/5 37/24 38/17 46/2 48/4 57/19 66/2 70/7 82/3	91/10 140/7 140/9 140/13 140/20 141/4 150/15 151/1 151/5 151/20 151/25 151/25 152/15 155/2 158/10 159/1 159/3 160/2 162/6 162/19 <b>lockdowns [3]</b> 66/1 159/8 163/15 <b>locked [3]</b> 32/18 40/5 140/10 <b>logistic [1]</b> 57/5 <b>London [5]</b> 8/23 9/1 112/9 121/7 167/17 <b>lone [2]</b> 10/23 12/19 <b>long [16]</b> 31/17 42/4 42/5 42/6 52/12 53/16 53/18 53/20 58/7 59/21 64/12 77/18 84/14 119/6 153/7 156/6 <b>long Covid [5]</b> 42/4 42/5 42/6 59/21 64/12 <b>long term [1]</b> 119/6 <b>long-running [1]</b> 84/14 <b>long-standing [1]</b> 53/18 <b>long-term [3]</b> 53/20 58/7 156/6 <b>longer [4]</b> 69/5 104/20 119/6 133/4 <b>Longfield [12]</b> 27/6 27/7 27/12 27/13 43/24 44/5 45/21 47/22 49/7 50/20 50/22 171/9 <b>look [28]</b> 4/21 4/22 4/24 6/3 6/4 6/24 19/16 49/2 59/25 61/3 61/17 64/21 64/22 65/5 65/21 69/5 82/12 86/19 88/8 93/6 96/12 99/25 105/16 108/14 130/15 131/17 132/7 167/4 <b>looked [5]</b> 68/19 87/7 100/3 136/24 139/2 <b>looking [26]</b> 16/5 77/9 78/1 80/7 85/13 91/4 95/23 96/18 108/21 114/20 114/20 123/11 124/2 134/2 139/6 139/9 139/9 139/10 140/6 152/12 154/19 155/21 155/23 156/2 158/23 160/3 <b>looks [1]</b> 169/4 <b>Lord [2]</b> 29/12 29/14 <b>Lord Laming [1]</b> 29/14 <b>Lord Laming's [1]</b> 29/12 <b>losing [3]</b> 46/20	120/14 135/4 <b>loss [4]</b> 35/14 36/1 36/2 140/22 <b>lost [8]</b> 34/24 35/2 35/3 35/3 53/24 59/14 59/18 59/24 <b>lost significant [1]</b> 34/24 <b>lot [7]</b> 25/9 59/2 89/16 102/24 103/3 131/22 153/5 <b>lots [3]</b> 3/22 22/8 112/22 <b>lottery [1]</b> 145/2 <b>low [5]</b> 36/12 38/3 46/3 55/14 73/16 <b>lower [7]</b> 8/14 71/11 77/4 130/18 132/1 137/13 137/13 <b>lowest [3]</b> 15/4 16/14 71/1 <b>lowest-paid [1]</b> 71/1 <b>lunch [1]</b> 54/17
			<b>M</b>	
			<b>machinery [1]</b> 43/7 <b>madam [2]</b> 55/9 82/24 <b>made [23]</b> 30/19 46/6 46/14 50/1 57/1 58/18 66/24 75/24 76/7 76/18 88/1 102/2 111/21 121/13 137/9 137/14 138/11 138/21 151/8 152/17 166/8 169/17 170/4 <b>magnitude [1]</b> 75/25 <b>Mail [1]</b> 162/22 <b>main [3]</b> 89/13 117/9 160/19 <b>mainly [3]</b> 113/3 124/9 138/19 <b>mainstream [2]</b> 141/17 142/10 <b>major [4]</b> 7/5 16/16 20/19 32/25 <b>majority [7]</b> 14/4 34/14 36/11 51/21 122/9 122/10 137/7 <b>make [10]</b> 69/3 101/23 107/20 115/20 116/7 125/23 139/24 140/19 145/4 153/25 <b>maker [1]</b> 47/6 <b>makers [5]</b> 29/20 30/8 52/18 88/25 90/17 <b>makes [2]</b> 6/1 104/8 <b>making [11]</b> 15/10 30/8 42/20 44/17 48/15 50/3 52/25 53/6 53/15 137/23 139/7 <b>male [4]</b> 93/2 114/22 125/15 137/17	

<b>M</b>	<b>masks [1]</b> 104/14	83/19 117/15 136/20	26/16 32/9 39/7 39/16	<b>Minister's [1]</b> 162/19
<b>man [1]</b> 133/9	<b>material [6]</b> 5/2 5/17	149/1 159/4 159/11	39/17 41/15 41/22	<b>ministerial [1]</b> 52/25
<b>manage [2]</b> 95/14	7/9 19/1 28/22 54/6	161/25	46/8 46/9 49/16 51/19	<b>ministers [2]</b> 77/7
145/17	<b>maternal [5]</b> 117/16	<b>measure [7]</b> 4/20	53/20 58/2 60/5 125/5	165/5
<b>managed [1]</b> 36/24	117/24 117/25 127/14	6/20 18/17 98/14	125/7 125/15 125/18	<b>Ministry [1]</b> 56/11
<b>management [1]</b>	127/21	109/15 159/4 159/5	137/11 158/3	<b>minorities [1]</b> 98/6
58/16	<b>maternity [8]</b> 124/10	<b>measured [3]</b> 19/14	<b>mention [7]</b> 8/18	<b>minoritised [5]</b>
<b>manager [1]</b> 79/21	127/10 127/12 133/2	98/6 98/11	32/24 98/22 99/22	149/10 149/13 154/8
<b>managerial [3]</b> 83/22	136/15 136/16 136/24	<b>measures [9]</b> 6/10	162/5 162/6 162/20	160/12 167/5
130/20 131/1	136/25	10/8 65/14 67/2	<b>mentioned [15]</b> 4/15	<b>minority [21]</b> 11/14
<b>managers [5]</b> 99/13	<b>matter [5]</b> 91/23	134/15 140/4 157/18	13/21 16/23 34/4	11/18 12/21 58/4 58/6
99/14 99/19 99/19	92/21 94/11 109/12	165/15 169/5	35/14 39/3 40/6 53/5	67/9 86/4 87/21 89/6
108/3	146/7	<b>mechanisms [2]</b>	56/21 61/18 64/10	94/22 95/15 98/18
<b>mandate [1]</b> 101/17	<b>matters [9]</b> 1/14	116/3 138/2	66/7 107/13 148/24	99/18 100/12 100/14
<b>mandates [2]</b> 99/5	27/16 29/2 56/21	<b>media [1]</b> 161/14	165/6	101/15 104/6 105/21
99/16	62/21 63/3 63/14	<b>median [1]</b> 131/9	<b>mess [1]</b> 108/5	106/7 106/19 107/5
<b>mandatory [1]</b> 65/18	112/13 162/18	<b>medical [11]</b> 57/7	<b>message [5]</b> 36/17	<b>minorty [1]</b> 102/12
<b>manifest [2]</b> 114/12	<b>may [53]</b> 22/19 23/21	57/20 68/19 91/13	100/20 101/15 163/3	<b>minute [3]</b> 146/4
126/20	29/8 31/17 37/9 42/2	91/18 96/21 99/11	163/23	146/5 146/10
<b>manifestation [1]</b>	51/10 60/11 60/21	103/15 110/6 110/10	<b>messages [5]</b> 36/15	<b>minutes [1]</b> 51/7
113/10	61/5 67/22 74/18	124/20	92/13 107/24 121/20	<b>mirror [1]</b> 60/1
<b>manifested [1]</b> 140/4	77/25 81/4 86/16	<b>medicine [1]</b> 87/13	163/20	<b>mirrored [1]</b> 119/25
<b>manufacturing [1]</b>	104/1 105/6 105/18	<b>meet [11]</b> 40/22 41/4	<b>messaging [10]</b>	<b>miserably [1]</b> 45/2
57/22	111/10 111/19 112/5	41/5 41/6 41/7 50/24	152/17 162/13 162/17	<b>missed [3]</b> 26/4
<b>many [61]</b> 9/13 9/21	112/13 116/19 117/8	74/5 145/14 153/2	162/23 163/1 163/16	136/9 139/11
30/25 31/11 33/1	118/22 121/10 124/1	168/8 168/16	163/18 167/7 168/4	<b>misses [1]</b> 132/14
34/11 34/19 34/21	124/23 125/5 125/22	<b>meeting [3]</b> 121/1	169/16	<b>missing [3]</b> 25/1 25/2
35/20 36/25 37/1 37/1	129/15 130/15 131/3	153/9 153/9	<b>met [4]</b> 65/11 74/12	25/13
43/5 46/25 49/12	134/6 134/8 136/9	<b>meetings [1]</b> 65/3	119/24 167/23	<b>mistake [1]</b> 37/22
49/13 50/15 52/15	137/20 146/15 146/24	<b>Mehta [1]</b> 93/10	<b>MHRA [2]</b> 110/7	<b>mistakes [1]</b> 47/21
52/19 55/20 55/23	147/16 149/9 150/7	<b>member [8]</b> 56/9	110/14	<b>mitigate [3]</b> 118/19
59/18 59/21 59/23	151/14 151/20 152/13	62/12 79/12 90/10	<b>microbes [1]</b> 107/22	137/9 137/14
60/8 63/22 64/3 64/7	152/17 152/23 154/14	96/19 96/24 97/22	<b>middle [1]</b> 79/13	<b>mitigated [1]</b> 49/6
64/10 64/11 64/13	154/24 155/11 167/19	104/4	<b>middle-aged [1]</b>	<b>mix [3]</b> 31/9 31/20
69/12 74/5 76/15	169/6 169/6	<b>members [27]</b> 55/17	79/13	89/4
81/22 83/12 84/17	<b>May 2020 [2]</b> 81/4	61/22 63/7 82/1 86/23	<b>Midlands [2]</b> 8/20 9/2	<b>mobile [2]</b> 9/21 32/15
88/11 89/19 90/1	154/14	88/6 89/5 89/6 89/11	<b>midwifery [1]</b> 127/23	<b>mobility [2]</b> 140/14
90/13 91/22 92/16	<b>maybe [1]</b> 128/1	92/13 92/21 94/16	<b>midwives [2]</b> 81/2	140/16
93/22 94/25 97/5	<b>Mayor [1]</b> 167/17	96/6 99/3 100/8 100/9	88/11	<b>modern [1]</b> 13/25
107/24 109/8 113/15	<b>me [22]</b> 2/3 5/11 23/1	101/6 102/4 105/1	<b>might [23]</b> 39/20	<b>module [9]</b> 26/23
117/22 123/20 128/21	23/1 23/2 23/3 27/21	105/8 105/25 107/4	45/12 47/5 50/24 53/8	28/25 42/3 50/25 77/9
141/25 148/2 151/3	36/23 37/22 39/21	108/7 109/1 109/9	69/7 74/11 98/23	77/13 123/23 129/14
153/6 156/11 160/7	41/11 45/17 76/8	110/5 110/15	108/14 120/3 122/25	129/16
160/9 162/8 163/25	82/25 84/6 89/9 94/10	<b>membership [2]</b>	124/13 124/14 124/14	<b>Module 2 [1]</b> 123/23
<b>March [18]</b> 39/5 39/5	95/20 105/12 105/13	87/14 90/12	124/16 124/17 124/19	<b>module's [1]</b> 160/19
46/2 47/2 57/18 70/4	131/3 132/19	<b>memo [1]</b> 99/8	126/20 128/16 138/25	<b>moment [14]</b> 8/3
70/6 72/12 72/23	<b>meals [3]</b> 19/15	<b>men [25]</b> 72/4 113/2	142/12 142/23 142/25	34/4 68/3 104/22
150/13 150/22 151/11	19/18 19/21	113/15 113/22 114/1	<b>migrant [15]</b> 122/25	115/11 117/3 122/7
152/5 152/7 152/9	<b>mean [18]</b> 3/5 5/10	114/15 117/20 119/7	127/22 136/7 141/9	123/5 124/22 127/11
154/11 162/22 164/25	10/10 17/11 36/21	124/6 124/9 125/6	141/11 142/23 143/1	136/25 150/20 160/15
<b>March 2020 [6]</b> 39/5	37/7 41/10 107/8	125/24 126/2 126/10	164/9 164/20 165/1	165/25
46/2 47/2 150/13	108/7 113/18 113/20	126/15 126/17 126/18	165/3 165/15 165/22	<b>momentarily [1]</b> 47/4
150/22 152/9	123/19 130/8 135/1	127/3 130/13 130/19	166/8 169/20	<b>moments [1]</b> 169/6
<b>March 2021 [1]</b> 39/5	143/13 159/21 164/15	130/25 131/7 139/1	<b>millennium [1]</b> 8/5	<b>momentum [1]</b> 53/24
<b>marginalised [2]</b>	169/1	140/2 141/16	<b>million [9]</b> 6/7 9/17	<b>Monday [2]</b> 170/16
167/4 168/5	<b>meaning [1]</b> 19/23	<b>mental [48]</b> 2/21 13/3	34/19 39/14 40/3	170/20
<b>marked [1]</b> 101/4	<b>meaningful [1]</b> 116/7	13/6 13/10 13/11	62/14 70/10 71/1	<b>money [5]</b> 71/6 74/14
<b>market [4]</b> 20/7 63/23	<b>meaningfully [1]</b>	13/13 13/18 13/19	76/10	74/21 76/4 76/7
129/15 131/23	90/5	13/24 14/4 14/8 14/9	<b>mind [4]</b> 23/12 27/1	<b>Monitoring [1]</b>
<b>markets [1]</b> 119/2	<b>means [6]</b> 25/8 41/12	14/12 14/19 14/20	76/10 114/9	119/18
<b>Martha's [1]</b> 101/10	131/23 133/7 143/5	14/23 15/6 15/15	<b>minimum [1]</b> 97/15	<b>month [3]</b> 37/8
<b>Martha's Rule [1]</b>	149/18	15/19 15/20 15/25	43/21 46/15 47/15	153/14 155/16
101/10	<b>meant [12]</b> 32/13	16/7 16/12 16/16	50/13 161/10 165/4	<b>months [9]</b> 25/1 25/2
	33/12 41/6 47/7 76/4	16/18 17/8 22/2 26/11		25/13 32/5 48/3 100/5

<b>M</b>	23/10 37/12 40/12 45/17 52/8 77/14 77/17 80/4 85/7 123/25 134/6 156/5 156/10 156/19 156/20	139/24 144/19 146/14 152/10 170/15 <b>Ms Davies [3]</b> 139/13 139/16 145/21 <b>Ms Goshawk [4]</b> 146/15 146/18 147/1 147/13 <b>Ms Longfield [8]</b> 27/13 43/24 44/5 45/21 47/22 49/7 50/20 50/22 <b>Ms Twite [5]</b> 22/16 23/8 23/9 44/4 45/11	22/25 26/19 27/3 27/6 28/25 45/20 50/21 51/13 54/5 54/16 60/10 77/15 84/25 85/7 85/10 110/21 139/18 145/20 146/15 160/20 162/12 170/2 170/14 <b>myriad [1]</b> 118/11 <b>myself [1]</b> 30/18	163/23 <b>needing [2]</b> 117/23 123/4 <b>needs [9]</b> 34/7 40/15 42/11 42/19 43/22 119/23 120/16 133/25 158/4 <b>negative [2]</b> 7/20 37/23 <b>neighbours [2]</b> 114/20 134/3 <b>nerve [1]</b> 102/7 <b>network [2]</b> 96/7 97/6 <b>networks [5]</b> 86/24 87/3 88/22 90/3 92/4 <b>neuroplasticity [1]</b> 25/22 <b>never [6]</b> 25/8 32/11 36/4 50/18 73/10 170/9 <b>new [4]</b> 8/4 59/9 80/11 80/17 <b>next [19]</b> 8/9 13/15 23/3 31/17 44/18 47/23 50/25 52/14 61/4 66/3 73/11 85/8 93/8 97/10 99/23 108/25 137/3 145/15 158/5 <b>NHS [34]</b> 13/9 16/10 58/15 58/25 59/18 84/1 88/4 89/7 89/11 89/18 89/23 91/12 94/4 94/18 98/7 98/11 98/14 99/4 99/6 99/16 99/17 100/21 101/8 101/16 102/6 102/22 103/9 106/25 109/7 110/8 128/2 128/12 129/3 129/20 <b>NHS Digital [1]</b> 13/9 <b>NHS England [6]</b> 94/18 99/6 99/17 100/21 101/16 102/6 <b>NHS trusts [1]</b> 102/22 <b>Nightingale [1]</b> 44/25 <b>nine [1]</b> 2/18 <b>no [54]</b> 9/18 12/8 22/25 29/14 36/11 41/16 43/8 43/10 48/7 55/21 56/2 57/8 59/4 59/19 60/4 60/6 63/11 64/10 66/22 69/12 69/23 71/17 76/4 85/13 85/13 88/19 96/6 96/15 98/15 99/3 104/3 104/4 105/4 123/24 129/13 136/1 143/4 143/14 143/14 143/24 145/23 152/11 155/17 157/22 160/20 162/5 162/16 162/16 162/20 165/16 165/19
<b>months... [3]</b> 100/16 138/22 152/22 <b>moral [1]</b> 4/9 <b>morbidity [1]</b> 92/23 <b>more [89]</b> 5/20 5/22 8/11 9/7 9/8 10/1 10/24 11/14 11/15 12/12 14/8 14/15 17/9 21/1 21/2 21/12 22/3 22/3 25/23 26/2 26/3 26/8 31/14 31/22 31/24 34/14 35/9 35/13 35/14 36/22 42/14 42/14 42/19 44/18 44/19 49/18 49/25 51/6 55/9 57/12 58/4 58/8 61/19 64/10 66/17 68/24 71/20 71/21 75/25 78/18 79/3 81/16 82/24 94/13 104/22 105/25 114/4 114/8 114/15 114/19 115/4 118/16 119/3 121/22 121/23 122/2 122/25 124/8 130/18 130/19 133/24 134/2 135/6 136/21 136/22 142/8 143/16 144/7 149/2 149/15 149/23 156/6 156/9 159/12 163/22 166/2 168/14 169/9 169/14 <b>morgue [1]</b> 59/4 <b>morning [15]</b> 1/3 1/4 7/18 16/23 27/9 27/10 31/20 44/14 46/7 48/7 51/12 52/5 53/3 55/5 85/9 <b>mortality [6]</b> 7/11 21/23 92/24 97/17 118/1 127/14 <b>most [32]</b> 6/14 6/21 10/21 14/18 14/24 15/16 17/25 18/3 18/7 18/8 20/25 21/12 22/12 30/3 31/8 32/25 37/2 38/7 39/22 46/20 57/16 59/16 91/7 94/16 100/9 106/10 108/7 126/14 126/14 126/15 127/18 136/10 <b>mostly [2]</b> 106/12 110/1 <b>mother [1]</b> 79/13 <b>mother's [1]</b> 133/8 <b>motherhood [2]</b> 132/22 132/25 <b>mothers [6]</b> 80/6 80/14 80/17 81/1 81/16 81/17 <b>move [21]</b> 5/5 20/8 22/23 23/1 23/2 23/9	23/10 37/12 40/12 45/17 52/8 77/14 77/17 80/4 85/7 123/25 134/6 156/5 156/10 156/19 156/20 <b>move-on [1]</b> 156/10 <b>moved [1]</b> 45/14 <b>movement [2]</b> 159/6 161/22 <b>moving [10]</b> 6/21 37/13 57/12 104/21 136/16 136/24 138/15 143/1 155/22 156/7 <b>Mr [25]</b> 1/4 23/11 23/13 45/14 45/16 54/9 54/15 54/19 54/24 55/1 56/9 56/12 56/16 77/10 85/8 85/15 85/18 85/19 86/16 89/15 91/1 102/13 105/20 110/17 172/1 <b>Mr Ade Adeyemi [1]</b> 85/18 <b>Mr Adeyemi [10]</b> 54/19 55/1 85/8 85/19 86/16 89/15 91/1 102/13 105/20 110/17 <b>Mr Gomes [3]</b> 56/9 56/12 56/16 <b>Mr Keating [2]</b> 1/4 54/9 <b>Mr O'Connor [3]</b> 54/15 54/24 77/10 <b>Mr Weatherby [1]</b> 23/13 <b>Mr Weatherby KC [1]</b> 45/16 <b>Ms [59]</b> 22/16 23/8 23/9 23/14 27/7 27/13 43/24 44/4 44/5 45/11 45/13 45/15 45/21 47/22 49/7 50/20 50/22 54/20 58/23 60/11 60/13 60/17 61/2 61/8 62/4 66/15 69/25 70/3 77/17 78/15 80/4 82/6 82/25 84/20 85/1 85/4 111/9 123/18 139/13 139/16 139/17 139/24 144/19 145/21 146/14 146/15 146/16 146/18 147/1 147/13 152/10 160/17 170/15 171/7 171/9 171/15 171/21 172/9 172/11 <b>Ms Bell [17]</b> 54/20 58/23 60/11 60/17 61/2 61/8 62/4 66/15 69/25 70/3 77/17 78/15 80/4 82/6 82/25 84/20 85/4 <b>Ms Cecil [6]</b> 111/9	139/24 144/19 146/14 152/10 170/15 <b>Ms Davies [3]</b> 139/13 139/16 145/21 <b>Ms Goshawk [4]</b> 146/15 146/18 147/1 147/13 <b>Ms Longfield [8]</b> 27/13 43/24 44/5 45/21 47/22 49/7 50/20 50/22 <b>Ms Twite [5]</b> 22/16 23/8 23/9 44/4 45/11 <b>much [49]</b> 1/12 11/14 11/14 11/15 14/8 17/9 23/12 25/23 26/2 26/3 26/20 26/21 27/2 27/13 28/5 33/4 35/5 42/19 45/6 45/9 47/20 49/18 49/24 50/22 51/1 51/3 54/9 61/19 70/16 72/16 73/8 74/22 84/20 85/4 85/11 85/14 90/7 110/17 110/22 131/25 139/15 145/19 145/24 151/17 166/6 170/1 170/5 170/7 170/11 <b>multi [1]</b> 86/22 <b>multi-disciplinary [1]</b> 86/22 <b>multiple [5]</b> 12/20 79/24 80/3 142/24 144/13 <b>multiply [1]</b> 99/21 <b>mums' [1]</b> 80/12 <b>murdered [1]</b> 29/14 <b>must [3]</b> 41/10 104/16 105/4 <b>my [74]</b> 1/3 1/16 4/19 21/17 22/16 22/20 22/25 26/19 26/25 27/3 27/6 27/21 28/10 28/20 28/25 31/13 33/8 39/14 40/19 44/1 45/20 45/25 47/23 48/9 50/21 51/6 51/13 54/5 54/16 59/9 59/14 59/16 59/21 59/24 60/1 60/2 60/10 61/16 62/2 72/24 76/22 77/15 79/17 79/20 79/20 79/24 80/1 84/25 85/7 85/10 85/24 86/10 87/9 89/21 104/3 105/11 110/21 114/6 123/3 139/18 145/16 145/20 145/22 146/3 146/15 146/23 151/11 152/19 154/3 160/20 162/12 168/24 170/2 170/14 <b>my Lady [27]</b> 1/3 21/17 22/16 22/20	<b>N</b> <b>name [5]</b> 1/9 27/11 60/15 85/17 146/19 <b>narrative [4]</b> 5/1 61/19 64/1 64/15 <b>narratives [1]</b> 61/22 <b>narrow [2]</b> 47/19 53/6 <b>narrowing [1]</b> 20/23 <b>NASS [1]</b> 141/20 <b>nation [3]</b> 99/21 115/15 115/15 <b>national [22]</b> 18/18 58/13 59/20 62/21 65/7 71/10 85/22 87/2 87/20 90/15 92/2 95/8 97/3 97/14 98/3 102/4 104/3 109/5 126/2 154/6 154/9 163/18 <b>nationally [1]</b> 13/23 <b>nations [12]</b> 7/24 8/1 8/12 49/19 50/10 115/11 115/12 115/20 116/6 120/1 128/10 135/25 <b>natural [2]</b> 3/14 51/11 <b>nature [5]</b> 43/5 56/25 64/14 76/2 157/23 <b>navigate [1]</b> 113/15 <b>Nazroo [2]</b> 11/3 107/8 <b>nearly [4]</b> 50/18 70/10 71/1 148/11 <b>necessarily [3]</b> 95/2 126/18 133/3 <b>necessary [2]</b> 37/8 96/2 <b>necessitating [1]</b> 128/24 <b>need [30]</b> 4/2 6/12 43/19 48/12 48/15 50/6 50/7 55/4 61/11 62/10 65/19 67/5 67/8 67/17 67/20 67/22 67/23 69/2 74/18 93/6 93/24 108/11 121/23 124/10 132/15 138/13 146/5 151/3 161/20 168/16 <b>needed [9]</b> 34/23 67/2 75/7 75/14 84/13 105/25 107/20 163/12	

<b>N</b>	138/10 142/18 146/5 146/23 152/11 152/11 153/9 156/16 157/22 160/8 160/10 160/16 162/4 162/16 163/5 163/7 164/1 166/4 166/14 166/18 168/5 168/16 168/23 169/25 170/10	13/24 16/22 17/2 17/7 17/8 18/6 22/5 24/14 26/13 41/14 41/22 <b>obfuscate [1]</b> 104/11 <b>objectives [2]</b> 62/6 99/7 <b>observations [3]</b> 115/19 116/7 138/12 <b>Observatory [1]</b> 110/9 <b>observe [1]</b> 68/5 <b>obstetric [2]</b> 117/19 127/23 <b>obtaining [1]</b> 159/19 <b>obviously [15]</b> 26/25 36/17 45/10 50/23 56/20 68/8 74/11 93/4 110/23 119/10 123/21 137/21 156/19 158/24 166/5 <b>occasions [6]</b> 33/9 33/23 34/1 57/15 65/12 66/24 <b>occupation [1]</b> 4/22 <b>occupational [2]</b> 130/6 130/17 <b>occupations [1]</b> 130/23 <b>occupying [1]</b> 130/25 <b>occur [1]</b> 127/18 <b>occurred [3]</b> 8/19 20/25 22/11 <b>occurring [1]</b> 135/3 <b>October [2]</b> 1/1 170/20 <b>off [3]</b> 70/19 128/18 133/6 <b>offer [1]</b> 74/18 <b>office [9]</b> 92/2 121/3 121/4 126/1 141/19 143/19 157/1 158/16 165/7 <b>officer [3]</b> 91/14 96/21 101/16 <b>officials [2]</b> 52/24 121/1 <b>often [28]</b> 4/21 19/14 30/18 32/3 33/11 33/17 33/24 34/1 35/18 35/22 39/22 41/6 44/22 46/13 46/17 46/20 87/19 88/1 119/10 126/11 149/1 149/4 149/6 156/24 159/12 165/23 169/22 169/24 <b>often 4 [1]</b> 33/17 <b>Oh [2]</b> 45/14 161/1 <b>okay [3]</b> 20/16 134/20 161/4 <b>older [10]</b> 24/16 93/2 94/3 94/3 94/6 94/13 94/22 95/18 167/5 167/6	<b>oldest [1]</b> 71/25 <b>olds [1]</b> 13/14 <b>on [259]</b> <b>once [3]</b> 55/10 102/1 133/11 <b>one [98]</b> 3/21 9/5 13/22 16/25 17/10 18/11 19/4 21/16 22/5 24/13 26/7 30/5 34/5 36/22 37/22 39/3 40/3 40/12 40/25 42/1 43/1 43/10 44/4 44/8 44/9 47/20 50/12 58/25 59/25 60/4 60/6 65/7 66/2 66/7 66/23 68/5 68/25 70/15 71/5 71/8 71/19 78/24 79/2 79/9 79/13 80/4 80/16 81/3 83/24 89/12 89/12 89/13 91/5 91/7 92/4 92/4 93/21 93/22 94/12 95/22 98/24 99/23 101/2 101/18 102/14 102/16 102/19 102/19 104/3 104/4 104/20 107/4 108/7 118/14 121/22 123/7 125/6 125/6 125/13 125/23 126/24 127/11 127/21 128/23 134/23 136/12 141/21 142/23 145/4 150/19 154/19 155/8 158/2 160/3 163/2 163/24 168/12 169/21 <b>one week [1]</b> 44/9 <b>ones [5]</b> 46/20 108/8 114/19 153/9 168/18 <b>online [8]</b> 10/3 32/10 32/14 34/17 34/18 55/1 156/20 163/24 <b>only [8]</b> 42/19 45/19 47/17 49/22 75/15 136/2 165/25 170/7 <b>onwards [4]</b> 20/22 81/4 116/19 168/11 <b>opaque [1]</b> 47/10 <b>open [10]</b> 33/13 36/5 37/11 37/16 38/2 38/15 38/15 44/6 48/13 48/22 <b>opened [2]</b> 155/10 155/22 <b>opening [3]</b> 37/13 37/21 53/12 <b>operating [2]</b> 38/14 99/8 <b>operation [2]</b> 75/9 75/13 <b>operator [1]</b> 95/20 <b>opinion [1]</b> 114/9 <b>opportunities [4]</b> 24/17 25/17 136/9 139/11	<b>opportunity [7]</b> 25/8 37/14 45/20 151/21 153/19 153/20 159/22 <b>opposed [1]</b> 124/6 <b>option [1]</b> 47/20 <b>options [2]</b> 155/13 156/10 <b>or [124]</b> 4/22 6/7 9/18 12/12 12/14 17/4 17/21 26/9 26/10 29/25 30/2 32/3 33/17 34/15 37/18 39/17 40/9 41/4 41/7 42/8 48/2 48/3 49/12 51/23 55/15 56/24 58/7 58/8 59/17 59/19 60/12 61/4 66/22 69/12 78/13 78/18 80/1 80/17 80/19 81/17 83/3 83/17 84/13 85/21 87/5 87/19 88/17 91/9 92/23 93/23 94/14 95/2 95/14 95/16 95/16 97/4 98/16 98/17 100/4 100/16 100/17 101/2 101/13 103/21 103/25 104/9 105/4 105/12 106/22 107/3 107/18 115/7 115/20 116/7 117/23 118/18 119/10 120/4 120/10 120/11 120/14 120/20 124/10 124/17 124/18 128/2 128/3 128/19 130/20 132/2 133/22 133/23 135/5 138/22 139/9 141/16 146/24 149/2 149/11 149/23 150/2 152/3 154/6 155/5 156/9 156/9 157/2 157/15 158/4 159/6 159/18 160/8 160/10 160/10 161/3 162/25 165/18 166/22 166/22 166/24 167/10 168/15 169/25 170/3 <b>oral [1]</b> 21/15 <b>orally [1]</b> 62/10 <b>order [5]</b> 30/14 55/18 59/5 84/13 96/2 <b>ordered [1]</b> 137/18 <b>organisation [21]</b> 45/22 53/1 53/23 54/19 55/16 56/8 62/5 62/7 62/23 62/24 63/1 63/16 77/21 86/2 86/17 89/16 90/14 96/19 102/15 147/18 164/23 <b>organisations [21]</b> 23/17 56/5 63/8 63/10 77/2 86/5 86/24 87/3 87/6 87/12 88/13
<b>no... [3]</b> 169/18 170/3 170/5 <b>no one [5]</b> 43/10 60/4 60/6 104/3 104/4 <b>nods [1]</b> 131/2 <b>noise [2]</b> 106/17 106/18 <b>non [5]</b> 10/24 47/24 81/17 135/16 165/24 <b>non-governmental [1]</b> 135/16 <b>non-parents [1]</b> 81/17 <b>non-pharmaceutical [1]</b> 47/24 <b>non-spousal [1]</b> 165/24 <b>non-white [1]</b> 10/24 <b>None [1]</b> 40/23 <b>normal [5]</b> 38/14 75/6 75/7 75/17 158/19 <b>normally [4]</b> 40/21 40/22 87/4 152/4 <b>norms [3]</b> 113/4 113/6 113/21 <b>northern [8]</b> 8/16 8/20 9/1 11/23 62/18 63/7 129/3 136/1 <b>Northern Ireland [6]</b> 8/16 11/23 62/18 63/7 129/3 136/1 <b>not [124]</b> 2/22 10/14 13/17 14/7 15/2 16/20 23/5 24/18 25/14 26/24 29/9 34/6 34/12 41/20 42/19 44/7 47/7 47/8 47/17 48/13 48/19 48/24 49/22 52/18 53/13 53/16 53/17 55/23 58/15 59/6 60/11 63/8 63/23 67/7 67/12 67/25 69/23 70/3 71/5 73/21 74/9 75/3 75/14 79/25 82/18 83/19 83/20 84/5 84/8 84/16 85/11 87/10 88/3 88/9 91/16 93/1 93/2 93/20 95/2 95/7 95/16 96/6 99/3 99/13 99/20 100/9 100/11 101/16 101/17 101/17 102/21 103/2 104/9 104/24 106/19 106/20 106/21 107/1 107/1 107/6 108/3 108/12 108/12 108/12 109/6 109/13 110/13 112/21 113/25 114/6 122/18 122/21 123/24 124/18 125/13 128/2 128/2 133/3 136/18	<b>not a [1]</b> 99/13 <b>note [14]</b> 66/22 72/24 76/22 91/3 117/4 119/18 123/14 126/4 126/24 129/12 146/22 154/20 155/24 158/13 <b>noted [4]</b> 55/20 56/1 57/4 115/18 <b>nothing [1]</b> 3/14 <b>noticeable [1]</b> 152/7 <b>noting [2]</b> 81/9 134/22 <b>now [43]</b> 17/18 22/16 41/7 46/25 48/1 54/10 54/16 55/9 59/17 61/17 62/16 68/16 80/7 82/7 82/12 85/23 93/4 95/20 104/13 111/19 112/8 112/13 115/2 116/4 116/19 116/23 117/7 119/15 120/3 121/10 124/4 125/5 128/6 129/15 131/5 134/6 138/11 146/3 147/16 150/7 158/23 164/9 165/12 <b>NPIs [5]</b> 65/8 65/9 66/3 67/1 159/8 <b>number [31]</b> 3/13 4/21 7/10 9/9 16/20 20/12 20/20 38/22 40/4 42/23 45/21 53/21 59/5 66/16 87/3 91/25 124/4 128/15 128/21 129/8 129/20 139/12 150/12 150/14 152/18 152/25 157/3 160/13 161/8 161/11 167/11 <b>numbered [1]</b> 103/12 <b>numbers [4]</b> 38/2 39/23 77/25 88/24 <b>numerous [5]</b> 28/21 64/25 65/11 76/21 76/24 <b>nurseries [1]</b> 38/15 <b>nurses [4]</b> 88/11 94/20 96/7 96/19 <b>nursing [1]</b> 132/1	<b>O</b> <b>O'Connor [3]</b> 54/15 54/24 77/10 <b>obese [2]</b> 17/22 18/4 <b>obesity [12]</b> 7/14		

<p><b>O</b></p> <p><b>organisations... [10]</b> 90/10 91/6 91/22 96/7 96/24 131/1 149/13 154/3 154/8 157/9</p> <p><b>organise [2]</b> 3/15 156/12</p> <p><b>organised [1]</b> 3/17</p> <p><b>origin [3]</b> 87/19 91/3 103/8</p> <p><b>origins [1]</b> 3/24</p> <p><b>ornaments [1]</b> 106/14</p> <p><b>other [70]</b> 9/4 11/1 23/23 24/11 24/22 28/12 28/14 30/13 31/1 32/13 32/16 35/1 35/24 44/16 50/5 53/8 54/23 65/14 67/2 68/13 69/2 72/1 76/13 77/14 83/24 88/11 91/25 92/14 94/20 94/24 96/14 96/23 97/6 99/11 99/14 102/14 105/12 105/13 106/14 106/17 110/18 113/2 117/1 118/9 118/16 122/17 128/19 131/24 132/2 132/20 133/15 133/23 135/10 138/9 144/24 145/6 148/8 151/2 154/3 154/19 156/6 156/17 157/18 161/15 165/7 166/4 166/25 167/11 168/17 169/13</p> <p><b>others [16]</b> 14/16 32/19 34/17 48/3 48/3 50/12 51/17 56/19 83/25 91/14 93/12 114/8 123/1 147/4 151/18 159/18</p> <p><b>ought [1]</b> 137/22</p> <p><b>our [51]</b> 11/10 27/18 27/19 43/7 51/11 59/4 59/14 59/18 60/23 62/24 65/23 66/10 67/4 76/15 79/19 81/3 87/10 89/13 89/25 91/7 92/4 92/11 92/13 92/21 92/21 94/16 96/6 96/6 96/16 96/17 97/6 99/3 106/7 107/4 108/7 109/7 109/8 110/15 113/24 148/25 149/4 150/11 150/16 153/5 153/16 155/7 157/13 163/10 163/12 163/21 166/14</p> <p><b>ours [2]</b> 159/23 159/25</p> <p><b>ourselves [3]</b> 72/9 87/22 110/8</p>	<p><b>out [66]</b> 1/22 2/23 6/4 6/5 7/25 15/10 19/10 29/11 32/18 34/24 35/7 36/16 37/21 37/21 38/4 38/13 38/23 46/20 50/10 53/1 54/22 57/17 58/9 59/22 61/18 64/2 71/18 76/12 76/13 78/6 78/21 79/8 80/15 80/19 81/25 87/10 93/18 96/8 97/10 98/19 99/10 100/7 100/10 102/9 102/11 105/10 105/20 106/10 112/6 113/4 116/24 124/4 124/7 125/12 130/22 131/18 133/1 136/17 149/20 151/3 156/5 160/13 166/9 167/11 168/10 170/8</p> <p><b>outbreak [4]</b> 37/18 117/12 118/8 119/24</p> <p><b>outbreaks [4]</b> 117/4 117/5 118/24 120/10</p> <p><b>outcome [1]</b> 104/6</p> <p><b>outcomes [14]</b> 4/13 11/11 14/3 14/4 31/15 51/19 52/3 58/2 102/11 104/18 113/2 124/16 127/3 127/12</p> <p><b>outdoor [2]</b> 24/17 26/9</p> <p><b>outline [4]</b> 7/11 9/22 11/12 161/20</p> <p><b>outlined [4]</b> 4/13 14/2 26/12 161/12</p> <p><b>outlines [1]</b> 11/12</p> <p><b>outset [4]</b> 111/20 115/8 127/7 139/8</p> <p><b>outsourced [2]</b> 56/10 56/23</p> <p><b>outsourcing [1]</b> 56/6</p> <p><b>over [37]</b> 2/25 3/21 5/3 5/12 7/6 8/9 10/9 10/12 14/11 14/24 17/17 24/14 26/13 28/12 44/17 62/16 62/17 70/23 71/21 72/24 85/23 88/1 88/4 93/8 99/21 108/14 121/14 125/10 125/11 135/21 135/23 142/14 144/10 147/21 152/22 162/15 167/8</p> <p><b>overall [5]</b> 21/11 31/5 49/23 88/3 126/23</p> <p><b>overarching [2]</b> 66/22 66/25</p> <p><b>overcomplicate [1]</b> 6/12</p> <p><b>overlooked [5]</b> 34/1 45/7 46/13 46/17 82/4</p> <p><b>overrepresentation [1]</b> 81/22</p>	<p><b>oversight [1]</b> 35/3</p> <p><b>overstretched [1]</b> 153/7</p> <p><b>overview [6]</b> 3/4 4/16 33/7 62/5 86/17 147/18</p> <p><b>own [16]</b> 35/5 43/1 59/14 61/25 67/18 74/2 96/16 96/17 96/21 98/20 98/20 111/23 111/24 163/10 164/20 169/22</p> <p><b>oximeter [1]</b> 109/22</p> <p><b>oximeters [1]</b> 109/13</p> <p><b>oxygen [1]</b> 109/16</p> <hr/> <p><b>P</b></p> <p><b>pace [2]</b> 27/18 146/23</p> <p><b>page [37]</b> 1/21 2/16 2/25 3/2 5/6 6/5 7/25 11/7 13/4 15/7 17/15 20/18 28/2 61/11 64/21 64/23 69/6 69/8 77/24 78/2 78/13 82/17 86/20 87/9 87/11 88/7 93/8 95/21 97/21 100/2 103/2 103/6 105/18 108/15 111/20 147/9 171/2</p> <p><b>page 11 [1]</b> 95/21</p> <p><b>page 12 [1]</b> 105/18</p> <p><b>page 14 [1]</b> 100/2</p> <p><b>page 2 [3]</b> 2/16 82/17 88/7</p> <p><b>page 22 [2]</b> 13/4 87/9</p> <p><b>page 23 [1]</b> 15/7</p> <p><b>page 3 [2]</b> 2/25 64/21</p> <p><b>page 31 [1]</b> 17/15</p> <p><b>page 44 [1]</b> 69/6</p> <p><b>page 46 [1]</b> 20/18</p> <p><b>page 5 [1]</b> 5/6</p> <p><b>page 6 [1]</b> 7/25</p> <p><b>page 63 [1]</b> 147/9</p> <p><b>page 78 [1]</b> 77/24</p> <p><b>page 9 [1]</b> 11/7</p> <p><b>page of [1]</b> 93/8</p> <p><b>pages [2]</b> 87/8 87/9</p> <p><b>paid [6]</b> 55/14 71/1 130/19 130/20 138/2 138/5</p> <p><b>pain [2]</b> 124/25 125/3</p> <p><b>pain-related [2]</b> 124/25 125/3</p> <p><b>painful [1]</b> 59/10</p> <p><b>palpable [1]</b> 108/9</p> <p><b>pandemic [135]</b> 2/14 2/20 6/7 6/18 6/22 7/2 7/7 7/20 9/6 9/14 9/15 10/3 10/17 12/4 12/19 13/1 13/7 13/8 13/16 15/19 16/6 16/9 16/15 16/16 18/6 19/9 19/19 20/13 21/19 21/20</p>	<p>22/10 24/15 26/14 28/18 28/24 29/5 30/8 30/11 31/5 32/1 32/22 39/11 39/16 41/18 41/24 42/10 42/12 42/13 43/3 43/4 47/17 47/25 49/4 49/17 52/11 53/22 54/4 55/14 59/20 60/5 60/22 64/17 64/20 65/2 65/22 66/20 66/21 67/12 68/14 68/19 69/16 69/22 72/11 74/15 76/13 76/20 77/22 78/4 78/5 78/7 79/2 81/9 81/21 82/3 83/9 83/13 84/3 84/15 88/17 88/23 89/3 89/3 90/8 90/11 91/9 91/19 94/18 97/25 98/4 99/2 100/6 100/10 103/23 106/5 115/9 119/19 125/17 126/8 129/12 135/22 136/10 138/22 139/9 140/6 140/6 140/8 144/22 145/5 145/10 148/16 148/18 150/8 150/10 155/5 156/19 158/7 158/8 158/14 158/20 159/5 164/12 164/16 164/17 166/21 168/21</p> <p><b>pandemics [4]</b> 116/21 117/1 118/16 163/22</p> <p><b>paragraph [66]</b> 5/7 6/24 7/18 8/18 9/7 9/16 10/7 12/3 12/15 13/5 15/3 15/18 18/13 20/10 23/19 25/17 30/22 32/24 38/5 38/20 64/23 64/24 69/7 70/24 78/1 78/2 78/3 78/13 80/7 80/9 81/7 82/16 82/19 82/22 88/8 92/19 93/17 93/23 94/2 95/21 96/18 97/8 97/10 97/11 100/1 100/5 105/19 105/20 108/15 116/19 131/12 132/21 135/20 139/24 140/20 141/10 143/2 144/19 148/19 149/21 154/20 155/1 155/9 158/13 160/15 165/11</p> <p><b>paragraph 11 [1]</b> 8/18</p> <p><b>paragraph 126 [1]</b> 18/13</p> <p><b>paragraph 13 [1]</b> 9/7</p> <p><b>paragraph 131 [1]</b> 20/10</p>	<p><b>paragraph 147 [1]</b> 69/7</p> <p><b>paragraph 17 [1]</b> 9/16</p> <p><b>paragraph 208 [2]</b> 154/20 158/13</p> <p><b>paragraph 21 [1]</b> 12/3</p> <p><b>paragraph 23 [1]</b> 30/22</p> <p><b>paragraph 25 [2]</b> 10/7 148/19</p> <p><b>paragraph 258 [2]</b> 78/2 78/3</p> <p><b>paragraph 26 [1]</b> 12/15</p> <p><b>paragraph 265 [1]</b> 78/13</p> <p><b>paragraph 271 [1]</b> 80/7</p> <p><b>paragraph 275 [1]</b> 80/9</p> <p><b>paragraph 280 [1]</b> 81/7</p> <p><b>paragraph 29 [1]</b> 95/21</p> <p><b>paragraph 30 [1]</b> 97/11</p> <p><b>paragraph 31 [1]</b> 149/21</p> <p><b>paragraph 33 [2]</b> 105/19 105/20</p> <p><b>paragraph 35 [1]</b> 108/15</p> <p><b>paragraph 36 [1]</b> 165/11</p> <p><b>paragraph 39 [2]</b> 100/1 131/12</p> <p><b>paragraph 4 [1]</b> 82/16</p> <p><b>paragraph 44 [1]</b> 132/21</p> <p><b>paragraph 47 [1]</b> 144/19</p> <p><b>paragraph 48 [2]</b> 139/24 155/1</p> <p><b>paragraph 49 [1]</b> 155/9</p> <p><b>paragraph 51 [1]</b> 141/10</p> <p><b>paragraph 53 [1]</b> 135/20</p> <p><b>paragraph 55 [2]</b> 23/19 25/17</p> <p><b>paragraph 58 [1]</b> 13/5</p> <p><b>paragraph 6 [1]</b> 88/8</p> <p><b>paragraph 62 [1]</b> 38/5</p> <p><b>paragraph 63 [1]</b> 38/20</p> <p><b>paragraph 7 [3]</b> 5/7 64/23 64/24</p> <p><b>paragraph 71 [1]</b></p>
--	--	--	--	--



<b>P</b>	<b>particularly [34]</b> 3/19 7/13 8/23 11/19 12/19 14/19 14/21 16/17 20/25 21/25 23/25 24/22 29/24 39/1 39/19 47/24 54/2 58/11 63/20 65/10 65/20 77/19 94/22 101/4 117/16 120/16 125/2 125/14 129/9 137/10 137/12 141/22 160/11 169/10	<b>penalty [2]</b> 132/22 132/25 <b>people [63]</b> 22/2 22/8 23/21 24/11 26/24 39/24 47/6 48/17 50/17 51/3 53/10 54/3 55/4 59/2 59/3 59/22 62/15 62/17 63/17 63/22 64/3 64/4 70/19 71/14 71/24 71/25 73/20 74/3 74/5 75/5 76/3 76/15 80/13 84/7 87/17 87/21 91/12 94/6 98/15 98/16 101/16 102/6 102/23 106/12 107/18 108/11 109/17 110/2 117/20 118/2 126/16 131/23 132/7 132/11 132/15 134/4 137/24 140/1 151/20 153/6 156/7 163/25 163/25	<b>personal [1]</b> 79/7 <b>persons [1]</b> 15/4 <b>perspective [3]</b> 4/1 158/23 168/10 <b>pharmaceutical [1]</b> 47/24 <b>phenomenon [1]</b> 132/25 <b>phone [4]</b> 9/21 32/15 36/25 39/21 <b>photos [2]</b> 48/17 48/18 <b>phrase [3]</b> 9/7 10/4 19/13 <b>physical [5]</b> 16/18 26/11 41/22 58/2 129/8 <b>Physicians [2]</b> 91/2 103/8 <b>pick [8]</b> 69/6 106/17 122/14 124/23 133/5 150/20 162/12 164/3 <b>picked [1]</b> 14/7 <b>picking [3]</b> 117/7 162/17 164/22 <b>picture [6]</b> 11/13 68/4 91/17 131/20 134/9 156/3 <b>pieces [1]</b> 78/20 <b>pigmentation [1]</b> 110/4 <b>pillars [1]</b> 23/6 <b>place [14]</b> 32/10 37/19 47/18 50/2 54/1 59/22 65/13 83/21 94/24 129/7 131/8 138/3 157/19 159/8 <b>placed [1]</b> 58/1 <b>places [3]</b> 22/22 128/14 149/3 <b>plan [1]</b> 146/3 <b>planning [2]</b> 37/17 37/18 <b>platforms [1]</b> 162/8 <b>play [13]</b> 23/20 23/21 23/25 24/3 24/6 24/11 24/17 24/21 32/17 41/2 41/13 94/7 113/4 <b>played [2]</b> 37/23 102/11 <b>playgrounds [2]</b> 26/10 48/21 <b>Playing [1]</b> 53/1 <b>please [40]</b> 1/5 1/9 1/17 2/25 6/24 12/15 27/6 27/11 60/15 61/6 69/5 70/1 72/7 77/8 77/24 78/2 78/12 79/11 80/9 81/7 85/17 87/1 88/7 90/24 93/9 95/21 96/13 100/1 111/10 114/17 121/17 123/5 124/7 126/13 134/19 146/15 146/19	160/14 162/14 162/16 <b>pleased [1]</b> 163/9 <b>plot [2]</b> 11/13 11/16 <b>plotted [1]</b> 20/18 <b>pm [5]</b> 111/6 111/8 146/11 146/13 170/18 <b>pockets [1]</b> 109/11 <b>point [31]</b> 15/10 37/12 39/12 48/8 65/21 66/4 66/9 68/16 72/13 73/2 73/7 73/11 74/7 99/24 101/23 103/12 103/20 105/3 124/4 124/23 125/12 130/22 131/9 139/23 140/19 145/4 153/13 155/8 162/13 167/16 169/17 <b>point 2 [1]</b> 103/20 <b>points [11]</b> 46/11 66/16 70/9 71/18 71/23 72/17 80/15 84/23 99/23 110/19 146/25 <b>police [8]</b> 39/20 154/21 154/23 160/4 160/4 160/8 160/8 160/21 <b>policies [8]</b> 23/23 49/22 113/5 113/13 113/23 118/18 119/21 138/24 <b>policy [13]</b> 2/5 30/2 30/14 33/11 40/24 42/20 52/22 58/13 99/9 112/9 112/11 116/5 116/16 <b>political [3]</b> 46/1 46/3 47/3 <b>poor [6]</b> 4/12 5/18 14/12 14/18 97/23 143/10 <b>poorest [1]</b> 140/1 <b>popped [1]</b> 44/13 <b>popular [1]</b> 92/7 <b>population [4]</b> 46/11 68/9 81/19 110/11 <b>pose [2]</b> 2/25 107/23 <b>posed [1]</b> 120/4 <b>position [25]</b> 8/21 13/6 15/23 20/12 23/4 31/16 38/21 94/13 112/2 112/18 115/10 115/25 126/8 128/10 135/25 139/9 139/10 142/9 144/7 148/16 148/21 149/11 155/22 158/8 164/9 <b>positioning [1]</b> 15/12 <b>positions [2]</b> 130/20 161/11 <b>positive [5]</b> 163/2 163/10 166/7 167/22 168/3
----------	--	---	---	--



<b>P</b>	21/20 126/8 139/9 140/6 144/22 148/16 158/8 <b>precarious [5]</b> 43/5 55/15 56/25 80/11 143/9 <b>precarity [2]</b> 141/23 142/14 <b>preceding [1]</b> 143/11 <b>predict [1]</b> 14/3 <b>predicted [3]</b> 48/3 48/5 49/5 <b>predominantly [6]</b> 123/16 127/18 129/25 130/1 130/12 137/16 <b>prefer [1]</b> 22/22 <b>pregnancies [2]</b> 128/7 128/8 <b>pregnancy [2]</b> 5/23 127/23 <b>pregnant [8]</b> 80/6 80/11 80/13 80/16 80/25 81/5 117/23 128/1 <b>preliminary [1]</b> 1/14 <b>prepare [1]</b> 52/24 <b>prepared [1]</b> 111/14 <b>preparedness [3]</b> 119/18 166/20 169/3 <b>present [4]</b> 11/20 14/5 97/2 97/14 <b>presentation [1]</b> 157/25 <b>press [5]</b> 51/6 70/3 70/18 72/25 74/4 <b>press release [4]</b> 70/3 70/18 72/25 74/4 <b>pressed [2]</b> 52/7 65/16 <b>pressure [11]</b> 15/22 58/5 77/3 134/15 134/25 139/25 140/9 140/24 141/4 141/5 158/11 <b>pressured [1]</b> 108/18 <b>pressures [3]</b> 3/23 16/4 140/8 <b>presumably [2]</b> 91/21 102/23 <b>prevalence [5]</b> 13/13 14/23 14/24 15/20 16/12 <b>prevalent [1]</b> 160/11 <b>prevent [2]</b> 21/8 21/8 <b>preventative [1]</b> 21/6 <b>prevented [1]</b> 56/16 <b>prevention [2]</b> 46/23 169/1 <b>previous [6]</b> 31/11 46/14 118/24 140/12 140/15 167/1 <b>previously [2]</b> 60/23 83/19 <b>primarily [1]</b> 66/8	<b>Prime [6]</b> 46/15 47/15 50/13 161/10 162/19 165/4 <b>Prime Minister [5]</b> 46/15 47/15 50/13 161/10 165/4 <b>Prime Minister's [1]</b> 162/19 <b>prior [13]</b> 9/6 9/14 10/17 12/4 13/7 16/6 18/5 20/23 22/10 46/2 125/17 135/22 142/1 <b>priorities [1]</b> 161/12 <b>prioritisation [1]</b> 58/16 <b>prioritise [1]</b> 99/7 <b>priority [6]</b> 46/1 46/4 47/3 52/18 99/13 103/13 <b>private [1]</b> 34/15 <b>probably [7]</b> 11/2 66/3 77/12 87/9 102/24 108/25 170/5 <b>problem [20]</b> 10/15 13/12 13/22 14/8 14/9 53/16 71/23 74/15 74/22 75/20 90/4 101/2 106/22 106/22 106/23 107/7 107/14 109/21 109/23 109/24 <b>problematic [1]</b> 4/8 <b>problems [21]</b> 3/23 13/11 13/18 13/19 13/24 14/5 14/20 14/20 14/24 15/21 16/12 19/4 39/17 39/19 90/11 101/1 107/4 107/19 110/5 160/23 161/4 <b>procedure [1]</b> 99/9 <b>process [5]</b> 20/3 59/10 75/7 76/1 159/19 <b>processes [1]</b> 75/6 <b>processing [1]</b> 64/9 <b>procured [2]</b> 106/11 137/16 <b>procurement [1]</b> 57/22 <b>produce [2]</b> 140/9 140/23 <b>produced [4]</b> 1/18 27/23 53/13 78/4 <b>productive [1]</b> 120/16 <b>productivity [2]</b> 14/10 20/7 <b>professional [10]</b> 2/2 28/6 28/8 85/19 85/20 87/4 89/24 95/12 112/6 124/20 <b>professionally [1]</b> 87/24 <b>professionals [5]</b>	31/1 89/24 94/21 94/22 95/5 <b>professions [5]</b> 87/18 88/12 89/5 131/18 132/1 <b>professor [19]</b> 1/5 1/6 1/11 1/12 2/4 2/6 11/3 20/14 21/10 22/14 23/15 26/17 26/21 27/4 41/21 52/4 107/8 112/9 171/3 <b>Professor Nazroo [2]</b> 11/3 107/8 <b>Professor Taylor-Robinson [4]</b> 1/5 22/14 41/21 52/4 <b>profoundly [2]</b> 3/14 17/9 <b>programme [3]</b> 47/12 47/13 47/15 <b>programmes [4]</b> 45/4 135/10 144/25 148/6 <b>progress [5]</b> 8/10 58/18 69/24 98/6 98/12 <b>project [3]</b> 155/11 155/16 167/18 <b>promote [1]</b> 30/15 <b>promoted [1]</b> 133/10 <b>proper [2]</b> 29/3 79/7 <b>properly [3]</b> 56/16 99/1 108/2 <b>proportion [3]</b> 10/18 17/21 129/17 <b>proportionate [2]</b> 54/2 107/7 <b>proposals [1]</b> 30/13 <b>propose [5]</b> 22/15 44/1 112/7 167/8 167/13 <b>prosecution [1]</b> 134/22 <b>Prospect [1]</b> 82/1 <b>protect [3]</b> 30/15 58/15 65/14 <b>protected [1]</b> 65/22 <b>protecting [1]</b> 161/13 <b>protections [1]</b> 56/7 <b>protective [2]</b> 57/8 79/7 <b>protects [2]</b> 98/15 101/12 <b>protocol [1]</b> 161/19 <b>protracted [1]</b> 64/12 <b>provide [12]</b> 3/3 58/15 69/20 70/14 93/15 103/24 111/25 115/15 147/9 147/18 148/3 148/22 <b>provided [18]</b> 11/3 22/17 28/22 30/12 57/8 58/23 59/6 61/2 75/25 84/22 86/7 107/16 110/20 135/24	141/19 147/1 157/9 168/13 <b>provides [1]</b> 147/25 <b>providing [5]</b> 29/4 34/16 75/14 148/11 150/4 <b>provision [16]</b> 52/12 54/3 58/13 117/15 128/12 128/15 128/20 128/23 129/3 132/11 135/17 135/18 136/15 137/1 157/7 169/11 <b>provisions [1]</b> 165/21 <b>proximate [1]</b> 119/19 <b>proximity [2]</b> 119/11 129/10 <b>psychosocial [1]</b> 5/19 <b>PTSD [1]</b> 59/17 <b>public [40]</b> 2/4 2/9 3/6 5/10 22/6 40/13 40/17 40/24 44/18 55/20 56/4 56/18 58/19 84/2 121/11 121/23 122/4 122/10 122/12 122/15 122/20 123/7 123/9 123/10 135/5 135/13 138/21 141/17 143/4 143/14 143/25 147/14 152/16 155/18 161/25 162/12 162/17 165/16 165/19 169/18 <b>publication [2]</b> 65/18 67/17 <b>publicly [1]</b> 37/3 <b>published [6]</b> 16/15 42/22 76/21 76/24 78/10 80/10 <b>publishing [1]</b> 48/10 <b>pubs [1]</b> 37/20 <b>pull [1]</b> 137/20 <b>pulling [1]</b> 81/25 <b>pulse [1]</b> 109/15 <b>pupils [2]</b> 37/4 66/13 <b>purposes [1]</b> 78/12 <b>put [18]</b> 28/6 42/24 43/12 45/5 47/14 50/11 54/1 77/2 79/2 86/25 92/8 93/20 109/15 134/15 138/3 140/14 157/19 159/8 <b>puts [3]</b> 29/21 139/25 144/7 <b>putting [2]</b> 39/13 169/22
			<b>Q</b>	
			<b>quacks [1]</b> 107/11 <b>qualified [1]</b> 145/15 <b>qualify [2]</b> 71/2 71/12 <b>quality [3]</b> 44/20 126/19 127/17	

<p><b>Q</b></p> <p><b>quarter [1]</b> 71/21</p> <p><b>question [20]</b> 1/16 3/1 3/4 26/7 47/23 66/1 74/2 92/20 93/5 104/19 104/23 105/16 107/15 114/7 120/3 124/1 132/6 139/3 149/9 158/5</p> <p><b>questionnaire [5]</b> 51/9 55/7 55/11 171/17 171/19</p> <p><b>questionnaires [1]</b> 51/13</p> <p><b>questions [48]</b> 1/7 22/15 22/16 22/17 23/9 23/14 23/16 26/18 27/8 27/21 44/1 44/3 45/11 45/15 45/21 45/25 60/14 78/8 82/8 82/15 84/25 85/3 85/16 94/9 95/23 110/21 111/12 115/5 136/6 139/13 139/17 139/21 145/22 146/17 147/16 164/22 170/2 170/4 171/5 171/7 171/11 171/13 171/15 171/23 172/3 172/7 172/9 172/13</p> <p><b>queue [1]</b> 45/7</p> <p><b>quick [1]</b> 107/6</p> <p><b>quickly [4]</b> 39/20 47/11 52/8 96/15</p> <p><b>quiet [1]</b> 151/10</p> <p><b>quieten [1]</b> 150/15</p> <p><b>quietness [1]</b> 34/23</p> <p><b>quintile [3]</b> 15/4 15/5 21/13</p> <p><b>quite [15]</b> 45/2 47/10 84/5 87/25 87/25 88/2 105/11 110/7 115/14 117/17 125/19 150/17 155/15 161/10 167/3</p> <p><b>quote [1]</b> 97/12</p>	<p><b>raised: [1]</b> 93/6</p> <p><b>raised: this [1]</b> 93/6</p> <p><b>raising [3]</b> 65/23 66/12 81/23</p> <p><b>range [7]</b> 2/20 28/23 30/9 48/11 91/25 122/1 125/9</p> <p><b>ranks [1]</b> 112/20</p> <p><b>rape [3]</b> 135/21 135/23 136/1</p> <p><b>rapes [1]</b> 154/15</p> <p><b>rate [4]</b> 55/22 125/19 127/14 133/9</p> <p><b>rates [6]</b> 6/25 7/1 7/4 117/25 125/24 126/3</p> <p><b>rather [10]</b> 48/18 55/18 63/5 75/5 102/22 137/17 139/10 140/7 152/9 168/22</p> <p><b>re [1]</b> 53/12</p> <p><b>re-opening [1]</b> 53/12</p> <p><b>reach [2]</b> 96/16 163/24</p> <p><b>react [1]</b> 166/22</p> <p><b>read [15]</b> 27/24 54/22 55/10 64/2 68/25 78/6 82/10 82/11 82/14 82/18 82/21 82/23 87/10 88/10 108/25</p> <p><b>reading [1]</b> 61/18</p> <p><b>reads [1]</b> 59/1</p> <p><b>real [11]</b> 38/24 39/11 42/17 47/4 73/13 144/3 149/18 156/7 158/2 162/7 162/10</p> <p><b>realised [1]</b> 88/23</p> <p><b>reality [2]</b> 42/17 47/9</p> <p><b>really [18]</b> 12/17 24/12 32/11 33/15 41/16 46/24 47/16 50/5 50/15 89/3 92/20 96/1 98/10 132/6 139/8 158/5 160/11 165/2</p> <p><b>reason [6]</b> 39/21 104/13 104/16 125/13 132/11 136/20</p> <p><b>reasonable [1]</b> 79/21</p> <p><b>reasons [6]</b> 14/1 24/3 24/18 51/16 89/14 128/24</p> <p><b>REBECCA [3]</b> 146/16 146/20 172/11</p> <p><b>recall [2]</b> 99/23 100/3</p> <p><b>receive [2]</b> 99/14 107/25</p> <p><b>received [4]</b> 54/6 55/11 57/8 152/18</p> <p><b>recent [2]</b> 61/19 101/9</p> <p><b>recently [4]</b> 8/11 27/25 88/17 94/19</p> <p><b>reception [1]</b> 19/23</p> <p><b>recognise [5]</b> 30/24</p>	<p>42/16 43/4 43/19 109/4</p> <p><b>recognised [3]</b> 46/16 53/12 119/19</p> <p><b>recognising [2]</b> 31/4 41/17</p> <p><b>recognition [4]</b> 53/10 59/19 119/15 119/17</p> <p><b>recollection [1]</b> 92/12</p> <p><b>recommendation [1]</b> 138/18</p> <p><b>recommendations [6]</b> 30/16 43/13 58/19 138/16 168/9 168/17</p> <p><b>record [1]</b> 126/5</p> <p><b>recording [1]</b> 27/20</p> <p><b>records [1]</b> 82/13</p> <p><b>recourse [7]</b> 143/4 143/14 143/25 155/17 165/16 165/19 169/18</p> <p><b>recover [5]</b> 25/23 26/2 26/4 47/17 54/4</p> <p><b>recovered [1]</b> 25/18</p> <p><b>recovering [1]</b> 110/24</p> <p><b>recovery [6]</b> 45/4 45/4 47/12 47/13 47/14 53/24</p> <p><b>rectified [1]</b> 123/6</p> <p><b>recurring [1]</b> 66/4</p> <p><b>redeployed [1]</b> 95/14</p> <p><b>reduce [1]</b> 138/4</p> <p><b>reduced [2]</b> 38/10 42/12</p> <p><b>reducing [2]</b> 33/5 80/24</p> <p><b>reduction [6]</b> 46/21 148/24 152/1 152/3 152/4 152/23</p> <p><b>redundancy [1]</b> 80/19</p> <p><b>refer [12]</b> 17/11 20/15 68/6 71/18 80/10 90/22 96/18 97/8 97/19 119/8 152/14 154/9</p> <p><b>reference [5]</b> 70/22 94/2 100/13 103/17 162/9</p> <p><b>referrals [5]</b> 35/21 38/16 155/2 155/7 155/25</p> <p><b>referred [5]</b> 141/20 148/10 165/23 167/1 167/18</p> <p><b>referring [2]</b> 127/2 136/12</p> <p><b>refers [2]</b> 83/1 115/18</p> <p><b>reflected [1]</b> 53/10</p> <p><b>reflective [1]</b> 148/2</p> <p><b>reforms [1]</b> 42/23</p>	<p><b>refuge [9]</b> 149/2 149/3 149/10 149/16 154/24 155/25 156/2 156/9 167/25</p> <p><b>refugee [4]</b> 136/7 141/11 142/5 142/16</p> <p><b>refuges [5]</b> 148/3 148/13 155/8 168/1 169/11</p> <p><b>refusal [1]</b> 165/14</p> <p><b>refused [3]</b> 79/6 79/7 79/19</p> <p><b>regard [11]</b> 65/9 116/25 119/17 133/14 133/21 135/9 138/16 149/19 157/10 166/13 168/17</p> <p><b>regarded [1]</b> 69/21</p> <p><b>regarding [2]</b> 37/25 53/20</p> <p><b>regardless [3]</b> 70/15 72/16 73/7</p> <p><b>regards [1]</b> 26/13</p> <p><b>regime [3]</b> 127/22 127/25 128/4</p> <p><b>region [1]</b> 11/22</p> <p><b>regional [2]</b> 11/17 95/8</p> <p><b>regions [2]</b> 8/20 9/2</p> <p><b>regular [1]</b> 66/22</p> <p><b>regularly [1]</b> 165/8</p> <p><b>regulations [3]</b> 51/22 53/2 162/10</p> <p><b>regulator [1]</b> 110/7</p> <p><b>regulators [1]</b> 94/19</p> <p><b>rejected [1]</b> 75/11</p> <p><b>relate [4]</b> 122/17 133/22 133/23 137/5</p> <p><b>related [9]</b> 55/13 68/7 88/12 109/12 120/1 121/21 124/25 125/3 159/16</p> <p><b>relates [4]</b> 83/5 116/20 127/21 139/23</p> <p><b>relating [8]</b> 54/22 57/12 63/3 66/1 66/8 78/4 90/12 94/9</p> <p><b>relation [50]</b> 2/18 11/5 12/16 13/6 16/8 17/5 18/14 20/12 34/7 38/5 39/4 39/6 40/12 40/16 40/18 41/22 42/3 51/13 51/16 52/14 53/4 57/21 63/4 115/6 116/1 116/4 117/11 118/6 121/11 121/13 122/20 123/14 127/10 127/12 128/10 131/17 131/19 132/24 136/7 137/21 138/12 138/15 141/21 148/1 149/9 154/19 157/7 165/11 167/9 168/15</p> <p><b>relations [2]</b> 63/3</p>	<p>140/1</p> <p><b>relationship [3]</b> 95/4 95/7 151/5</p> <p><b>relationships [2]</b> 35/19 36/23</p> <p><b>relative [5]</b> 6/8 6/10 6/11 6/25 7/3</p> <p><b>relatively [4]</b> 23/22 32/14 38/3 112/20</p> <p><b>relatives [4]</b> 29/14 59/13 133/23 134/1</p> <p><b>release [4]</b> 70/3 70/18 72/25 74/4</p> <p><b>relevance [3]</b> 4/17 29/23 129/16</p> <p><b>relevant [7]</b> 9/13 26/9 29/21 55/12 97/13 120/7 123/21</p> <p><b>relies [1]</b> 110/3</p> <p><b>relieved [1]</b> 33/15</p> <p><b>religious [1]</b> 106/13</p> <p><b>reluctant [1]</b> 68/21</p> <p><b>remain [7]</b> 116/16 129/4 129/7 142/7 143/3 143/4 143/7</p> <p><b>remained [1]</b> 38/3</p> <p><b>remains [1]</b> 46/10</p> <p><b>remember [2]</b> 40/2 44/14</p> <p><b>Remembering [1]</b> 168/21</p> <p><b>remind [2]</b> 72/9 114/2</p> <p><b>remnant [1]</b> 71/10</p> <p><b>remove [1]</b> 77/4</p> <p><b>removed [1]</b> 73/5</p> <p><b>repeal [1]</b> 129/6</p> <p><b>repeated [2]</b> 66/24 165/4</p> <p><b>repeatedly [4]</b> 65/16 67/20 67/24 81/3</p> <p><b>rephrase [2]</b> 1/17 27/21</p> <p><b>replaced [1]</b> 47/19</p> <p><b>replicated [1]</b> 154/2</p> <p><b>report [57]</b> 1/18 1/19 2/16 2/17 4/4 4/14 5/6 6/4 7/11 11/4 11/7 11/10 11/12 11/12 11/21 12/17 13/4 13/17 15/18 17/2 20/11 23/20 25/17 27/2 27/13 38/4 38/21 58/8 58/20 78/20 80/10 80/16 109/13 111/14 111/20 111/23 112/7 112/14 112/23 115/3 115/5 115/11 115/25 116/20 116/25 121/12 123/14 126/24 131/6 131/12 132/21 138/9 139/8 141/10 149/21 149/22 155/9</p> <p><b>reported [9]</b> 39/5</p>
(66) quarter - reported				

<b>R</b>	106/20 107/2 108/13	142/19 144/11 147/6	139/13 170/3	18/13 24/25 25/16
<b>reported... [8]</b> 56/15 78/24 81/1 83/9 108/18 109/1 143/18 154/15	<b>respondents [5]</b> 51/18 51/21 52/15 53/21 56/22	148/13 152/22 154/12 155/25 158/15	<b>Rule 10 [2]</b> 139/13 170/3	26/1 26/21 31/2 35/15 38/10 38/19 41/10
<b>reporting [6]</b> 39/21 81/3 82/1 82/3 97/17 158/24	<b>response [14]</b> 51/14 54/2 54/5 67/25 68/14 92/1 92/11 101/9 101/19 101/20 107/4 107/6 110/12 166/13	<b>rights [12]</b> 23/16 23/17 24/2 30/4 45/22 45/23 49/20 52/17 52/22 53/14 60/23 80/19	<b>rules [2]</b> 98/14 98/15 <b>run [1]</b> 153/18 <b>running [2]</b> 57/17 84/14 <b>runs [1]</b> 4/4	43/1 44/7 45/16 45/24 48/5 49/10 52/20 62/6 68/2 69/9 74/1 78/18 81/10 81/20 86/2 87/18 88/16 94/23 98/13 100/8 100/25 104/11 106/24 109/1 112/21 113/7 116/4 116/23 122/9 123/3 125/6 125/9 132/12 136/1 137/21 141/21 141/25 142/20 143/9 144/2 144/13 144/23 147/25 150/11 152/1 155/15 167/12 170/8
<b>reports [12]</b> 16/19 39/3 48/8 48/10 72/2 76/21 76/24 78/3 78/9 98/23 109/3 135/21	<b>responses [7]</b> 51/9 55/7 55/11 55/13 57/12 171/17 171/19	<b>rise [11]</b> 7/19 13/18 13/21 20/22 20/24 21/4 21/5 24/14 32/6 47/7 158/24	<b>S</b>	155/15 167/12 170/8
<b>represent [9]</b> 29/18 29/19 29/19 43/9 43/22 88/4 94/16 139/19 157/1	<b>responsibilities [3]</b> 29/24 132/20 133/15	<b>risen [2]</b> 10/9 13/14	<b>sacrifice [1]</b> 69/4	<b>saying [5]</b> 26/24 77/6 106/16 109/14 163/13
<b>representations [2]</b> 161/23 161/25	<b>responsibility [2]</b> 30/20 63/2	<b>rises [1]</b> 8/19	<b>sadly [3]</b> 44/7 79/15 168/25	<b>says [4]</b> 12/4 79/12 79/16 79/23
<b>represented [1]</b> 64/19	<b>responsible [2]</b> 74/16 79/18	<b>rising [13]</b> 6/25 7/3 7/13 7/14 7/16 13/12 15/20 16/1 20/19 21/22 21/23 22/4 22/11	<b>safe [9]</b> 19/1 24/11 36/15 81/5 87/25 93/15 159/23 161/20 169/11	<b>scale [3]</b> 84/8 84/12 107/7
<b>representing [2]</b> 66/10 66/11	<b>rest [3]</b> 5/3 19/18 68/14	<b>risk [58]</b> 4/11 21/9 30/3 31/8 31/14 38/1 41/14 46/20 55/19 56/17 56/18 57/10 58/1 58/17 65/18 65/19 65/20 67/8 67/17 78/10 79/3 79/8 79/8 81/11 81/24 93/3 93/4 93/16 93/19 94/24 99/10 99/17 99/22 100/6 100/9 100/14 100/17 100/22 100/25 101/1 101/3 101/22 101/25 102/1 102/8 103/10 103/14 107/23 114/22 142/20 142/24 143/11 144/2 144/14 163/5 164/17 169/7 169/23	<b>safeguarding [4]</b> 35/2 38/6 39/2 157/8	<b>scared [4]</b> 117/22 117/24 118/3 136/18
<b>represents [2]</b> 62/20 63/17	<b>restaurants [2]</b> 37/20 48/13	<b>Robinson [7]</b> 1/5 1/6 1/11 22/14 41/21 52/4 171/3	<b>safety [6]</b> 56/21 65/11 65/24 66/13 67/11 79/20	<b>scarfs [1]</b> 106/14
<b>reproductive [3]</b> 119/24 124/11 127/9	<b>resting [1]</b> 56/16	<b>role [14]</b> 4/15 28/14 28/14 29/9 29/10 29/17 30/11 33/3 119/12 130/15 133/14 137/13 157/6 159/10	<b>SAGE [3]</b> 97/9 97/11 97/18	<b>scheme [8]</b> 68/7 74/14 75/13 75/21 76/8 76/12 77/4 169/13
<b>Republic [3]</b> 63/8 117/5 117/13	<b>restrict [1]</b> 159/6	<b>roles [5]</b> 28/13 56/23 119/9 130/25 131/1	<b>said [30]</b> 25/15 28/25 29/14 39/14 40/8 45/10 48/1 51/16 53/18 57/7 58/14 58/21 63/15 68/16 69/14 70/9 74/4 78/25 79/2 82/7 84/20 90/6 90/13 97/12 100/15 100/19 108/9 110/17 139/7 151/24	<b>schemes [3]</b> 68/8 76/13 167/25
<b>request [6]</b> 47/15 79/22 93/23 95/24 103/10 103/20	<b>restriction [2]</b> 140/14 140/16	<b>roll [1]</b> 102/9	<b>same [26]</b> 22/11 56/7 56/8 63/9 97/7 102/15 102/16 103/3 113/25 117/19 120/11 120/11 120/17 121/8 126/12 126/18 127/3 128/3 133/3 133/9 133/11 134/15 138/6 140/16 144/20 163/17	<b>school [25]</b> 18/21 19/5 19/7 19/15 19/17 19/21 19/23 20/2 20/6 34/25 35/4 35/15 35/18 35/19 36/6 36/10 36/20 36/22 36/23 112/9 153/12 153/18 153/18 153/21 159/8
<b>requested [1]</b> 156/24	<b>restrictions [4]</b> 50/5 53/25 160/2 164/17	<b>roll-out [1]</b> 102/9	<b>sample [2]</b> 57/6 57/10	<b>schooling [2]</b> 32/14 157/13
<b>requests [6]</b> 75/12 76/18 93/21 93/22 154/7 170/3	<b>result [8]</b> 33/25 41/24 43/3 49/16 58/3 80/3 128/9 161/22	<b>room [2]</b> 23/6 48/19	<b>sanitiser [1]</b> 59/11	<b>schools [36]</b> 33/13 34/5 34/8 34/10 34/15 34/15 35/11 35/16 36/3 36/4 36/4 37/4 37/6 37/10 37/13 37/16 37/19 37/21 38/2 38/15 44/6 44/18 45/2 48/13 49/14 49/14 51/25 53/7 53/13 66/8 66/9 66/14 138/1 157/6 157/20 157/21
<b>required [1]</b> 64/14	<b>results [2]</b> 80/13 108/3	<b>rose [1]</b> 33/17	<b>Save [3]</b> 23/18 45/23 52/16	<b>science [1]</b> 104/11
<b>requirement [1]</b> 131/5	<b>retired [3]</b> 63/23 94/20 103/17	<b>rough [1]</b> 169/13	<b>saw [36]</b> 7/7 7/12 19/9 20/22 24/14 30/18 33/8 39/20 44/16 46/21 95/24 99/19 99/19 99/21 103/4 117/12 117/22 117/25 145/10 150/11 150/14 150/21 150/22 151/2 153/14 154/6 155/6 156/7 158/1 158/3 158/9 161/15 161/25 163/10 164/20 169/13	<b>scientific [1]</b> 5/13
<b>research [16]</b> 2/12 75/8 76/15 77/1 97/13 110/9 116/24 126/7 126/9 126/14 126/15 127/13 143/13 149/22 158/16 158/17	<b>return [4]</b> 54/10 67/16 111/5 119/6	<b>roughly [1]</b> 18/4	<b>say [68]</b> 1/16 1/17 3/13 6/20 6/24 7/18 8/15 12/17 15/2 15/18	<b>scope [4]</b> 37/9 90/7 115/2 115/5
<b>research [16]</b> 2/12 75/8 76/15 77/1 97/13 110/9 116/24 126/7 126/9 126/14 126/15 127/13 143/13 149/22 158/16 158/17	<b>returning [4]</b> 94/20 95/19 103/17 153/18	<b>round [1]</b> 3/8		<b>Scotland [5]</b> 8/16 41/8 49/8 62/18 129/2
<b>resentment [2]</b> 84/2 84/4	<b>reviewed [1]</b> 97/16	<b>Royal [1]</b> 81/2		<b>Scottish [1]</b> 63/5
<b>reserves [1]</b> 44/21	<b>reviews [1]</b> 79/25	<b>Royal College [1]</b> 81/2		<b>Scottish TUC [1]</b>
<b>resilience [1]</b> 7/21	<b>rewarded [1]</b> 59/19	<b>rule [7]</b> 41/5 41/9 50/5 101/10 101/17		
<b>resistance [1]</b> 103/25	<b>RIDDOR [2]</b> 98/23 99/10			
<b>resolved [3]</b> 94/14 94/15 94/17	<b>right [73]</b> 4/7 7/22 8/7 23/20 23/21 23/22 28/17 30/16 38/11 38/12 38/18 40/19 41/25 54/10 55/8 60/21 60/23 61/1 62/16 63/10 63/19 64/5 66/10 69/12 69/17 70/8 70/17 71/6 71/7 71/10 72/1 73/25 74/23 74/24 78/16 78/17 81/2 81/22 84/5 85/21 86/6 87/9 88/15 88/16 88/18 88/20 89/9 90/8 91/15 91/20 96/22 102/25 103/1 103/18 105/11 106/15 108/23 109/6 109/14 109/18 109/19 111/5 123/17 142/10 142/16			
<b>resources [5]</b> 52/9 67/21 117/14 118/4 145/7	<b>right [73]</b> 4/7 7/22 8/7 23/20 23/21 23/22 28/17 30/16 38/11 38/12 38/18 40/19 41/25 54/10 55/8 60/21 60/23 61/1 62/16 63/10 63/19 64/5 66/10 69/12 69/17 70/8 70/17 71/6 71/7 71/10 72/1 73/25 74/23 74/24 78/16 78/17 81/2 81/22 84/5 85/21 86/6 87/9 88/15 88/16 88/18 88/20 89/9 90/8 91/15 91/20 96/22 102/25 103/1 103/18 105/11 106/15 108/23 109/6 109/14 109/18 109/19 111/5 123/17 142/10 142/16			
<b>respect [2]</b> 162/19 164/24	<b>rights [12]</b> 23/16 23/17 24/2 30/4 45/22 45/23 49/20 52/17 52/22 53/14 60/23 80/19			
<b>respects [1]</b> 114/8	<b>risen [2]</b> 10/9 13/14			
<b>respiratory [1]</b> 68/23	<b>rises [1]</b> 8/19			
<b>respond [2]</b> 100/24 101/8	<b>rising [13]</b> 6/25 7/3 7/13 7/14 7/16 13/12 15/20 16/1 20/19 21/22 21/23 22/4 22/11			
<b>responded [7]</b> 57/4 78/18 78/25 80/14	<b>responsible [2]</b> 74/16 79/18			

<b>S</b>	93/17 96/14 97/11 98/19 99/11 101/7 101/9 101/10 101/12 102/19 102/20 103/7 103/10 103/16 103/20 108/25 109/17 110/15 113/10 120/9 122/1 130/16 133/15 136/10 152/1 152/4 153/12 156/22 158/7 159/10 161/24 162/23 162/25 166/17 169/1	<b>sentence [2]</b> 109/1 143/11 <b>sentiment [2]</b> 121/6 121/7 <b>separate [3]</b> 26/22 72/17 121/10 <b>separately [1]</b> 63/5 <b>September [12]</b> 1/19 27/23 37/17 40/7 61/20 74/24 76/17 86/8 111/17 147/6 153/11 153/14 <b>September 2020 [1]</b> 76/17 <b>series [6]</b> 58/24 61/22 75/12 78/3 82/8 91/11 <b>serious [4]</b> 40/6 40/7 56/17 98/1 <b>seriously [2]</b> 92/11 95/2 <b>servants [1]</b> 77/7 <b>serve [1]</b> 148/23 <b>service [22]</b> 52/7 54/2 56/23 59/20 85/23 87/2 87/20 89/22 90/15 92/3 97/3 98/4 101/13 102/5 104/3 109/6 128/17 136/22 159/22 160/25 161/1 161/1 <b>services [49]</b> 3/24 15/22 16/2 16/4 21/6 22/12 26/3 35/22 38/14 38/17 46/21 46/22 117/17 121/23 121/25 122/2 122/12 122/13 123/1 123/10 124/9 124/11 124/14 124/15 127/9 127/10 127/10 128/19 129/10 136/17 136/18 136/24 137/1 143/15 145/12 145/14 148/1 148/3 148/5 148/22 149/1 149/4 149/7 149/24 151/22 154/5 156/20 156/21 159/25 <b>set [23]</b> 6/4 6/5 7/25 38/4 43/8 50/10 71/18 75/15 78/20 98/5 105/20 107/4 110/8 112/6 113/23 116/24 124/7 131/18 149/20 160/13 167/11 167/17 168/10 <b>sets [2]</b> 97/15 97/16 <b>setting [1]</b> 1/22 <b>settings [3]</b> 100/22 108/19 157/4 <b>settle [1]</b> 152/24 <b>seven [3]</b> 10/12 65/4 79/14 <b>seven years [1]</b>	79/14 <b>several [3]</b> 28/12 50/18 57/15 <b>severe [2]</b> 32/8 39/17 <b>severely [1]</b> 64/13 <b>severity [1]</b> 38/20 <b>sex [2]</b> 103/14 138/16 <b>sexual [3]</b> 120/16 124/10 135/20 <b>shadow [1]</b> 31/17 <b>shall [3]</b> 54/10 111/5 170/16 <b>share [6]</b> 32/15 79/10 87/22 87/23 90/3 98/3 <b>shared [1]</b> 154/4 <b>sharing [2]</b> 90/16 109/9 <b>sharp [1]</b> 3/6 <b>she [8]</b> 22/19 60/3 79/12 79/16 79/16 79/23 80/2 80/2 <b>she's [3]</b> 60/12 79/13 79/13 <b>shelters [2]</b> 135/10 144/24 <b>shift [2]</b> 56/14 59/25 <b>shocks [1]</b> 7/21 <b>short [15]</b> 4/16 39/24 54/13 61/22 86/5 102/2 104/19 105/16 111/7 112/8 119/5 146/4 146/12 164/6 167/9 <b>shortage [2]</b> 48/7 59/8 <b>shortages [1]</b> 58/5 <b>shorter [1]</b> 51/17 <b>shortly [2]</b> 58/23 82/24 <b>should [16]</b> 29/15 37/10 37/16 42/24 68/5 93/18 94/5 97/13 97/15 97/16 97/17 97/25 98/25 99/6 104/12 137/22 <b>shouldn't [1]</b> 25/20 <b>show [8]</b> 28/22 48/8 76/15 90/21 102/14 126/2 126/4 158/17 <b>showed [4]</b> 13/10 16/15 50/3 50/3 <b>showering [1]</b> 59/7 <b>showing [2]</b> 78/22 125/1 <b>shown [3]</b> 21/3 127/14 133/7 <b>shows [12]</b> 11/16 14/23 15/13 17/14 17/17 17/21 20/24 104/2 104/15 129/19 136/16 143/13 <b>siblings [1]</b> 32/16 <b>sick [32]</b> 44/23 55/21	55/22 56/3 56/13 56/15 60/1 60/8 68/18 69/13 70/11 70/14 70/18 70/20 71/2 71/8 71/9 71/13 71/15 71/17 72/5 72/14 72/19 73/12 73/15 73/23 74/10 74/17 75/7 75/16 77/4 133/6 <b>sickness [3]</b> 70/15 72/15 72/18 <b>side [3]</b> 124/18 140/7 166/4 <b>Sierra [2]</b> 117/18 120/10 <b>Sierra Leone [1]</b> 117/18 <b>sight [1]</b> 38/13 <b>signals [1]</b> 106/17 <b>signed [4]</b> 1/21 28/2 61/12 86/11 <b>significant [31]</b> 2/12 8/8 8/15 10/18 11/22 16/8 18/11 20/9 28/14 31/7 34/13 34/24 40/4 41/23 47/16 51/14 53/22 54/5 57/10 73/19 115/21 121/13 129/8 135/14 136/10 149/5 150/3 150/12 154/5 157/3 161/20 <b>significantly [2]</b> 9/5 11/24 <b>signposting [1]</b> 157/8 <b>signs [1]</b> 35/20 <b>silent [1]</b> 59/13 <b>similar [8]</b> 50/8 96/25 96/25 129/20 130/16 140/9 140/24 149/11 <b>similarly [3]</b> 56/2 57/20 154/14 <b>Simon [3]</b> 91/13 93/12 102/21 <b>Simon Stevens [3]</b> 91/13 93/12 102/21 <b>simple [2]</b> 41/10 114/7 <b>simply [4]</b> 71/8 71/14 90/7 107/15 <b>since [10]</b> 16/8 42/13 47/2 60/25 116/1 121/11 134/12 140/3 144/23 149/17 <b>single [2]</b> 123/16 155/2 <b>singled [2]</b> 79/8 80/19 <b>Sir [1]</b> 47/14 <b>Sir Kevan Collins [1]</b> 47/14 <b>sister [1]</b> 68/7 <b>Sisters [4]</b> 139/14 139/20 161/19 164/11
----------	---	--	--	---

<b>S</b>	4/19 7/7 12/23 14/14 19/24 19/25 122/24	<b>sometimes [7]</b> 32/7 32/15 40/20 87/19 142/7 142/8 153/18	<b>sponsored [1]</b> 143/7	167/13 168/11 168/15	
<b>sit [1]</b> 1/8	<b>socio-demographic [1]</b> 122/24	<b>somewhere [3]</b> 23/1 23/2 76/22	<b>sporadic [1]</b> 34/18	<b>statements [4]</b> 28/21 61/3 84/21 161/25	
<b>site [1]</b> 79/19	<b>socio-economic [7]</b> 4/15 4/17 4/19 7/7 12/23 14/14 19/24	<b>sorry [11]</b> 75/2 78/1 82/3 82/20 114/5 123/18 123/23 152/10 152/12 156/15 162/14	<b>sports [1]</b> 41/14	<b>states [2]</b> 120/5 158/2	
<b>situation [5]</b> 74/20 94/3 95/15 101/12 144/15	<b>socio-emotional [1]</b> 19/25	<b>sort [15]</b> 35/16 68/7 68/23 73/8 74/14 83/21 96/3 96/4 96/9 140/14 152/7 159/15 162/9 164/16 169/16	<b>spousal [1]</b> 165/24	<b>statistics [5]</b> 81/8 81/20 103/3 108/16 126/2	
<b>situations [6]</b> 33/10 39/8 39/16 48/22 94/24 105/10	<b>Solace [14]</b> 139/14 139/19 147/14 147/17 147/25 150/8 150/20 153/2 155/10 157/24 158/24 161/18 164/11 168/10	<b>sort of [10]</b> 68/7 68/23 83/21 96/3 96/4 140/14 152/7 159/15 162/9 169/16	<b>spreading [1]</b> 119/2	<b>status [9]</b> 87/5 87/21 141/15 141/21 142/16 142/23 143/10 165/15 169/21	
<b>six [7]</b> 40/3 41/5 41/5 41/9 50/5 79/2 149/23	<b>Solace's [1]</b> 153/15	<b>sorts [3]</b> 5/15 83/8 130/22	<b>stability [1]</b> 134/14	<b>statutes [1]</b> 141/12	
<b>size [1]</b> 137/17	<b>solely [1]</b> 29/1	<b>sound [1]</b> 108/22	<b>stable [3]</b> 18/7 19/1 142/8	<b>statutory [21]</b> 29/10 29/17 55/22 56/2 56/13 70/11 70/18 70/20 71/2 71/8 71/12 71/15 71/17 72/14 72/19 73/15 74/10 74/17 77/3 101/10 131/5	
<b>skills [5]</b> 24/9 24/9 25/25 26/1 26/1	<b>solve [1]</b> 74/15	<b>sounds [1]</b> 74/13	<b>staff [18]</b> 36/6 44/22 57/7 58/11 58/15 59/7 60/6 66/13 88/6 91/18 103/13 103/21 104/6 122/12 150/16 152/19 153/5 153/10	<b>stayed [1]</b> 37/19	
<b>skin [3]</b> 104/7 110/1 110/3	<b>some [85]</b> 2/23 6/3 12/21 19/6 22/17 23/21 29/8 29/8 31/8 31/14 32/2 32/20 33/10 38/8 42/8 42/11 44/9 45/11 45/18 45/25 48/2 55/13 56/1 59/22 60/20 61/20 62/8 63/25 67/4 68/22 74/18 75/8 75/23 76/3 76/23 77/20 81/8 83/18 83/22 83/25 84/23 86/23 88/2 88/3 90/9 95/4 95/9 96/6 96/24 99/19 99/20 100/5 102/7 102/23 105/12 105/13 106/9 106/13 108/2 108/10 108/15 109/1 110/19 111/19 112/13 114/7 114/13 114/24 115/3 120/4 120/4 127/13 132/23 140/14 147/16 150/25 151/16 158/12 159/21 161/9 161/24 166/24 167/21 168/4 168/14	<b>source [1]</b> 162/23	<b>staged [3]</b> 129/25 130/2 130/13	<b>staying [1]</b> 159/9	
<b>skip [1]</b> 70/23	<b>Southall [4]</b> 139/14 139/20 161/18 164/11	<b>south [1]</b> 120/6	<b>stage [5]</b> 72/10 72/20 91/17 100/15 103/23	<b>stenographer [6]</b> 1/15 27/19 35/8 51/11 114/3 146/21	
<b>skipping [1]</b> 74/7	<b>space [12]</b> 26/9 26/10 34/22 40/13 40/17 40/24 44/19 88/1 135/17 155/2 155/6 155/23	<b>South [1]</b> 120/6	<b>stages [1]</b> 158/20	<b>step [6]</b> 16/11 44/22 75/23 163/10 165/1 165/20	
<b>skyrocketed [1]</b> 39/23	<b>spaces [9]</b> 92/16 149/3 149/17 154/25 155/1 155/17 155/18 156/2 167/20	<b>Southall [4]</b> 139/14 139/20 161/18 164/11	<b>stalled [1]</b> 8/10	<b>stepping [1]</b> 8/3	
<b>sleeping [1]</b> 169/13	<b>speaks [1]</b> 26/5	<b>space [12]</b> 26/9 26/10 34/22 40/13 40/17 40/24 44/19 88/1 135/17 155/2 155/6 155/23	<b>standard [2]</b> 98/6 99/8	<b>steps [9]</b> 77/22 96/2 96/3 96/25 97/25 160/23 161/5 161/8 168/4	
<b>slightly [4]</b> 16/5 24/24 77/25 141/13	<b>speaker [1]</b> 145/15	<b>speaking [5]</b> 11/19 89/5 101/6 105/10 154/1	<b>standards [1]</b> 126/19	<b>Stevens [3]</b> 91/13 93/12 102/21	
<b>slipped [1]</b> 33/24	<b>speaking [5]</b> 11/19 89/5 101/6 105/10 154/1	<b>speaks [1]</b> 26/5	<b>standing [3]</b> 53/16 53/18 105/6	<b>stick [1]</b> 45/11	
<b>slow [7]</b> 36/12 110/13 134/17 146/23 146/24 156/14 166/22	<b>speaking [5]</b> 11/19 89/5 101/6 105/10 154/1	<b>speaks [1]</b> 26/5	<b>stands [1]</b> 74/5	<b>sticking [1]</b> 81/6	
<b>slowly [2]</b> 114/4 114/17	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>stark [2]</b> 87/25 90/1 49/4 62/4 80/8 86/16 124/8 170/16	<b>still [17]</b> 8/15 8/23 10/16 11/24 11/25 16/3 16/3 31/16 41/11 89/12 92/25 100/16 102/22 108/4 112/24 129/4 152/24	
<b>sluggish [1]</b> 110/13	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>started [4]</b> 7/9 41/3 102/2 150/16	<b>stillbirths [1]</b> 127/18	
<b>small [2]</b> 109/14 167/3	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>starting [5]</b> 37/16 39/12 70/24 88/10 151/19	<b>stimulate [2]</b> 92/5 92/17	
<b>smallest [1]</b> 11/23	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>starts [2]</b> 23/8 82/17	<b>stomach [1]</b> 60/2	
<b>smoking [1]</b> 5/23	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>state [10]</b> 43/14 64/24 89/8 99/5 100/4 116/21 135/11 141/18 145/8 146/18	<b>stop [4]</b> 56/5 68/22 80/22 119/1	
<b>snapshot [2]</b> 134/9 148/10	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>stated [3]</b> 52/16 55/16 57/13	<b>stopped [2]</b> 98/7 98/7	
<b>so [265]</b>	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>statement [73]</b> 27/23 28/3 30/22 32/24 38/4 43/25 58/24 60/7 61/5 61/9 61/12 61/17 61/19 61/21 62/9 62/11 62/25 64/4 64/19 64/22 64/22 68/6 69/5 69/7 76/9 77/18 77/18 77/25 78/13 80/5 80/8 81/7 82/9 82/17 83/11 83/25 86/7 86/9 86/10 86/20 88/7 88/8 89/8 89/15 90/22 91/5 94/10 94/12 95/21 98/22 100/1 101/24 105/17 105/18 105/19 107/17 108/15 111/21 147/1 147/5 147/8 147/9 151/13 152/14 154/9 154/20 160/13 164/3 165/11 167/12	<b>staying [1]</b> 159/9	<b>story [3]</b> 10/14 18/17 56/9
<b>social [30]</b> 3/12 9/23 13/19 14/17 14/21 16/13 18/21 24/10 25/25 31/1 35/16 35/22 36/2 44/19 60/24 64/8 65/14 81/14 89/23 113/5 113/21 119/1 121/15 129/24 130/4 130/12 137/5 137/8 139/4 141/3	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>standards [1]</b> 126/19	<b>straight [1]</b> 85/7	
<b>social care [7]</b> 64/8 81/14 89/23 121/15 130/4 137/8 141/3	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>standing [3]</b> 53/16 53/18 105/6	<b>stratified [2]</b> 93/18 103/10	
<b>socialisation [1]</b> 26/15	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>stands [1]</b> 74/5	<b>straying [1]</b> 123/18	
<b>socialising [5]</b> 25/1 25/2 37/10 40/24 41/15	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>stark [2]</b> 87/25 90/1 49/4 62/4 80/8 86/16 124/8 170/16	<b>strengthen [1]</b> 88/24	
<b>socially [1]</b> 17/9	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>started [4]</b> 7/9 41/3 102/2 150/16	<b>strengthened [1]</b> 49/18	
<b>societal [1]</b> 14/13	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>starting [5]</b> 37/16 39/12 70/24 88/10 151/19	<b>stress [4]</b> 5/21 5/21 159/13 159/15	
<b>societies [1]</b> 114/19	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>starts [2]</b> 23/8 82/17		
<b>society [9]</b> 3/15 3/17 3/23 20/7 31/9 113/24 114/9 139/1 168/24	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>state [10]</b> 43/14 64/24 89/8 99/5 100/4 116/21 135/11 141/18 145/8 146/18		
<b>socio [9]</b> 4/15 4/17	<b>speaks [1]</b> 26/5	<b>speaks [1]</b> 26/5	<b>stated [3]</b> 52/16 55/16 57/13		

<b>S</b>	101/11	50/24	35/4 35/20 36/6 44/21 66/11	168/22
<b>stressed [1]</b> 140/2	<b>suggesting [1]</b> 74/17	<b>suspected [1]</b> 56/10	<b>technology [2]</b> 109/23 110/2	<b>thank [121]</b> 1/8 1/10 1/12 3/5 15/9 15/9 15/17 21/10 22/14 23/12 23/13 24/20 26/17 26/19 26/20 26/21 27/2 27/3 27/4 27/13 28/5 32/23 42/21 45/9 50/20 50/21 50/22 51/1 51/3 54/9 54/11 54/24 62/3 66/15 77/16 82/6 84/20 84/24 85/4 85/5 85/11 85/14 95/18 102/13 104/20 110/17 110/22 110/25 111/2 111/3 111/13 112/4 114/2 114/11 115/1 115/19 115/24 116/13 116/18 118/5 118/21 119/8 119/14 120/2 120/19 121/9 122/8 123/2 123/24 125/4 126/6 126/22 127/6 128/5 129/1 129/11 129/22 130/14 132/18 133/13 134/5 134/25 135/8 135/19 136/5 137/19 138/8 139/6 139/15 139/18 141/8 144/17 145/19 145/20 145/21 145/22 145/24 146/1 146/18 147/5 147/12 147/24 148/15 149/8 150/6 153/20 154/18 155/20 156/14 157/5 157/17 158/22 164/8 165/10 166/10 170/1 170/7 170/11 170/12 170/15 170/17
<b>striking [2]</b> 81/8 81/20	<b>suggestions [1]</b> 80/21	<b>suspension [2]</b> 165/18 169/18	<b>teenagers [1]</b> 39/1	
<b>strive [1]</b> 89/12	<b>suicidal [1]</b> 158/4	<b>sworn [3]</b> 60/12 85/15 172/1	<b>telephone [1]</b> 156/21	
<b>structural [12]</b> 107/9 111/15 112/14 113/3 113/8 113/11 124/4 128/15 129/8 132/7 135/2 167/9	<b>suicide [4]</b> 125/22 125/25 126/3 126/5	<b>symptoms [3]</b> 64/12 124/25 125/3	<b>tell [11]</b> 47/25 65/8 84/3 84/6 89/9 94/13 96/12 106/5 107/18 109/20 109/21	
<b>structure [6]</b> 35/2 35/15 35/23 43/17 43/20 112/16	<b>suitable [1]</b> 81/25	<b>system [16]</b> 7/15 20/20 20/23 21/2 22/4 30/19 44/8 71/11 83/22 89/23 90/15 92/6 96/12 106/16 106/25 110/12	<b>temporary [2]</b> 150/1 156/9	
<b>structured [1]</b> 113/24	<b>summarised [1]</b> 112/1	<b>systematic [1]</b> 116/8	<b>ten [3]</b> 3/10 10/12 71/19	
<b>structures [6]</b> 5/14 10/21 12/24 62/8 113/13 113/23	<b>summary [18]</b> 15/23 28/9 29/5 30/12 51/8 51/9 51/10 51/17 54/22 55/7 55/10 60/10 68/24 82/11 121/17 124/7 171/17 171/19	<b>systemic [4]</b> 89/10 107/3 107/6 109/24	<b>ten years [1]</b> 3/10	
<b>structuring [1]</b> 5/3	<b>summer [3]</b> 32/2 152/22 152/25	<b>systemically [1]</b> 106/24	<b>tend [2]</b> 14/6 119/9	
<b>struggles [1]</b> 149/12	<b>summit [1]</b> 67/11	<b>systems [4]</b> 3/23 113/22 124/3 124/6	<b>tended [1]</b> 149/16	
<b>struggling [4]</b> 32/15 100/24 145/17 148/20	<b>supplements [2]</b> 103/22 103/24	<b>T</b>	<b>tendencies [1]</b> 116/11	
<b>studies [2]</b> 34/13 97/13	<b>supply [3]</b> 57/17 57/22 124/18	<b>table [2]</b> 43/11 43/16	<b>tends [2]</b> 132/8 141/20	
<b>study [1]</b> 100/13	<b>support [46]</b> 22/12 31/2 32/19 33/20 34/21 34/23 35/17 36/20 37/7 42/12 43/8 50/6 50/7 52/8 67/23 67/24 69/12 74/19 75/3 75/14 75/24 75/25 76/6 76/16 77/10 83/19 121/24 134/4 135/10 135/18 135/24 136/2 141/19 143/15 144/25 145/6 148/11 154/7 154/14 156/17 156/23 157/1 163/12 165/9 166/9 169/23	<b>tablet [1]</b> 9/18	<b>tension [1]</b> 135/6	
<b>stuff [1]</b> 48/2	<b>supported [4]</b> 9/10 33/15 52/10 147/22	<b>tackling [1]</b> 93/20	<b>tensions [1]</b> 159/12	
<b>subgroup [2]</b> 20/9 20/9	<b>supporting [1]</b> 53/9	<b>take [20]</b> 3/7 23/19 37/19 41/13 44/17 51/5 69/18 70/19 82/24 96/2 114/3 119/12 128/18 132/12 133/6 152/13 153/21 161/5 164/4 169/6	<b>term [8]</b> 37/17 53/20 58/7 107/9 119/5 119/6 133/4 156/6	
<b>subgroups [1]</b> 51/24	<b>suppose [5]</b> 44/24 68/4 152/24 156/8 169/21	<b>taken [16]</b> 21/2 22/4 30/17 45/14 51/22 53/7 67/2 67/7 92/10 95/2 96/3 97/25 138/17 162/14 165/21 168/4	<b>termed [1]</b> 25/11	
<b>subject [4]</b> 126/11 142/12 143/4 144/8	<b>supposed [1]</b> 100/22	<b>takes [1]</b> 102/7	<b>terminology [1]</b> 6/9	
<b>subjected [1]</b> 142/1	<b>sure [14]</b> 15/2 26/22 60/11 61/8 63/16 107/20 121/20 124/8 131/21 132/25 134/18 137/4 146/5 146/20	<b>taking [5]</b> 43/11 50/2 83/16 96/25 146/21	<b>terms [51]</b> 3/10 3/11 6/9 7/8 7/24 9/25 11/8 24/4 33/11 35/16 36/3 39/23 45/1 47/10 50/4 69/19 92/11 102/11 112/17 112/20 115/19 116/15 116/21 117/9 118/15 119/15 122/16 125/7 125/18 127/8 128/13 129/4 129/10 129/23 130/16 130/25 133/14 133/16 135/24 148/3 148/21 149/19 152/16 153/1 153/2 155/12 156/23 157/25 158/5 159/20 162/18	
<b>submitted [2]</b> 108/16 161/19	<b>surprising [1]</b> 105/6	<b>talk [15]</b> 10/7 11/1 16/22 23/20 25/22 31/20 53/23 60/7 69/18 104/15 115/2 131/16 134/25 141/10 143/2	<b>terrible [2]</b> 37/22 83/12	
<b>submitting [1]</b> 96/21	<b>survey [5]</b> 9/16 13/9 13/16 16/10 80/13	<b>talked [12]</b> 29/7 35/11 46/1 65/19 79/6 83/18 84/15 101/24 136/13 159/21 164/16 169/19	<b>test [5]</b> 46/16 75/3 75/10 107/20 108/2	
<b>subsequent [2]</b> 6/2 151/9	<b>surprised [2]</b> 91/25 92/10	<b>talking [9]</b> 17/4 59/2 104/2 133/18 143/8 144/22 144/22 161/14 161/15	<b>testament [1]</b> 24/15	
<b>subsequently [3]</b> 25/23 127/14 162/21	<b>surprising [1]</b> 105/6	<b>Taylor [7]</b> 1/5 1/6 1/11 22/14 41/21 52/4 171/3	<b>tested [1]</b> 103/21	
<b>substandard [1]</b> 56/24	<b>surveys [2]</b> 96/16 97/1	<b>teacher [1]</b> 60/4	<b>testing [4]</b> 57/6 57/24 79/18 169/25	
<b>substantial [1]</b> 5/5	<b>survive [1]</b> 55/18	<b>teachers [6]</b> 30/25	<b>tests [1]</b> 109/25	
<b>substantively [1]</b> 90/5	<b>survivors [4]</b> 145/3 148/11 161/3 169/23		<b>texts [1]</b> 92/13	
<b>successful [3]</b> 66/18 67/4 142/6	<b>suspect [2]</b> 26/24		<b>than [31]</b> 9/8 14/16 48/18 51/17 55/10 55/18 71/20 71/21 75/5 81/16 90/7 106/1 110/24 113/15 114/15 119/7 123/1 124/9 125/15 126/3 127/15 131/24 137/17 140/7 144/8 149/3 149/5 152/9 154/15 155/16	
<b>such [16]</b> 5/23 6/1 35/11 51/25 52/21 53/9 55/23 56/1 56/23 118/9 118/25 119/2 128/16 131/21 135/3 169/10			<b>thank you [93]</b> 1/8 1/10 1/12 3/5 15/9 15/9 15/17 21/10 22/14 23/13 24/20 26/17 26/19 27/3 27/4 27/13 28/5 32/23 42/21 50/20 50/21 54/11 62/3 66/15 77/16 82/6 84/24 85/5 95/18 102/13 104/20 111/2 111/3 111/13 112/4 114/2 114/11 115/19 115/24 116/13 116/18 118/5 118/21 119/8 119/14 120/2 120/19 121/9 122/8 123/2 123/24 125/4 126/6 126/22 127/6 128/5 129/1 129/11 129/22 130/14 134/5 134/25 135/8 135/19 137/19 138/8 139/6 139/18 141/8 144/17 145/20 145/21 146/18	
<b>suffer [4]</b> 41/16 59/17 125/14 137/11				
<b>suffered [2]</b> 80/3 105/22				
<b>suffering [5]</b> 32/20 42/12 64/11 77/21 125/7				
<b>sufficient [3]</b> 58/6 69/23 77/12				
<b>suggest [4]</b> 76/9 87/7 100/4 102/1				
<b>suggested [2]</b> 55/21				

<b>T</b>	75/6 79/1 79/3 80/19 83/15 84/14 84/14 84/16 90/12 90/14 95/10 96/8 96/11 98/20 98/20 98/20 106/1 109/7 115/13 119/20 124/9 125/15 127/8 127/16 133/22 134/24 138/4 138/4 141/23 141/24 142/6 143/3 143/7 143/7 143/19 143/25 144/1 144/1 144/3 145/11 145/14 151/6 151/18 157/25 159/6 160/1 160/10 164/19 168/6 168/6 169/22	162/17 164/20 <b>therapeutic [2]</b> 148/5 149/7 <b>there [223]</b> <b>there's [31]</b> 3/14 5/21 5/21 5/21 6/9 8/2 16/10 16/11 22/16 25/21 36/1 43/22 53/25 76/4 87/11 98/2 98/15 99/7 101/9 101/18 106/18 108/5 109/24 110/10 118/2 125/9 125/10 134/13 146/21 168/7 168/14 <b>thereabouts [1]</b> 85/21 <b>thereafter [1]</b> 42/9 <b>therefore [9]</b> 24/25 81/24 83/21 93/14 126/15 137/8 143/6 143/15 143/19 <b>these [38]</b> 6/15 8/4 22/9 22/10 25/17 25/20 32/15 32/17 33/10 57/9 66/19 76/13 83/12 87/12 87/17 88/1 88/22 90/2 90/2 90/17 93/4 94/1 96/10 106/24 108/10 110/5 114/24 118/10 120/5 120/9 120/12 122/2 122/11 122/25 128/19 139/2 140/13 141/25 <b>they [170]</b> 2/20 5/4 10/16 14/2 14/3 14/6 18/21 20/2 25/4 25/19 31/7 31/16 32/4 32/11 33/5 34/2 34/12 34/19 34/21 35/2 35/3 35/3 35/5 36/5 36/25 37/6 37/14 38/6 39/21 40/21 40/22 41/1 41/12 41/12 41/13 41/14 42/11 45/5 46/5 48/17 49/18 49/21 49/22 50/15 50/16 52/7 52/20 55/4 55/5 55/20 56/5 56/11 56/15 57/7 57/13 58/13 58/21 64/14 68/22 69/2 70/16 71/14 71/15 71/17 72/16 73/8 74/6 75/7 77/21 78/25 79/4 79/6 80/21 80/22 80/25 83/8 84/8 84/10 84/11 84/12 84/13 86/14 86/15 90/11 94/5 98/7 98/9 98/17 99/15 102/2 105/9 105/13 106/4 106/5 109/16 109/20 109/21 109/23 115/20 115/22 117/24	118/12 119/11 120/7 120/10 122/23 122/24 122/24 128/16 133/10 136/19 136/21 136/21 138/6 138/21 138/24 138/25 139/22 141/3 141/13 141/18 142/5 142/6 142/9 142/12 143/3 143/5 143/16 143/24 143/25 144/1 144/4 144/9 145/10 145/17 145/17 149/10 149/11 150/1 150/3 150/5 151/2 152/21 154/14 155/14 155/18 156/8 156/12 156/23 159/23 159/23 159/24 159/25 160/1 160/2 161/4 161/16 162/3 162/3 162/4 163/13 163/13 163/13 164/19 165/2 165/20 166/14 166/14 166/22 169/5 <b>they'd [3]</b> 36/24 75/4 79/2 <b>they're [26]</b> 3/13 3/15 5/17 5/19 5/20 5/22 14/1 14/6 25/4 25/13 63/10 69/1 69/1 87/15 95/13 95/14 95/16 108/4 109/6 114/19 121/23 122/2 133/3 134/2 136/19 141/22 <b>thing [18]</b> 9/23 19/22 33/14 48/5 50/12 60/4 68/5 70/5 92/6 92/9 97/7 98/18 105/7 105/12 108/9 109/4 120/9 144/3 <b>things [21]</b> 3/13 4/7 5/15 24/13 25/20 35/11 49/13 60/8 64/18 79/4 87/17 95/14 99/9 106/24 108/1 108/10 114/3 118/20 136/12 149/6 168/3 <b>think [132]</b> 17/10 17/18 19/13 21/20 22/7 23/21 31/15 33/8 33/23 33/24 39/24 42/16 43/4 43/17 44/10 44/11 44/16 45/10 45/12 46/5 47/1 47/11 47/22 48/1 48/12 48/14 48/20 49/1 49/25 51/5 60/20 60/25 62/4 62/25 66/21 67/4 67/22 67/25 69/14 69/24 70/23 72/20 72/23 73/22 73/24 74/24 76/5 76/14 77/5 77/12 78/22 83/10 83/10	83/11 84/4 84/4 85/20 86/11 87/8 88/16 93/10 93/12 94/11 97/9 97/12 100/1 101/23 102/1 102/16 104/2 104/5 105/15 109/8 109/8 109/14 109/20 113/1 113/7 119/8 123/18 123/21 125/9 125/11 125/17 126/3 132/6 132/6 136/12 142/20 144/11 150/13 150/25 151/2 151/7 151/16 151/18 152/5 152/6 153/4 153/24 154/3 154/4 155/15 158/2 158/16 158/18 159/1 159/11 159/12 159/14 159/21 160/7 160/19 160/22 161/24 162/3 163/10 163/17 163/24 164/20 166/7 167/17 167/23 168/3 168/5 168/7 168/20 169/1 169/3 169/16 169/19 170/5 <b>thinking [2]</b> 50/17 60/8 <b>third [7]</b> 5/12 70/11 70/17 88/10 135/9 143/1 144/18 <b>thirds [1]</b> 122/15 <b>this [186]</b> <b>those [191]</b> <b>though [1]</b> 90/9 <b>thought [5]</b> 47/4 68/13 103/23 131/16 151/3 <b>thousand [1]</b> 25/11 <b>thousand days [1]</b> 25/11 <b>threads [1]</b> 12/16 <b>threat [5]</b> 41/14 144/10 164/14 164/18 164/21 <b>threaten [2]</b> 143/12 144/5 <b>three [15]</b> 6/15 25/1 25/2 52/2 70/6 72/20 72/21 73/3 73/5 94/7 100/16 117/9 139/21 141/12 163/14 <b>three days [1]</b> 72/20 <b>three months [3]</b> 25/1 25/2 100/16 <b>three weeks [1]</b> 70/6 <b>three-day [2]</b> 73/3 73/5 <b>threshold [3]</b> 71/4 73/3 73/9 <b>through [44]</b> 3/17 3/20 4/4 4/6 18/23 19/7 30/24 32/20 33/11 33/18 33/20
----------	--	--	--	---



<b>T</b>	<b>took [10]</b> 33/6 52/12 77/22 119/6 129/7 155/15 160/23 161/8 169/14 169/14	<b>trigger [1]</b> 79/25	<b>type [6]</b> 75/19 98/24 101/19 101/20 106/11 157/23	109/10 112/3
<b>through... [33]</b> 34/6 36/5 36/19 36/25 46/5 48/16 52/21 55/17 55/24 56/12 59/20 60/3 75/4 75/6 75/6 82/14 82/23 83/24 84/4 112/7 117/8 121/24 121/25 122/1 135/6 135/15 152/21 158/10 163/11 163/16 164/4 167/13 168/1	<b>tool [2]</b> 109/17 163/24	<b>triple [2]</b> 152/18 164/14	<b>types [4]</b> 76/11 80/25 130/16 165/25	<b>undertake [3]</b> 30/2 76/25 116/10
<b>throughout [6]</b> 11/22 36/5 52/11 76/20 83/10 153/1	<b>top [11]</b> 2/2 3/2 3/20 6/13 8/2 92/2 93/13 95/3 95/4 96/10 102/20	<b>trivial [1]</b> 23/22	<b>typically [2]</b> 119/10 130/25	<b>undertaken [6]</b> 37/17 42/8 96/3 99/2 101/25 138/21
<b>thus [1]</b> 140/10	<b>topic [10]</b> 18/10 18/12 40/12 42/1 105/16 121/10 134/6 139/23 141/9 144/18	<b>true [8]</b> 28/3 61/14 61/25 62/8 63/24 86/14 92/15 92/16		<b>undertook [1]</b> 166/20
<b>tier [1]</b> 56/5	<b>topics [1]</b> 139/21	<b>truly [1]</b> 43/21	<b>U</b>	<b>unease [1]</b> 95/11
<b>time [58]</b> 6/22 10/10 17/17 20/21 22/11 23/3 25/5 26/4 30/23 31/3 34/14 34/24 35/21 39/2 39/25 40/14 42/7 47/21 50/17 59/9 60/20 70/19 73/17 80/13 89/20 89/21 94/4 94/8 102/6 102/7 102/20 102/24 105/1 105/8 128/18 131/14 131/15 132/5 132/8 132/12 132/14 132/14 133/5 133/8 134/15 135/24 138/6 144/20 148/22 152/6 152/20 153/10 153/11 153/24 159/2 159/13 161/17 166/2	<b>touch [11]</b> 7/17 9/15 11/6 18/12 38/7 53/21 66/16 84/23 115/25 125/22 135/25	<b>trust [3]</b> 59/5 103/9 160/4	<b>UK [33]</b> 6/7 9/18 15/21 16/24 21/21 52/19 53/5 53/17 62/18 62/20 65/1 112/18 112/20 112/22 112/24 114/8 120/7 120/18 120/20 120/23 121/21 126/24 127/13 127/16 128/8 130/10 131/6 133/17 134/10 136/24 142/2 142/17 151/4	<b>uneasiness [1]</b> 104/2
<b>times [6]</b> 50/18 80/3 127/15 149/23 158/19 169/8	<b>touched [11]</b> 12/3 14/14 16/18 24/4 26/7 36/7 97/22 110/19 127/7 167/7 167/14	<b>trying [8]</b> 16/3 90/7 90/11 92/5 92/17 96/12 150/1 160/17	<b>UK Government [2]</b> 52/19 53/17	<b>uneasy [1]</b> 104/14
<b>tirelessly [1]</b> 31/2	<b>Touching [1]</b> 157/6	<b>TUC [26]</b> 54/19 57/13 58/22 60/18 60/20 62/5 62/9 62/12 62/20 62/23 62/23 63/1 63/5 63/9 63/9 63/15 63/16 64/19 64/25 66/5 70/3 75/4 78/4 78/10 80/11 81/21	<b>UK Youth [1]</b> 53/5	<b>unemployment [1]</b> 10/15
<b>tiring [1]</b> 96/11	<b>tough [1]</b> 98/18	<b>TUC's [1]</b> 70/13	<b>ultimately [1]</b> 20/1	<b>unequal [1]</b> 140/1
<b>titled [1]</b> 15/24	<b>towards [2]</b> 40/25 117/15	<b>turbans [1]</b> 107/18	<b>un [2]</b> 24/2 25/4	<b>unfair [4]</b> 3/14 4/10 80/17 132/12
<b>to: [1]</b> 71/18	<b>toxic [6]</b> 5/11 5/21 6/1 31/9 31/20 108/5	<b>turn [19]</b> 2/16 2/25 9/7 12/15 13/3 34/8 103/6 116/19 119/16 121/10 129/15 135/7 136/9 144/15 144/16 148/16 149/1 150/7 160/4	<b>UN Convention [1]</b> 24/2	<b>unfairly [1]</b> 79/1
<b>to: 34 [1]</b> 71/18	<b>Trace [2]</b> 75/3 75/10	<b>turned [4]</b> 45/5 47/19 76/16 149/23	<b>unable [2]</b> 32/18 115/17	<b>unfortunately [3]</b> 89/4 102/10 170/10
<b>today [13]</b> 1/12 2/24 22/15 26/24 27/15 29/4 43/25 53/20 84/23 109/10 110/19 168/14 170/14	<b>track [4]</b> 3/20 14/6 18/23 19/7	<b>turning [11]</b> 47/12 125/5 126/7 128/6 134/8 135/20 137/3 155/24 156/17 157/23 164/9	<b>unavailable [1]</b> 105/24	<b>unfortunate [3]</b> 89/4 102/10 170/10
<b>together [17]</b> 12/16 41/2 41/7 41/7 42/22 63/12 63/13 65/5 66/25 87/4 87/17 88/19 88/25 89/3 89/14 137/20 140/17	<b>trade [3]</b> 63/6 66/23 92/7	<b>twice [4]</b> 11/15 15/4 18/4 72/3	<b>uncertain [1]</b> 83/22	<b>union [3]</b> 57/3 68/12 79/12
<b>told [7]</b> 36/23 43/14 49/7 60/2 69/2 76/4 80/22	<b>trade unions [1]</b> 66/23	<b>Twite [10]</b> 22/16 23/8 23/9 23/14 44/4 45/11 45/13 45/15 171/7 171/15	<b>uncertainty [1]</b> 83/17	<b>union/business/gove</b>
<b>toll [1]</b> 83/12	<b>tragedies [2]</b> 101/8 101/19	<b>two [18]</b> 27/17 54/17 56/5 59/14 60/1 61/2 63/8 72/17 78/13 84/21 94/10 100/16 118/20 121/20 122/15 137/20 155/2 158/19	<b>unclear [2]</b> 1/17 27/21	<b>rnment [1]</b> 68/12
<b>too [11]</b> 50/12 52/12 52/13 53/6 72/10 85/11 151/17 163/19 166/15 166/15 170/5	<b>tragedy [1]</b> 101/14	<b>tutoring [1]</b> 54/3	<b>uncomfortable [1]</b> 109/4	<b>unions [8]</b> 61/23 62/12 62/17 63/6 65/6 66/11 66/23 66/25
	<b>training [1]</b> 148/8	<b>two days [1]</b> 60/1	<b>under [9]</b> 38/24 38/25 40/9 41/8 126/5 140/14 141/3 147/22 160/2	<b>United [8]</b> 49/19 55/16 56/4 56/8 115/23 116/2 120/1 120/5
	<b>transfer [1]</b> 20/3	<b>two-thirds [1]</b> 122/15	<b>underappreciated [3]</b> 84/10 84/11 84/11	<b>United Kingdom [1]</b> 115/23
	<b>translates [1]</b> 116/15	<b>two-tier [1]</b> 56/5	<b>underfunded [1]</b> 148/20	<b>United Nations [2]</b> 49/19 120/1
	<b>transport [3]</b> 57/5 64/8 168/2		<b>underfunding [1]</b> 168/13	<b>United States [1]</b> 120/5
	<b>trauma [1]</b> 79/24		<b>underlined [1]</b> 57/20	<b>units [1]</b> 106/9
	<b>traumatic [1]</b> 107/25		<b>underlying [1]</b> 89/10	<b>universal [4]</b> 36/17 46/13 123/15 160/9
	<b>travel [2]</b> 128/24 129/5		<b>undermined [1]</b> 160/10	<b>Universal Credit [1]</b> 123/15
	<b>Treasury [1]</b> 76/8		<b>understand [13]</b> 33/9 42/16 50/6 50/6 62/25 77/1 84/8 102/5 111/25 136/4 146/3 159/24 168/6	<b>University [2]</b> 2/5 2/7
	<b>treat [2]</b> 16/2 126/16		<b>understanding [15]</b> 33/8 33/19 33/24 34/6 43/19 98/9 107/2 151/12 151/19 152/19 154/22 154/23 157/13 163/21 166/24	<b>unless [2]</b> 49/5 71/5
	<b>treated [2]</b> 14/7 78/25		<b>understood [3]</b> 47/6	<b>unnecessarily [1]</b> 93/20
	<b>treatment [2]</b> 80/17 127/22			<b>unpaid [10]</b> 114/18 120/13 132/9 132/20 132/24 133/18 133/21 133/25 137/21 138/6
	<b>treatments [2]</b> 26/3 126/20			<b>unplanned [2]</b> 128/6 128/8
	<b>trends [4]</b> 22/9 120/11 120/17 125/13			<b>unsafe [7]</b> 32/7 32/21 38/12 40/5 40/21 80/20 105/5
	<b>trial [1]</b> 110/1			<b>unseen [1]</b> 29/15
	<b>trials [2]</b> 109/25 126/11			<b>unsustainable [1]</b> 15/22
	<b>Tribunal [1]</b> 1/9			<b>until [4]</b> 58/17 100/10 162/7 170/19
	<b>tried [1]</b> 22/25			<b>unusual [1]</b> 100/24
	<b>tries [2]</b> 86/18 104/11			<b>unwanted [1]</b> 128/6
				<b>up [51]</b> 1/15 2/20 5/16 5/20 6/18 7/2 12/18 13/7 14/7 16/3 17/18 20/13 25/19



<b>U</b>	<p><b>variety [1]</b> 142/24</p> <p><b>various [11]</b> 21/3 44/13 46/11 55/11 74/11 77/19 85/22 131/17 135/2 142/7 146/25</p> <p><b>varying [1]</b> 142/22</p> <p><b>vast [3]</b> 34/14 36/11 132/17</p> <p><b>verify [1]</b> 109/25</p> <p><b>versus [1]</b> 102/12</p> <p><b>very [105]</b> 2/18 4/8 11/5 23/8 23/11 23/12 26/11 26/20 26/21 27/1 27/2 28/7 32/5 33/14 33/15 33/16 35/5 36/12 36/23 37/8 37/12 37/23 39/13 39/20 39/24 40/1 42/17 43/10 43/15 43/24 45/2 45/6 45/9 46/7 47/19 48/11 48/11 49/17 50/9 50/22 50/23 51/1 51/3 51/12 54/6 54/9 62/7 63/15 63/24 66/5 66/17 67/11 69/3 69/12 69/15 71/24 71/25 72/9 72/10 73/16 76/14 79/15 81/8 84/20 84/21 84/22 85/4 85/11 85/14 88/9 89/5 89/21 90/10 91/11 98/18 100/18 100/24 102/23 104/14 104/20 109/3 110/17 110/19 110/22 110/25 111/20 114/7 118/22 119/16 123/8 125/22 127/7 131/3 139/15 141/4 145/19 145/24 145/25 146/4 147/8 149/20 166/5 170/1 170/7 170/11</p> <p><b>via [1]</b> 9/21</p> <p><b>victim [2]</b> 154/14 159/12</p> <p><b>Victim Support [1]</b> 154/14</p> <p><b>victims [8]</b> 135/10 144/25 161/3 161/13 165/3 165/22 166/9 169/15</p> <p><b>Victoria [1]</b> 29/13</p> <p><b>Victoria Climbié [1]</b> 29/13</p> <p><b>videos [1]</b> 42/2</p> <p><b>view [17]</b> 29/13 33/25 37/5 51/20 52/11 66/9 96/6 97/9 113/14 120/19 121/19 153/15 153/15 153/22 165/17 166/11 166/14</p> <p><b>views [7]</b> 29/18 29/18</p>	<p>29/19 29/21 66/10 163/8 167/7</p> <p><b>violence [37]</b> 5/22 32/8 39/6 39/18 39/22 39/23 114/21 114/22 118/7 118/11 118/14 134/7 134/8 134/11 134/14 135/7 135/20 140/5 141/23 142/1 143/17 144/14 144/20 145/8 145/13 147/20 148/2 148/17 149/20 156/18 157/11 162/24 164/19 166/18 167/10 169/2 169/4</p> <p><b>violent [1]</b> 140/2</p> <p><b>virus [5]</b> 56/19 68/23 83/16 103/25 136/19</p> <p><b>Visa [1]</b> 95/6</p> <p><b>visas [2]</b> 165/24 165/25</p> <p><b>visibility [2]</b> 38/10 38/11</p> <p><b>visit [4]</b> 29/22 118/3 124/17 124/17</p> <p><b>visitors [1]</b> 79/19</p> <p><b>visits [2]</b> 37/1 128/3</p> <p><b>vitamin [4]</b> 103/21 103/22 103/24 104/10</p> <p><b>vitamin D [4]</b> 103/21 103/22 103/24 104/10</p> <p><b>vocal [1]</b> 40/14</p> <p><b>voice [4]</b> 1/15 27/17 30/5 30/7</p> <p><b>Voices [3]</b> 55/16 56/4 56/8</p> <p><b>volume [1]</b> 126/19</p> <p><b>voluntarily [1]</b> 96/10</p> <p><b>voluntary [4]</b> 86/22 87/15 90/13 134/3</p> <p><b>vulnerabilities [3]</b> 33/2 48/24 142/22</p> <p><b>vulnerability [7]</b> 7/19 12/13 12/25 21/18 46/23 47/5 94/6</p> <p><b>vulnerable [27]</b> 20/8 22/13 29/25 33/10 33/14 33/16 36/8 36/9 36/11 36/19 36/24 37/25 38/16 39/1 39/15 40/2 44/6 48/16 53/9 65/22 77/19 128/1 141/23 143/16 144/7 157/12 157/17</p>	<p>128/11 134/23</p> <p><b>walking [1]</b> 59/24</p> <p><b>walks [1]</b> 107/11</p> <p><b>want [27]</b> 2/23 4/1 13/3 37/25 38/7 40/12 48/18 62/4 82/7 82/9 82/12 82/16 86/16 89/20 102/14 104/21 115/2 117/8 121/10 132/13 135/24 141/12 149/5 150/7 152/13 154/24 169/1</p> <p><b>wanted [3]</b> 23/19 42/5 90/21</p> <p><b>wants [1]</b> 60/7</p> <p><b>ward [4]</b> 99/14 99/19 108/3 109/5</p> <p><b>wards [2]</b> 106/9 106/23</p> <p><b>was [376]</b></p> <p><b>wash [1]</b> 5/12</p> <p><b>washing [1]</b> 59/10</p> <p><b>wasn't [18]</b> 33/18 33/18 33/20 36/11 36/19 37/1 43/15 71/8 73/3 92/10 94/17 96/15 97/4 110/7 119/5 121/7 157/14 163/11</p> <p><b>waste [1]</b> 89/20</p> <p><b>watching [3]</b> 55/5 83/14 162/8</p> <p><b>wave [1]</b> 13/15</p> <p><b>way [25]</b> 3/4 27/16 28/6 33/7 38/14 41/17 43/8 58/22 63/9 75/5 82/25 90/22 93/21 96/8 98/20 98/24 105/13 113/23 113/23 113/25 114/1 116/9 116/11 124/5 128/3</p> <p><b>ways [9]</b> 4/21 11/11 35/5 67/4 74/11 112/23 118/12 120/11 122/1</p> <p><b>we [369]</b></p> <p><b>we'd [6]</b> 67/11 74/4 135/14 149/6 152/7 155/6</p> <p><b>we'll [11]</b> 7/17 23/12 27/18 34/4 54/10 58/23 61/3 69/18 70/23 100/3 123/4</p> <p><b>we're [21]</b> 2/17 16/3 16/3 17/18 26/24 30/7 31/19 54/5 54/17 77/9 84/21 85/7 96/18 106/21 108/1 108/1 109/9 110/19 115/3 138/10 141/14</p> <p><b>we've [34]</b> 6/10 16/18 21/3 24/4 24/14 36/3 52/4 53/3 53/19 63/20 64/1 64/7 64/15 65/8</p>	<p>68/24 77/12 83/18 84/22 86/8 90/2 101/24 103/11 108/25 109/3 110/17 110/18 110/19 118/8 123/8 140/12 160/18 167/7 167/12 167/13</p> <p><b>wealth [1]</b> 116/23</p> <p><b>wealthier [1]</b> 32/2</p> <p><b>wear [1]</b> 107/18</p> <p><b>weather [1]</b> 169/10</p> <p><b>Weatherby [4]</b> 23/11 23/13 45/14 45/16</p> <p><b>webinars [2]</b> 90/16 97/1</p> <p><b>week [13]</b> 44/9 60/2 71/6 72/24 73/3 73/13 73/18 73/19 73/24 91/9 152/18 155/19 158/19</p> <p><b>weekend [1]</b> 170/17</p> <p><b>weeks [5]</b> 70/6 91/10 102/17 103/5 158/21</p> <p><b>welcome [1]</b> 145/25</p> <p><b>welcomed [1]</b> 166/6</p> <p><b>welfare [11]</b> 28/8 40/18 43/2 121/16 122/20 140/23 141/14 141/17 141/18 142/10 143/5</p> <p><b>well [66]</b> 5/10 5/12 6/3 7/5 11/10 18/3 20/15 25/20 28/10 31/7 31/25 34/11 37/7 40/19 41/1 42/10 44/10 47/4 48/5 49/12 55/9 62/7 63/15 66/21 68/2 68/17 72/6 75/17 76/14 78/22 82/23 87/11 88/22 91/24 93/5 94/10 94/17 95/11 98/13 102/10 104/20 105/14 105/15 106/4 108/4 108/10 109/21 110/2 118/8 120/9 122/4 122/21 124/19 128/14 130/21 131/14 134/11 135/13 140/15 142/15 143/13 150/25 153/24 161/3 163/18 168/7</p> <p><b>well known [4]</b> 62/7 63/15 75/17 91/24</p> <p><b>wellbeing [3]</b> 7/2 12/24 52/17</p> <p><b>Welsh [4]</b> 62/23 63/3 63/4 63/9</p> <p><b>Welsh Government [1]</b> 63/4</p> <p><b>Welsh TUC [1]</b> 62/23</p> <p><b>Wenham [11]</b> 111/10 111/11 111/13 114/2 118/23 123/4 134/17 139/19 145/19 145/24</p>
<b>V</b>	<p><b>vaccination [1]</b> 169/25</p> <p><b>valuable [1]</b> 104/20</p> <p><b>value [1]</b> 87/20</p> <p><b>variance [1]</b> 102/10</p> <p><b>variant [1]</b> 37/18</p>	<p><b>wage [1]</b> 73/13</p> <p><b>wages [2]</b> 131/7 132/1</p> <p><b>wait [1]</b> 135/23</p> <p><b>waiting [4]</b> 72/21 73/5 141/24 149/6</p> <p><b>Wales [8]</b> 8/2 8/14 41/8 49/8 49/25 62/19</p>	<p><b>W</b></p>	

<b>W</b>	18/20 19/4 19/23 23/5 23/22 33/15 37/6 37/15 41/3 43/12 45/8 46/13 46/19 49/25 50/2 53/6 56/10 68/18 75/8 80/23 82/4 91/4 96/11 106/18 106/23 106/24 110/4 117/22 117/23 117/23 118/25 124/14 124/16 131/15 133/1 133/6 136/19 137/10 143/8 150/1 150/2 150/15 151/2 151/10 151/16 151/19 153/11 153/17 155/14 155/22 156/12 159/23 159/23 161/16 163/9 163/13 166/14 167/3 168/9	53/18 54/6 60/5 60/8 61/18 61/21 63/6 63/12 63/13 64/23 66/3 66/5 67/7 67/15 68/8 68/12 68/16 70/5 70/23 71/6 72/2 74/2 74/12 75/25 76/9 77/20 78/10 78/18 78/20 79/10 81/9 82/13 83/17 84/15 86/8 87/12 88/2 88/12 88/13 91/6 92/8 93/4 94/11 94/12 95/10 95/22 96/9 96/11 96/14 97/22 98/3 98/8 98/23 98/23 98/24 99/12 99/20 100/15 100/19 100/20 101/10 101/17 102/10 104/8 104/23 105/21 108/6 109/15 109/24 109/25 110/9 112/23 113/4 113/5 113/14 113/14 113/21 115/18 116/20 119/9 120/12 121/11 124/5 125/11 129/13 132/25 135/2 135/7 136/13 141/18 144/18 144/25 161/12 162/7 162/10 165/20 167/25 168/24	163/12 169/7 169/22 <b>whole [9]</b> 24/18 28/10 30/9 40/23 48/11 81/19 82/18 82/21 115/22 <b>whom [2]</b> 63/22 63/25 <b>why [15]</b> 3/1 5/9 25/19 26/5 89/14 95/11 120/7 120/18 125/7 132/7 132/11 132/15 152/1 153/15 160/5 <b>wide [3]</b> 28/23 31/25 51/14 <b>widening [2]</b> 12/22 18/5 <b>wider [7]</b> 19/12 55/20 56/18 92/21 102/24 109/24 166/18 <b>will [36]</b> 23/3 26/22 26/22 26/25 29/2 29/8 35/18 35/20 35/21 45/10 45/10 51/5 54/16 61/20 62/4 66/15 69/15 92/3 99/14 99/15 99/23 102/19 105/11 105/12 105/13 105/15 129/13 133/9 134/23 136/6 139/3 139/4 139/22 144/1 146/21 164/1 <b>window [2]</b> 158/17 159/22 <b>windows [1]</b> 25/8 <b>wise [1]</b> 87/24 <b>wish [5]</b> 43/2 55/5 116/19 125/22 134/6 <b>withdrew [6]</b> 27/5 51/4 85/6 111/4 146/2 170/13 <b>within [45]</b> 8/18 51/24 62/12 62/23 66/13 87/20 89/1 89/11 89/18 90/15 91/12 91/22 92/5 92/6 97/3 98/7 100/20 101/10 111/24 112/7 112/18 112/22 112/24 114/18 115/25 116/25 122/12 123/14 126/24 130/20 131/1 132/9 132/21 134/4 135/7 147/8 151/13 152/14 155/19 156/4 156/19 160/13 164/3 167/12 168/15 <b>without [12]</b> 9/9 22/23 32/9 34/18 36/1 50/1 51/23 58/6 70/20 83/15 106/2 165/9 <b>witness [18]</b> 23/1 27/5 28/25 31/12 51/4 54/20 76/9 78/13 85/6	85/8 86/7 89/8 90/22 111/4 131/2 146/2 167/1 170/13 <b>witnesses [3]</b> 54/17 110/18 123/20 <b>woefully [1]</b> 148/19 <b>woman [4]</b> 133/1 142/12 142/25 163/12 <b>women [175]</b> <b>women's [12]</b> 125/17 134/8 135/10 136/17 137/17 138/2 139/14 139/20 143/9 144/24 147/14 147/17 <b>won't [3]</b> 74/5 78/6 91/5 <b>wonderful [1]</b> 27/19 <b>word [1]</b> 84/5 <b>words [2]</b> 36/3 43/1 <b>work [66]</b> 2/12 3/5 3/9 10/9 10/10 10/16 10/22 42/8 43/20 53/11 53/24 55/12 55/24 56/12 58/5 59/6 59/22 63/11 63/12 64/14 65/11 65/15 67/16 70/19 71/20 72/5 73/21 74/6 75/6 78/10 79/1 79/5 79/8 80/18 80/20 80/22 83/3 89/17 89/24 90/6 94/19 98/15 98/16 104/7 106/2 108/5 108/19 109/23 110/2 110/11 111/23 119/6 119/9 120/14 126/21 128/18 132/5 132/8 132/12 132/13 132/15 132/20 132/24 142/10 148/10 149/4 <b>worked [12]</b> 31/2 59/23 60/20 66/9 77/2 79/14 85/22 110/5 130/13 153/5 167/17 169/24 <b>worker [8]</b> 54/18 74/1 79/9 81/23 82/13 83/2 83/14 169/21 <b>workers [77]</b> 31/1 36/7 44/7 53/9 53/11 53/12 55/14 55/20 55/23 56/1 56/6 56/23 57/5 57/13 57/24 57/25 62/20 63/25 64/8 64/10 64/13 65/15 67/9 67/13 67/17 68/20 68/25 70/10 70/12 70/15 71/2 71/19 71/20 71/21 72/15 74/9 75/15 75/22 77/1 78/5 78/19 78/23 81/11 81/13 81/16 81/18 83/12 84/1 84/1 84/17
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<b>W</b>	109/9 120/18 135/12 138/1 141/1 141/5 141/7 143/21 144/6 144/11 144/13 144/15 144/15 145/16 145/17 149/3 149/5 150/11 151/1 152/4 160/22 163/2 164/19 165/20 <b>wouldn't [4]</b> 38/13 71/15 109/8 121/8 <b>write [1]</b> 161/8 <b>writing [6]</b> 16/21 60/7 84/22 90/16 92/5 110/18 <b>written [8]</b> 2/23 22/9 91/9 91/11 102/15 102/21 102/23 103/5 <b>wrong [2]</b> 69/8 77/25 <b>wrote [1]</b> 93/10	68/15 69/8 70/5 70/22 74/16 76/21 77/11 78/1 78/2 79/11 81/6 83/10 84/19 84/20 85/10 85/22 86/3 86/6 86/10 86/15 87/7 87/9 87/15 87/16 88/5 88/15 89/4 89/8 89/14 90/13 90/19 90/20 90/25 91/7 91/7 91/15 93/7 93/22 96/22 97/1 97/5 97/20 98/2 101/21 102/7 102/8 102/18 103/19 104/1 104/19 104/25 105/2 105/9 105/13 105/15 109/3 110/16 111/9 111/10 111/16 112/3 112/12 114/10 114/10 116/17 118/17 119/13 119/25 120/22 125/21 126/1 127/1 127/5 127/13 127/20 130/1 130/5 130/7 130/24 133/19 133/24 136/4 139/16 140/12 140/18 141/1 141/2 141/7 142/4 142/19 143/13 144/5 144/6 144/11 146/7 146/8 146/9 147/3 147/7 147/11 147/15 147/20 148/4 148/7 148/9 148/24 150/1 150/11 152/20 152/23 152/24 154/13 154/17 155/3 155/13 156/1 156/7 158/16 158/21 159/1 161/24 162/14 164/7 165/13 166/7 167/17 168/23 169/1	136/21 138/19 140/13 169/23 <b>you'd [3]</b> 44/18 168/18 170/8 <b>you'll [1]</b> 2/3 <b>you're [27]</b> 2/9 14/8 16/5 18/1 19/1 21/15 29/4 48/15 61/8 70/2 73/11 82/18 83/1 85/11 86/1 96/12 98/13 107/8 110/23 112/8 128/17 128/18 133/18 144/22 144/22 145/25 158/24 <b>you've [42]</b> 1/18 11/6 12/2 14/14 22/17 25/15 25/15 26/7 27/24 28/2 31/11 39/3 40/6 42/22 45/24 46/7 47/22 48/1 48/6 60/20 66/3 69/14 76/17 84/21 85/9 86/7 86/11 90/6 107/13 110/22 120/19 127/7 138/11 139/12 139/19 148/10 157/23 162/18 164/11 164/22 168/10 168/13 <b>young [7]</b> 15/3 24/12 26/23 51/2 53/9 54/3 125/17 <b>younger [2]</b> 125/14 137/12 <b>youngest [1]</b> 71/24 <b>your [179]</b> <b>yours [2]</b> 114/6 146/24 <b>youth [6]</b> 21/6 53/5 53/9 53/11 53/11 53/13
<b>workers... [27]</b> 95/6 95/15 95/16 98/19 99/18 100/12 100/14 101/3 101/13 101/14 101/15 101/19 101/20 102/12 102/12 105/22 106/19 107/5 107/15 107/23 122/5 129/17 129/17 131/14 137/5 141/5 169/22 <b>Workers' [1]</b> 57/3 <b>workforce [14]</b> 80/22 80/24 81/9 81/14 98/5 122/10 122/14 122/16 123/9 129/20 131/15 137/8 137/12 137/15 <b>workforces [1]</b> 129/23 <b>working [33]</b> 10/13 10/19 28/10 32/3 51/12 55/17 56/10 56/14 56/21 59/15 59/18 62/14 63/17 64/3 64/4 64/8 64/16 68/9 68/22 81/14 81/17 81/19 83/13 93/15 96/10 102/6 105/5 119/4 121/1 134/3 141/2 159/9 159/11 <b>workplace [7]</b> 65/6 65/24 67/3 71/24 71/25 75/17 83/20 <b>workplaces [1]</b> 56/6 <b>works [4]</b> 98/11 98/14 99/4 130/9 <b>world [4]</b> 55/16 56/4 56/8 113/14 <b>worldwide [1]</b> 126/25 <b>worried [2]</b> 58/8 75/14 <b>worries [1]</b> 140/21 <b>worry [3]</b> 83/16 123/5 144/4 <b>worrying [2]</b> 22/9 59/13 <b>worsening [1]</b> 7/1 <b>worst [1]</b> 59/24 <b>worth [1]</b> 81/9 <b>would [64]</b> 10/2 11/25 18/13 21/17 22/21 24/24 32/4 35/15 36/21 39/16 40/21 40/22 41/14 41/15 41/16 43/1 43/3 47/16 49/5 50/1 63/22 67/2 68/13 68/21 68/21 71/17 71/22 73/18 74/1 77/5 79/17 82/7 93/14 94/16 94/24 102/3 103/24 104/4 107/9 109/7	<b>Y</b> <b>yeah [46]</b> 2/8 2/11 6/16 6/19 8/7 8/17 8/25 9/12 11/23 12/1 12/11 13/24 14/17 15/13 15/24 16/10 17/8 17/24 19/14 28/10 29/6 44/10 44/12 44/12 73/1 92/16 98/18 102/4 106/7 108/24 111/22 121/5 123/13 137/2 149/6 150/3 152/19 153/14 154/23 160/9 161/7 165/6 166/3 168/8 168/20 169/14 <b>year [14]</b> 1/20 7/12 13/13 19/6 19/6 27/24 28/20 61/5 61/20 84/18 86/8 89/2 111/17 152/9 <b>years [31]</b> 3/10 3/10 6/17 8/9 18/25 19/3 20/4 24/7 24/10 25/18 26/6 31/17 48/9 52/20 59/14 59/23 79/14 85/21 85/23 89/20 90/2 129/24 130/3 130/12 131/19 131/21 132/1 144/23 145/5 147/21 157/7 <b>Yemen [2]</b> 117/6 120/11 <b>Yep [1]</b> 28/1 <b>yes [161]</b> 1/24 2/8 3/5 3/5 8/22 15/9 17/13 17/16 17/20 20/17 22/19 24/23 25/4 28/14 29/10 35/10 35/18 38/18 38/22 39/10 39/12 45/18 49/1 55/3 62/2 62/13 62/20 62/24 63/4 63/15 65/25 66/6 68/2	<b>Z</b> <b>zag [1]</b> 8/4 <b>zero [3]</b> 70/11 71/19 72/4 <b>zero-hours [2]</b> 70/11 72/4 <b>zig [1]</b> 8/4 <b>zig-zag [1]</b> 8/4 <b>Zika [2]</b> 117/5 118/8 <b>zoom [1]</b> 97/10 <b>zooming [1]</b> 106/10	