

Tuesday, 19 March 2024

(10.30 am)

**Introductory remarks by THE CHAIR**

**LADY HALLETT:** Good morning, everyone.

This is the first preliminary hearing into Module 6, which will be focusing on the care sector.

Leading Counsel to the Inquiry team for Module 6, and indeed for Module 3, is Ms Jac Carey King's Counsel.

In a moment, she will tell us what the issues are that I have to consider today and as a result of this hearing. After Ms Carey has spoken, I will then hear from those core participants who wish to make opening submissions.

Just so everyone knows who is following online or here in the hearing room, I will also be receiving written submissions, they will all be published, so the aim of the oral submissions from core participants is to highlight the most significant issues that they wish highlighted. It's not that they need to go through all the matters that they've set out in their oral submissions, and we have quite a few to get through today so I shall immediately call on Ms Carey.

**Statement by LEAD COUNSEL TO THE INQUIRY for MODULE 6**

**MS CAREY:** Thank you, my Lady.

My Lady, the devastating impact of the Covid-19

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So whilst those tragic statistics from care homes may have made the headlines, the impact of the pandemic was felt not just in residential and care homes, but also more widely across the adult social care sector.

In fact, most adult social care in the UK is not provided in care homes, but in what is sometimes called domiciliary care, ie services provided to support someone in their own home. It's not just about old people, my Lady. Moreover, adults of a working age, ie those between 18 and 64, make up a significant proportion of those accessing and requiring social care. So Module 6 is considering the impact not only on the elderly and those in later life but also on those other adults that require that care.

Of course, in addition to those receiving care and the impact on their families, there is the impact on those providing care. And whilst the size of the workforce in each nation inevitably varies, the adult social care workforce in England alone is estimated to be in the region of 1.5 million people, with more women than men working in this sector, women provide more unpaid care than men, the sector has a high proportion of workers from black, Asian and ethnic minority groups, and in some parts of the UK, for example here in London, a high proportion of migrant workers.

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pandemic on those living and working in the adult social care sector is going to need little introduction, and certainly little introduction to those in the hearing room today and those following online. But by way of context for this module, the ONS statistics for March 2020 to the week ending 21 January 2022 suggest there were 45,632 Covid-19-related deaths of residents in care homes in England and Wales, and in Scotland between March 2020 and June 2022 the Care Inspectorate received 3,592 notifications of deaths related to Covid-19 from care homes, and in Northern Ireland between March of 2020 and March of 2022, according to the Northern Ireland Statistics and Research Agency, there were 953 Covid-19 deaths in care homes.

My Lady, that's over 50,000 deaths.

The decisions that may have contributed to those figures will doubtless be examined in Module 6, but it is not just a question of statistics and data. Each number represents the loss of a loved one, often, as we will hear, in circumstances where they were not accompanied by family and friends saying goodbye at bedsides, but they died surrounded by PPE and by the imposition of visiting restrictions which prevented or inhibited them dying in the company and presence of those who loved them.

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Sadly, care workers and those providing care in the home were in the occupations at the highest risk of death from Covid-19.

Now, that brief and sobering introduction gives an indication of the breadth and scale of the adult social care sector and explains in part why Module 6 has had to focus on particular care settings and issues, and I'll return to that, if I may, when we look at the provisional outline of scope.

These proceedings are, of course, being recorded and livestreamed to other locations and there are a number of core participants who are following online this morning. In live streaming these proceedings, your Ladyship is fulfilling the obligation set out in the Inquiries Act to take such steps as you consider reasonable to ensure that members of the public are able to attend or see and hear the simultaneous transmission of proceedings. It also allows, live streaming, the hearing to be followed by more people than can be present in the hearing room at Dorland House.

Although we don't anticipate it to arise today, as is routine in public inquiries, where there may be matters mentioned that are potentially sensitive, the broadcasting of the hearing is subject to a three-minute delay, and that provides the opportunity for the feed to

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1 be paused if something sensitive arises and anything  
2 unexpected is aired which should not be.

3 As I say, I mention that feature not because we  
4 anticipate it arising today but so that those who are  
5 following from further afield understand the reasons if  
6 there is a break in proceedings.

7 My Lady will have an agenda for today's hearing  
8 which has been circulated and indeed is displayed on the  
9 screens here at Dorland House, and the first item for  
10 consideration this morning is the designation of  
11 core participants.

12 Module 6 received over 50 applications, some of  
13 which were joint applications, for core participant  
14 status, of which 27 have been granted. Given that it is  
15 the first preliminary hearing in this module, it is  
16 appropriate for me to introduce them, and indeed there  
17 are 14 core participants in the hearing room this  
18 morning.

19 There are those representing the Covid Bereaved  
20 Families for Justice UK, and the Covid-19 Bereaved  
21 Families for Justice Cymru, the Northern Ireland Covid  
22 Bereaved Families for Justice and the Scottish Covid  
23 Bereaved are here, along with the core participant group  
24 John's Campaign, Care Rights UK and the Patients  
25 Association. Disability Rights UK, Disability Action

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1 designated for Module 6 is now published online on the  
2 website.

3 My Lady, for those who were not granted  
4 core participant status, or for those who did not apply  
5 to be designated as a core participant, can I reiterate  
6 that not being a core participant in Module 6 in no way  
7 precludes any person or group from: applying in a later  
8 module; bringing any matter to the attention of the  
9 Inquiry and, importantly, providing evidence and  
10 information to Module 6; if appropriate and relevant,  
11 giving evidence at the public hearing. And if  
12 an individual affected by the pandemic wishes to take  
13 part, they can do so in the Inquiry's listening  
14 exercise, Every Story Matters.

15 Item 2 on the agenda is the provisional outline of  
16 scope for Module 6, and I've asked that it is put up on  
17 the screens in front of your Ladyship, and indeed around  
18 the room, because it's an important document and it's  
19 a document about which you will hear submissions  
20 throughout the day.

21 Module 6 will examine the impact of the pandemic on  
22 the publicly and privately funded adult social care  
23 sector, known as the care sector, in England, Scotland,  
24 Wales and Northern Ireland. As you can see, set out  
25 there it will consider the consequences of government

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1 Northern Ireland, Disability Wales and  
2 Inclusion Scotland have been known or are known as the  
3 disabled people's organisations, and they are to your  
4 right, my Lady.

5 We have the Frontline Migrant Health Workers Group,  
6 the British Association of Social Workers, the National  
7 Association of Care and Support Workers, the Royal  
8 College of Nursing, the Trades Union Congress.

9 Care England, National Care Forum and the Homecare  
10 Association are a core participant group.  
11 Scottish Care. A joint core participant group of the  
12 Association of Directors of Adult Social Services, the  
13 Local Government Association and the Welsh Local  
14 Government Association. The Care Quality Commission,  
15 the Regulation and Quality Improvement Authority and the  
16 Care Inspectorate.

17 The Department of Health and Social Care, Department  
18 for Health Northern Ireland, the Scottish Territorial  
19 and Special Health Boards, the Convention of Scottish  
20 Local Authorities (known colloquially as COSLA), the  
21 Scottish Ministers, the Welsh Government.

22 And we have the four public health authorities:  
23 Public Health Wales, UKHSA, Public Health Scotland, and  
24 the Public Health Agency, Northern Ireland.

25 A list of all of the core participants that you have

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1 decision-making on those living and working within the  
2 care sector. This includes adult care in residential  
3 homes, including care provided in the home, but not care  
4 provided within daycare centres or in supported housing.  
5 It includes the decisions to free up capacity in  
6 hospitals by discharging patients into adult care and  
7 residential homes. It will address the steps taken in  
8 adult care and residential homes to prevent the spread  
9 of Covid-19 and examine the capacity of the adult  
10 care sector to respond to the pandemic. And the module  
11 will consider the impact of the pandemic on the  
12 residents, their loved ones and the impact on staff  
13 working within the care sector.

14 Set out below are particular aspects that the module  
15 will examine. There are eight in total. They are not  
16 ordered in terms of any hierarchy, and I make that clear  
17 at the outset, but the matters that will feature include  
18 this: the impact of the pandemic on people's experience  
19 of the care sector. This will focus on residents and  
20 their loved ones, and those working within the  
21 care sector, and will include consideration of the  
22 unequal impacts on them.

23 The structure of the care sector and the key bodies  
24 in the UK and the devolved administrations will be  
25 looked at, at the start of and during the pandemic.

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1 That will include staffing levels and bed capacity  
 2 immediately prior to the pandemic.  
 3 It will look at the key decisions made by the  
 4 UK Government and the devolved administrations in  
 5 respect of the care sector, including the decisions  
 6 relating to the discharge of people from hospitals into  
 7 the adult care and residential homes in the early stages  
 8 of the pandemic.

9 The module will examine the management of the  
 10 pandemic in adult care and residential homes. This will  
 11 include the measures preventing the spread of Covid-19,  
 12 such as infection prevention and control measures (also  
 13 known as IPC), look at testing for Covid-19, the  
 14 availability and adequacy of personal protective  
 15 equipment (PPE), restrictions on access by and to  
 16 healthcare professionals, and visits from loved ones.

17 The module will consider the use of Do Not Attempt  
 18 Cardiopulmonary Resuscitation orders, or DNACPRs, and  
 19 the communications with residents and their loved ones  
 20 about the resident's condition and treatment, including  
 21 discussions and decisions about DNACPRs.

22 The module will look at changes to the regulatory  
 23 inspection regimes within the care sector, deaths  
 24 related to the infection of Covid-19, including deaths  
 25 of residents and staff, and infection prevention and

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1 The Inquiry considers that the provisional scope  
 2 provides a proper framework of the key issues and  
 3 matters that the Inquiry is likely to enquire into, and  
 4 that it sufficiently indicates for people and  
 5 organisations who have relevant information and  
 6 evidence, as well as the core participants, to be able  
 7 to commence their preparations.

8 These issues will, however, be further developed  
 9 once the response to the majority of the Rule 9 requests  
 10 for evidence have been received.

11 A number of core participants have made suggestions  
 12 for other matters that should be included in the  
 13 provisional outline of scope. It's not practical for me  
 14 to address you on all of those today. They all require  
 15 careful consideration and it may be that some of those  
 16 areas, for example the impact of the proposal to make  
 17 vaccination a condition of deployment for healthcare  
 18 workers in England, are intended to be covered by the  
 19 scope and are already within our contemplation, albeit  
 20 they've not been expressly referred to in that scope.

21 There are, however, some specific matters raised in  
 22 the submissions received about the scope that I would  
 23 like to address today. The Covid Bereaved Families for  
 24 Justice Cymru submit that Module 6 should be subdivided  
 25 so that, in addition to Module 6, there are Modules 6A,

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1 control measures for those providing care in the home,  
 2 including by unpaid carers.

3 Now, my Lady, that scope is necessarily provisional.  
 4 Although it introduces a wide range of topics, it's  
 5 neither practical nor advisable to identify at this  
 6 stage all the issues that the evidence and material  
 7 obtained under the Rule 9 process will address. Once  
 8 that material has been obtained, the module is designed  
 9 to accommodate and obtain documentation and from which  
 10 then issues can be further distilled.

11 In due course Module 6 will circulate a list of  
 12 issues to help identify the key issues arising from  
 13 evidence, and in this regard we are grateful for the  
 14 many helpful and thoughtful suggestions set out in the  
 15 written submissions.

16 At the outset, though, given the public concern  
 17 about the discharge decisions, and the fact that this  
 18 policy primarily affected adult patients, I should make  
 19 clear that the Inquiry does not intend to examine  
 20 children in care in this module, and indeed aspects of  
 21 the impact of the pandemic on children and young people  
 22 will in any event be considered in a later module.  
 23 Moreover, Module 6 provisional scope encompasses all  
 24 adults requiring social care and not, as has been  
 25 suggested by one core participant, only the elderly.

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1 6B and 6C, looking at the social care systems in  
 2 Scotland, Wales and Northern Ireland respectively. It  
 3 is said that this would not only reflect the  
 4 constitutional position, given that social care is  
 5 a devolved matter, but also reflect the fact that the  
 6 way social care is structured is different in each  
 7 country, and that different decisions were taken in the  
 8 countries at different times.

9 In our submission, no such division is necessary.  
 10 The themes and topics identified in the provisional  
 11 outline of scope enable the Inquiry to take account of  
 12 any structural differences in the way each country's  
 13 social care system is set up, without the need for  
 14 individual hearings.

15 Moreover, your Ladyship has made plain that this  
 16 Inquiry must be conducted efficiently, and the addition  
 17 of further hearings would be contrary to your clear  
 18 intentions in that regard.

19 It is further suggested that the scope should be  
 20 re-worded so that there are specific subparagraphs for  
 21 each nation, essentially repeating each part of the  
 22 scope three more times. My Lady, in our submission,  
 23 that is an unnecessary amendment. The opening of the  
 24 scope makes clear that the module will consider the  
 25 impact of the pandemic on the publicly and privately

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1 funded adult social care sector systems in England,  
2 Scotland, Wales and Northern Ireland.

3 A number of core participants have submitted that  
4 the scope of Module 6 should be widened to include the  
5 impact of the pandemic on other care settings, such as  
6 sheltered accommodation, supported living, shared lives  
7 schemes, hospices, assisted living and respite care.

8 Now, some of those settings in effect provide care  
9 to an individual in their own home, with the amount of  
10 support being provided varying greatly. For example,  
11 care in the home encompasses a carer visiting  
12 an individual's private residence for a short time to  
13 provide personal care, for example getting someone up in  
14 the morning or helping them to wash or dress, but it  
15 also includes much more intensive support. Other  
16 settings, such as supported living, involve care in  
17 a home where there are a small number of residents and  
18 individuals, or sheltered accommodation where there is  
19 a warden on site.

20 So although there are a number of different settings  
21 in which people are provided care, it will not be  
22 necessary or proportionate to examine all the settings.  
23 The Inquiry considers that by focusing on adult and  
24 residential care and care provided in the home, by which  
25 we mean care provided in one zone accommodation by

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1 So, understandably, some core participants have  
2 urged the Inquiry to examine a multitude not only of  
3 settings but of other issues, such as the potential  
4 increased use of restraints or sedation for some  
5 individuals needing care. They are obviously important  
6 issues for some adults in social care, but it will be  
7 appreciated, I hope, that it is not possible to examine  
8 each and every area of concern, nor would it be  
9 proportionate to do so.

10 Doubtless, my Lady, you will wish to consider the  
11 submissions made about the other settings and other  
12 matters that should fall into scope, and indeed, as the  
13 evidence emerges, if it suggests that other settings or  
14 issues need to be considered, the Inquiry will keep that  
15 matter under review.

16 May I just make two other observations in relation  
17 to the scope. In relation to preparedness, Module 6  
18 does not intend to repeat or rehearse the evidence given  
19 in Module 1, although in due course Module 6 will  
20 obviously disclose relevant material that's been  
21 provided to Module 1 and indeed any of the other earlier  
22 modules. However, it is not part of the Inquiry's terms  
23 of reference to consider the state of the adult social  
24 care systems in the UK prior to the pandemic, save  
25 unless it is necessary to do so to understand how the

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1 carers who do not live or work in the home, and  
2 therefore which doesn't fall under the umbrella of  
3 supported housing, the Inquiry will have a sufficiently  
4 broad base upon which to make meaningful recommendations  
5 with regard to the critical issues.

6 There will necessarily be a significant focus on  
7 residential care homes due to the risks the pandemic  
8 posed to residents and their inherently vulnerable  
9 status across all the age demographics and the  
10 challenges of implementing effective IPC in care and  
11 residential homes, as well as their role as potential  
12 vectors of transmission.

13 My Lady, that is not to diminish the importance of  
14 other settings, but instead it reflects the very real  
15 need to make meaningful recommendations in advance of  
16 any future pandemic, and to address the stark impact of  
17 Covid-19 on such residents, including the  
18 disproportionate number of deaths.

19 It follows from what I have said that -- the  
20 emphasis on critical issues, that the Inquiry will be  
21 unable to examine all the potential issues arising  
22 within the adult social care sector. There will  
23 necessarily need to be a focus on issues of  
24 significance, of wide impact, and of relevance to  
25 recommendations in the event of future pandemics.

14

1 pandemic in fact affected adult social care during 2020  
2 to 2022.

3 Finally, this observation: it may be that the  
4 pandemic threw a harsh and painful light on issues such  
5 as pre-pandemic underfunding and the undervaluing of the  
6 adult social care sector, but Module 6 is focused on the  
7 impact of the pandemic, not on those wide-reaching and  
8 historic concerns and problems, and so, in our  
9 submission, it is not, therefore, within Module 6's  
10 remit or scope to seek to fix or address those  
11 long-standing issues, although, again, I know you will  
12 want to consider very carefully the submissions that are  
13 made on that topic.

14 Turning to the next item on the agenda, which is  
15 evidence gathering and the Rule 9 requests for  
16 information.

17 Module 6 has started the process of identifying and  
18 issuing Rule 9 requests from relevant organisations and  
19 individuals, and they will include, just to give the  
20 headlines, the relevant government departments and  
21 agencies and ministers responsible for adult social  
22 care, the regulators, trade unions and membership  
23 organisations, relevant care providers, charities and  
24 interest groups, and bodies and organisations and  
25 core participants that can provide impact evidence.

16

1 The Inquiry is grateful for all the suggestions made  
2 in the written submissions as to who should receive  
3 a Rule 9 request and the Inquiry legal team has already  
4 started to consider those proposals.

5 One aspect of the Rule 9 work being undertaken is to  
6 try to obtain evidence from the local authorities in  
7 England, Wales, Scotland -- and there are different  
8 arrangements in Northern Ireland so I'll just focus on  
9 England, Wales and Scotland for the moment -- looking at  
10 the local authorities who are responsible for  
11 social care.

12 In this regard, in November 2023, Module 6 asked the  
13 Local Government Association to conduct an online survey  
14 of all its members. All 337 members in England and  
15 Wales responded. My Lady, the survey covered a wide  
16 range of topics, but I'd like to give you a flavour of  
17 some of the findings of the survey. There's just seven  
18 I'd like to refer to this morning, the first of which is  
19 this:

20 Following the onset of the pandemic, councils  
21 responded saying they adapted rapidly, with a large  
22 majority of the councils reporting a change in the  
23 structural mechanisms of decision-making. So,  
24 for example, councils reported undertaking a wide range  
25 of activities to support care providers, with nine out

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1 it harder to control outbreaks of Covid-19. Nine out of  
2 ten councils reported that test result delays made it  
3 difficult to control outbreaks, and to some extent  
4 compounded the difficulties caused by obtaining the  
5 tests in the first place.

6 Respondents to the survey consistently emphasised  
7 the confusing nature of key guidance distributed by  
8 central government and some national agencies. In this  
9 regard, three-fifths of respondents in England reported  
10 that the national infection prevention and control  
11 policies worked either not very well or not at all well,  
12 although 95% of respondents said that care homes in  
13 their area were able to isolate residents who  
14 potentially had Covid-19 at least to some extent.

15 My Lady, finally, this: the Covid-19 pandemic was  
16 reported by respondents to have had a highly negative  
17 impact on unpaid carers, with councils stepping up to  
18 help provide them and those they cared for with support.  
19 Over nine out of ten respondents reported that unpaid  
20 carers in their area suffered from mental stress,  
21 increased physical demands and/or a lessening of  
22 available respite.

23 Now, that is just a snapshot of the findings of the  
24 survey, and the Inquiry anticipates being able to  
25 publish the findings in one of the early phases of

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1 of ten providing and purchasing and distributing PPE.

2 Local government respondees felt that social care  
3 was sometimes treated as an afterthought compared to the  
4 NHS. In those survey responses they said two fifths of  
5 English councils reported that their orders for PPE were  
6 deferred to the NHS very or fairly often during the  
7 first six months of the pandemic. And respondents noted  
8 differences in staff capacity and vaccination and  
9 testing guidelines between the NHS and the social care  
10 sector, putting the latter at a perceived disadvantage.

11 Respondees commented on visits by healthcare  
12 professionals and said they were frequently limited by  
13 the restrictions imposed during the pandemic, and it was  
14 reported that those limitations resulted in longer waits  
15 for treatment, inadequate treatment, necessary transfers  
16 to hospital not being undertaken, or, conversely,  
17 unnecessary transfers to hospital being undertaken.

18 Eight in ten English councils reported that the NHS  
19 discharged people from acute hospitals into care homes  
20 without routinely testing them first, and almost nine in  
21 ten respondents said that care homes in their area were  
22 sometimes unaware of patients' Covid-19 status on  
23 receiving them from hospital.

24 The survey asked about delays in receiving Covid-19  
25 tests, and indeed delays in receiving the results made

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1 disclosure.

2 In relation to Scotland, the Inquiry is grateful to  
3 COSLA, the Convention of Scottish Local Authorities, for  
4 their offer of assistance with providing a Scottish  
5 version of the survey, an offer which Module 6 will  
6 gladly accept.

7 The arrangements in Northern Ireland are somewhat  
8 different, because there the five health and social care  
9 trusts are responsible for social care, and so Module 6  
10 is in the process of considering how best to obtain this  
11 evidence, if possible, in relation to Northern Ireland.

12 More generally across the Inquiry, Rule 9 requests  
13 for documentation and witness statements are being  
14 issued on an iterative basis, and additional requests  
15 may be made of some recipients focusing on particular  
16 issues in due course.

17 As the Rule 9 requests will be issued on a rolling  
18 basis to organisations and witnesses, some issues will  
19 come into greater focus, no doubt, during the course of  
20 the investigation.

21 In line with your determination made in Module 1,  
22 core participants will not be provided with copies of  
23 the Rule 9 requests made by the Inquiry, but disclosure  
24 to the core participants of the Rule 9 requests  
25 themselves, as opposed to the documents and the material

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1 generated by those requests, is neither required by the  
2 rules nor generally established by past practice and,  
3 furthermore, in our submission it would serve little  
4 practical purpose, given the wide scope and the detailed  
5 nature of Rule 9 requests that are being made.

6 Whilst dealing with that, in addition your Ladyship  
7 has already determined that position statements are not  
8 required or needed and we would invite you to confirm  
9 that this remains the position in Module 6.

10 To ensure, though, that core participants are  
11 properly informed, the Inquiry will ensure that Module 6  
12 lead solicitor provides monthly updates to  
13 core participants on the progress of Rule 9 work, and  
14 those updates will include a summary of who's received  
15 Rule 9 requests, the topics those requests cover, what  
16 categories of documents have been requested, when the  
17 request was made and, indeed, when the response is  
18 expected.

19 That brings me on to disclosure to core participants  
20 and item 4 on the agenda.

21 In common with the approach taken in the preceding  
22 modules, Module 6 will adopt the following approach to  
23 disclosure: all core participants will receive all  
24 documents disclosed in Module 6, not just those  
25 documents relevant to them. The disclosure will be

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1 and the instruction of expert witnesses.

2 Module 6 has provisionally identified a number of  
3 areas where expert evidence is likely to assist in  
4 examining some of the matters set out in the provisional  
5 outline of scope, and there are three areas that have  
6 already provisionally been identified.

7 The first is an expert on what I have called the  
8 structure and capacity of the adult social care sector  
9 across the UK. It is envisaged that this expert or  
10 experts will include an outline of how the care sector  
11 is structured and funded, and any key differences across  
12 the UK. And there are in effect four different adult  
13 social care sector systems at play here.

14 It will look at the numbers and types of care homes  
15 and providers, workforce capacity at the start of and  
16 during the pandemic, and the expert report, I repeat,  
17 will consider the position in all four nations.

18 Module 6 also intends to instruct an infection  
19 prevention and control expert. This is likely to  
20 include matters such as the development of the  
21 scientific understanding of Covid-19, including routes  
22 of transmission, and in particular in relation to care  
23 settings at the start and then throughout the pandemic.  
24 It will also look at IPC guidance relevant to the  
25 care sector, and issues relating to PPE within the

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1 subject to three things: a relevance review,  
2 a de-duplication exercise, and redactions in accordance  
3 with the Inquiry's redactions protocol. There is  
4 a significant team of solicitors, barristers, paralegals  
5 already in place to review the relevance of material  
6 that has been received.

7 We will make disclosure in tranches on a rolling  
8 basis, and disclosure updates will also be provided in  
9 the monthly update by the Module 6 solicitors team,  
10 informing core participants of the progress that has  
11 been made in obtaining relevant documents.

12 Now, the Inquiry has already identified material  
13 potentially relevant to Module 6 that has been provided  
14 to other modules. This material will be reviewed for  
15 disclosure and we hope to start making disclosure in the  
16 summer of 2024. I know that some core participants have  
17 queried why disclosure cannot be made earlier, and if it  
18 can be, it will be. But in reality, drafting the Rule 9  
19 requests, allowing the recipients sufficient time to  
20 respond, reviewing and providing feedback on draft  
21 statements and then redacting and then disclosing the  
22 final signed statement and exhibits takes many months,  
23 such that, in our submission, summer seems a realistic  
24 start date.

25 Allied to disclosure is the issue of expert material

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1 care sector.

2 Module 6 has also identified this area for potential  
3 expert evidence, and it's to look at the impact of the  
4 pandemic on those with specific conditions which  
5 commonly underpin the need for social care.

6 Now, the Inquiry is already considering which  
7 specific condition or conditions should be covered by  
8 expert evidence into the impact. This part of the  
9 module's work is focused not on the providers of care,  
10 but very much on the individual receiving care and how  
11 the pandemic affected them, and to include where  
12 possible what are called indirect harms.

13 For obvious reasons, the Inquiry will not be able to  
14 obtain expert evidence on all relevant conditions, but  
15 it is hoped that expert evidence will be complemented by  
16 other evidence obtained through the Rule 9 gathering  
17 process, and we are considering looking at the impact on  
18 those with learning difficulties, people with mental  
19 health difficulties, those with dementia, physical  
20 difficulties, and those with multiple or complex needs.

21 That's not to say that some people don't,  
22 I'm afraid, suffer from a number of those conditions,  
23 nor is it to pigeonhole people, but there has to be  
24 a sensible way to try to understand the way the pandemic  
25 impacted people with those kinds of difficulties.

24

1 In this regard, we note the disabled people's  
2 organisations' submission that expert evidence on impact  
3 should not be based solely on condition but on whether  
4 the eligibility criteria is met.

5 Now, the Inquiry legal team wants to consider that  
6 submission, but note that one part of the eligibility  
7 criteria is looking at the adult's needs and whether  
8 they arise from or are related to a physical or mental  
9 impairment of illness, and so it may be that,  
10 practically speaking, these are two sides of the same  
11 coin. But, again, we are considering the submissions  
12 received in that regard.

13 In relation to those three areas, and indeed any  
14 other future area for expert evidence, the identity of  
15 the expert witnesses and the questions and issues they  
16 will be asked to address will be disclosed to the  
17 core participants before the expert reports are  
18 finalised. So the core participants will be able to  
19 provide observations on the draft expert report. We  
20 anticipate that where there are significant differences  
21 of view amongst expert opinion, these will be made clear  
22 on the face of the reports, and of course in due course  
23 can be tested during oral hearings.

24 The appointment of the experts to the Inquiry are,  
25 though, matters exclusively for the Inquiry, although we  
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1 including the residents living within the adult social  
2 care sector and those who are cared for at home and  
3 their loved ones, those managing public and privately  
4 funded care homes, people working in adult social care  
5 settings during the pandemic, including those providing  
6 care at home, whether they are paid or unpaid.

7 To date, nearly 5,500 people have shared their  
8 experiences of the care sector with Every Story Matters  
9 and there have been a number of listening events at  
10 care homes that have taken place, but can I reiterate  
11 the Inquiry encourages anyone else who would like to  
12 participate to go online and share their story.

13 In addition to that, Every Story Matters is going to  
14 commission targeted research about the impact of  
15 lockdowns and visiting restrictions, including on the  
16 physical and mental health of those who receive and  
17 provide care, and looking at end-of-life care, DNACPR  
18 decisions and bereavement, the information that was  
19 provided to and about patients being discharged from  
20 hospitals, access to emergency and routine healthcare  
21 for residents in care homes, and it will look at IPC  
22 measures.

23 There is a proposed what are called key lines of  
24 enquiry that have been shared with core participants,  
25 along with the categories of potential audience groups  
27

1 have received already a number of helpful suggestions  
2 from core participants as to who should be appointed.  
3 We will consider those experts, and indeed the  
4 additional areas of expert evidence, and I've no doubt  
5 that you will hear further submissions about that today.  
6 So, before deciding on any additional areas, no doubt  
7 you'll wish to listen to those oral submissions.

8 My Lady, item 5 on the agenda considers  
9 the Inquiry's listening exercise, Every Story Matters.

10 Every Story Matters has been established to gather,  
11 analyse and summarise the experiences of those affected  
12 by the pandemic and the UK's response to it. Module 6  
13 will have an Every Story Matters report covering  
14 people's experiences of care. The report will be  
15 anonymised but disclosed to the core participants and  
16 used in evidence so they can form part of the Inquiry's  
17 written record. The report will identify trends and  
18 themes and include illustrative case studies which may  
19 demonstrate systemic failures.

20 Every Story Matters aims to obtain information from  
21 anyone who wishes to contribute and has been designed so  
22 that anyone and everyone in the UK can contribute if  
23 they wish to do so. Specifically in relation to  
24 Module 6, the Inquiry is particularly interested to hear  
25 from people who have interacted with the care sector,  
26

1 that it is proposed are included in the sampling for  
2 those qualitative interviews, and again we are grateful  
3 for all the submissions that have been made in respect  
4 of the key lines of enquiry. These will be revisited  
5 once your Ladyship has had a chance to consider all of  
6 the submissions and made any necessary final decisions  
7 about the scope of Module 6.

8 The final matter on the agenda is this, my Lady, in  
9 relation to future hearings. There will be a further  
10 preliminary hearing for Module 6 held in due course at  
11 Dorland House. We anticipate that the public hearing in  
12 Module 6 will take place in London in the summer of  
13 2025. The disabled people's organisations have asked  
14 the Inquiry to consider whether a British Sign Language  
15 interpreter could be used in Module 6 for some or all of  
16 the public hearing. The need, feasibility and cost of  
17 this suggestion is a matter that the Inquiry is looking  
18 into, and your decision about this can be communicated  
19 to core participants in due course.

20 Your Ladyship has already indicated that you will  
21 publish the written submissions that you received. In  
22 addition to those written submissions there are  
23 12 core participants present today who wish to make oral  
24 submissions, and the first to address you is Ms Morris  
25 King's Counsel on behalf of the Covid Bereaved Families  
28

1 for Justice UK.  
 2 **LADY HALLETT:** Thank you very much indeed, Ms Carey, I'm  
 3 very grateful.  
 4 Ms Morris.

5 **Submissions on behalf of Covid Bereaved Families for Justice**  
 6 **UK by MS ANNA MORRIS KC**

7 **MS MORRIS:** My Lady, I appear on behalf of the Covid  
 8 Bereaved Families for Justice UK. You have received our  
 9 written submissions and I propose to use the short time  
 10 I have to focus on and highlight some key topics.

11 The first topic I'd like to address with you,  
 12 please, is the issue of the provisional scope, and  
 13 firstly in relation to preparedness.

14 This is not just an issue, in our submission, for  
 15 Module 1. The Inquiry should look at the preparedness  
 16 of the adult social care sector as a core theme of  
 17 Module 6, and at paragraph 13 of our submissions we have  
 18 made it clear that it will be essential for the Inquiry  
 19 to understand the significant variations in the way that  
 20 the adult social care sector is regulated, commissioned  
 21 and provided across the four nations and jurisdictions,  
 22 to inform both the investigation and the impact of the  
 23 pandemic and any recommendations on the integration and  
 24 governance of adult social care to strengthen future  
 25 pandemic response.

29

1 from each of the four jurisdictions. In our submission,  
 2 this would be a proportionate approach, but one that  
 3 requires some modification for Module 6 because of the  
 4 disparate and fragmented nature of the adult social care  
 5 sector and the way it's provided across both community  
 6 and residential settings, and regularly both.

7 In particular, we suggest the Inquiry could  
 8 spotlight residential settings with the highest and  
 9 lowest infection and mortality rates, to compare  
 10 approaches and match settings and provide -- as against  
 11 inspection ratings. We recognise that the Inquiry will  
 12 not be able to focus on individual experiences. Our  
 13 families suggest that there are examples of  
 14 exceptionally good and exceptionally poor practice and  
 15 there may be a case for spotlighting residential  
 16 settings and care providers in the catchment areas of  
 17 the spotlight hospitals that are being focused on for  
 18 Module 3.

19 We welcome within the inclusion of the Inquiry's  
 20 scope an examination of domiciliary care, because the  
 21 Health Foundation reports that there were over 4,500  
 22 excess deaths amongst people receiving domiciliary care  
 23 in England during the first wave of the pandemic up  
 24 until July 2020, which is higher in proportional terms  
 25 that in care homes during the same period. A large

31

1 This needs to be properly reflected in the  
 2 timetable, in our submission, my Lady. It's been  
 3 helpfully set out this morning by Ms Carey  
 4 King's Counsel that the four different sectors will be  
 5 examined with care, but of course that requires  
 6 timetabling consideration for England, Scotland, Wales  
 7 and Northern Ireland to have appropriate time to be  
 8 addressed and properly explored.

9 One issue that is necessary to explore in addition  
 10 is whether the pandemic highlighted the urgent need for  
 11 a national care service or services in each of the four  
 12 jurisdictions. In our submission, the absence of  
 13 a joined up national care service is an issue which may  
 14 be highly relevant to the recommendations you may wish  
 15 to make in due course and should be kept in the  
 16 forefront of the Inquiry's mind throughout Module 6.

17 We repeat our concern that the Inquiry needs to set  
 18 time aside to deal with all four systems sufficiently as  
 19 there are likely to be differences in structures,  
 20 resourcing and operation, and we urge the Inquiry to  
 21 discuss with the core participants how that can be  
 22 achieved.

23 One way we say that can be achieved is to replicate  
 24 the Inquiry's approach in Module 3 and spotlight  
 25 residential care settings and domiciliary care providers

30

1 number of our families' loved ones died whilst living at  
 2 home and receiving care and support from unpaid carers,  
 3 adult social care and nursing professionals.

4 However, any investigation into different settings  
 5 where care is delivered is incomplete without a thorough  
 6 investigation into infection prevention and control and  
 7 movement of staff across settings. This must include  
 8 the role of agency staff, the regulation of cross-sector  
 9 workers, as well as the impact of zero-hours contracts  
 10 and staff sickness.

11 We also ask the Inquiry to further clarify on how  
 12 far the scope goes with respect to which parts of the  
 13 sector are included and which are not, for example  
 14 within the context of sheltered accommodation, and if  
 15 not, why not.

16 Can I touch now, please, on the issue of  
 17 discrimination. It's recognised that disparities of  
 18 outcome from the pandemic for some racialised minorities  
 19 is a persistent factor in most aspects of this Inquiry.  
 20 Likewise, the impact of ageism and ableism in the  
 21 matters the Inquiry proposes to investigate in Module 6  
 22 cannot be overstated.

23 Although paragraph 1 of the provisional outline of  
 24 scope may be broad enough to cover these issues and  
 25 broader issues of socioeconomic inequalities, it's

32



1 submitted that the impact of structural and  
2 institutional discrimination, and particularly racism,  
3 ageism, ableism and sexism, should be expressly included  
4 in the scope for Module 6.

5 The Inquiry may to some degree carry forward the  
6 evidence from earlier modules but there is also a clear  
7 need for further reports that relate specifically to  
8 this module.

9 It's important that the scope of Module 6 includes  
10 the whole spectrum of social care, not only the adult  
11 social care sector as it relates to older people. The  
12 experience and impact on adults with intellectual  
13 disabilities is essential given the high mortality rates  
14 amongst this group, as outlined by Professors Watson and  
15 Shakespeare in their evidence to Module 2.

16 Covid Bereaved Families for Justice families were  
17 appalled at the evidence of tacit and actual ageism  
18 uncovered by the Inquiry in Module 2, which was deeply  
19 painful and concerning. Given the impact of ageism  
20 during the pandemic was beyond the scope of  
21 Professor Nazroo's Module 2 report, the Inquiry is  
22 invited to seek expert evidence on the impact in  
23 Module 6 from Professor Nazroo or another suitably  
24 qualified expert.

25 We're grateful to the Inquiry for agreeing to  
33

1 not tasked with undertaking a wide-ranging international  
2 comparative study or judging where the UK finished in  
3 league tables. Our submission relates to providing  
4 limited comparators against which to pose the  
5 performance of the adult social care sector across  
6 the UK. Furthermore, by identifying systems which may  
7 have performed better, the Inquiry may be assisted in  
8 terms of recommendations for the future.

9 This submission is made on a proportionate basis.  
10 There are eminent experts in the field of comparative  
11 international health and social care, and to commission  
12 for such evidence would be both proportionate and likely  
13 to be of assistance to you, in our submission.

14 Before moving away from experts, we do note with  
15 some concern that in departure from other modules  
16 the Inquiry is not providing core participants with the  
17 names of experts to be instructed. In our submission,  
18 given the time between now and the start of the module,  
19 it's difficult to see what purpose this lack of  
20 disclosure can serve, but we will in all situations  
21 assist the Inquiry by the provision of any experts that  
22 we submit could assist the Chair's exploration.

23 If I may make some final points on scope. We  
24 welcome the inclusion of visits from loved ones at  
25 paragraph 4 of the provisional outline of scope.

35

1 instruct an expert to provide evidence to the Inquiry on  
2 the impact on those with dementia, and we also ask the  
3 Inquiry to consider expert evidence on the unequal  
4 impact of the pandemic on people with intellectual  
5 disabilities, and we press upon you our paragraph 41 of  
6 our submissions regarding the unequal impacts in respect  
7 of certain physical health conditions.

8 I hear what Ms Carey says about the reality that  
9 the Inquiry cannot consider all physical and mental  
10 health conditions, but we press upon the Inquiry the  
11 consideration of specific conditions including COPD,  
12 autoimmune diseases, type 2 diabetes and those that have  
13 suffered a stroke.

14 We make a specific submission at paragraph 42 of our  
15 written submissions about additional areas of evidence  
16 that can be assisted with expertise, and we invite  
17 the Inquiry to obtain expert evidence on the structural  
18 and institutional discrimination as it relates to the  
19 impact of the Covid-19 pandemic on the ASC sector, as  
20 set out above, and in doing so the structures and  
21 performance of the sector in two other countries where  
22 the ASC sector is said to be well developed, in order to  
23 compare impacts and to seek learning for  
24 recommendations.

25 My Lady, we entirely recognise that the Inquiry is  
34

1 Clearly, this was a matter of utmost public concern  
2 during the pandemic and is a matter of great concern to  
3 our families. At its heart the issue underlines the  
4 importance of family, community and dignity in death and  
5 bereavement during a pandemic.

6 Given the obvious impact on residents who were  
7 particularly vulnerable when not receiving visits from  
8 their loved ones, such as those with dementia or  
9 learning disabilities, the Inquiry is invited to include  
10 visits from loved ones as a distinct issue and not only  
11 as an aspect of infection prevention and control.

12 More broadly, my Lady, in relation to witnesses,  
13 this is a module which we say cries out for evidence  
14 from the bereaved to identify systemic issues from the  
15 perspective of those most affected and their lived  
16 experience. We can supply the Inquiry with a schedule  
17 of family witnesses, as in other modules, from which  
18 we'll invite you to call a proportionate number to give  
19 oral evidence. These are submissions that you will also  
20 find echoed in those made by the disabled people's  
21 organisations and John's Campaign.

22 Some practical matters, my Lady. We continue to  
23 note the difficulties caused for our ability to  
24 effectively engage and assist the Inquiry when  
25 the Inquiry does not share Rule 9 letters of instruction

36

1 to the experts. We have made oral and written  
2 submissions on this issue on a number of occasions, as  
3 have we made in respect of the requirement for position  
4 statements. I won't repeat them here, but in our  
5 submission the Inquiry's evidence gathering process does  
6 not appear to us to be getting smoother, and we repeat  
7 that position statements would greatly assist  
8 the Inquiry in its processes.

9 In respect of disclosure, there's a pressing need  
10 for disclosure to be made early. We entirely recognise  
11 the Inquiry will have very few significant breaks from  
12 September 2024 before Module 6 commences, and will be  
13 having to prepare concurrently Module 3, Module 4 and  
14 Module 5, as will the bereaved families, and we would  
15 require a commitment to disclosure being made as early  
16 as possible and starting as soon as possible.

17 In respect of Every Story Matters, we have made  
18 submissions on a number of occasions about our position  
19 for the bereaved families. We continue to ask questions  
20 about who is doing the evidence gathering, what the  
21 analysis is, and who is writing the reports. These  
22 questions, in our submission, have still not been  
23 answered to our families' satisfaction, which undermines  
24 their confidence in that process.

25 Finally, my Lady, we entirely understand the amount  
37

1 pandemic. 90%. And although that figure is appalling,  
2 it perhaps becomes less surprising when statistics that  
3 are available from the Northern Ireland Statistics and  
4 Research Agency are considered. Those indicate that  
5 between March 2020 and June 2022 persons aged over 75,  
6 or persons aged 75 and over, accounted for almost 74% of  
7 Covid-related deaths in Northern Ireland, and over the  
8 same period almost, that being March 2020 until  
9 May 2022, there were some 1,284 Covid-related deaths of  
10 care home residents.

11 That figure is slightly more than the figure my  
12 learned friend Ms Carey King's Counsel quoted to you  
13 this morning, only because the bracket, the window, is  
14 extended by some eight weeks.

15 But whatever figures we look at, the stark reality  
16 is that almost one in three people who died in  
17 Northern Ireland from Covid were care home residents,  
18 and that figure doesn't reflect the deaths of those who  
19 lived at home and who were receiving support from the  
20 care sector, or those who died at home or in hospital.  
21 And nor, of course, do those figures alone properly  
22 expose or reflect the intersectional nature of  
23 discrimination that may have faced by many of those who  
24 died, discrimination on grounds of ageism or ableism or  
25 low socioeconomic status or sex or race.

39

1 of work and preparation that goes into the Inquiry's  
2 work around Module 6, but in order for all  
3 core participants to work effectively to assist you and  
4 to ensure that those we represent can effectively  
5 participate in the process, there needs to be clarity  
6 and certainty around the start date and the time  
7 estimate.

8 My Lady, those are my submissions, unless I can  
9 assist you further.

10 **LADY HALLETT:** Thank you very much, Ms Morris.

11 Ms Campbell, I think you're going next.

12 **Submissions on behalf of the Northern Ireland Covid-19  
13 Bereaved Families for Justice by MS CAMPBELL KC**

14 **MS CAMPBELL:** My Lady, thank you.

15 You know that, together with my colleagues here in  
16 court today and those who will be following these  
17 proceedings, we represent the Northern Ireland Covid  
18 Bereaved Families for Justice, and, my Lady, it would be  
19 difficult for me today to overstate the importance of  
20 this particular module to the Northern Ireland Covid  
21 Bereaved.

22 In conversations with my colleagues, we estimate  
23 that some 90% of our client group have raised with us  
24 concerns about the treatment of their loved ones in the  
25 Northern Ireland care sector in the course of the

38

1 My Lady, the experience of the Northern Ireland  
2 Covid Bereaved will show that for many it felt like  
3 those who were most vulnerable to contracting Covid-19  
4 also became the most likely to be exposed to the  
5 illness, by virtue of their contact with or residence  
6 within the Northern Ireland care sector.

7 If I may, on behalf of the Northern Ireland Covid  
8 Bereaved, bring to your attention the following seven  
9 points that arise from their shared experience.

10 Far too many of those who died from Covid were  
11 acutely vulnerable to contracting Covid because of  
12 ill-thought out policies within the health and social  
13 care system, and with particular reference to that  
14 policy of discharging Covid positive patients from  
15 hospital into the care sector.

16 That discharge of Covid patients into care homes had  
17 a devastating and far-reaching impact in the north, and  
18 many of our clients believe they lost their loved ones  
19 as a direct result of that policy.

20 Secondly, far too many who lost their lives were  
21 acutely vulnerable to contracting Covid because of poor  
22 infection prevention and control policies within  
23 individual home settings. Many care homes, it seems,  
24 struggled to simply isolate individuals, struggled due  
25 to lack of facilities, struggled due to adequate staff

40

1 or resources.

2 Thirdly, far too many who died, including those  
3 receiving home help, as we call it, or domiciliary care,  
4 were vulnerable due to staffing practices, including:  
5 care workers who wittingly or, of course, in most cases,  
6 unwittingly carried the virus from home to home, from  
7 patient to patient; care workers who were not provided  
8 with or who were not adequately or appropriately using  
9 personal protective equipment; and those on zero-hours  
10 contracts who felt that they had no choice but to  
11 continue to work.

12 Fourthly, there were significant delays in the  
13 diagnosis of Covid within care home settings, and  
14 therefore delays in isolating those who had become  
15 infected.

16 My Lady, mindful of the risks that Covid brought to  
17 vulnerable people within a care home setting, the need  
18 for proper testing, proper equipment, adequately trained  
19 staff to undertake symptom monitoring in line with  
20 guidance is of key importance, and there is concerning  
21 evidence from our client group that many care homes in  
22 the north, certainly within the first year of the  
23 pandemic, didn't have all of the required equipment or  
24 trained staff to effectively monitor symptoms.

25 Fifth, far, far too many of those who died were cut  
41

1 or have been reflected in submissions from your counsel  
2 this morning.

3 You know, because you've spoken to many of our  
4 client group, that we have a great deal to say on the  
5 issue, that a great number of bereaved families have  
6 a lot to say about their experience of the adult social  
7 care sector in the north, and they have been patient in  
8 Module 1 and in Module 2, biding their time for the  
9 appropriate opportunity to give evidence.

10 That opportunity, we say, should come in Module 6.  
11 We urge you in this module to allocate sufficient time  
12 to hear the evidence of sufficient numbers of the  
13 bereaved, recognising that their evidence can assist you  
14 a great deal in the issues that are outlined in your  
15 provisional and, in due course, your final scope of this  
16 module.

17 My Lady, a word about the social care system in  
18 Northern Ireland, or rather, if I may, three words:  
19 underfunded, complicated, and, during the pandemic,  
20 unregulated.

21 Underfunded. You have heard evidence in Module 1  
22 about the dire state of the Northern Ireland health and  
23 social care system, you already know about the reports  
24 and the reviews and the recommendations that had been  
25 made but not enacted. But perhaps what has not been as  
43

1 off from their families and isolated during the  
2 pandemic, with no family members to communicate with,  
3 much less to advocate on their behalf in their  
4 isolation.

5 The importance -- and, my Lady, we know you know  
6 this -- of family contact with residents, the negative  
7 and sometimes traumatic effect of visiting restrictions  
8 on the physical and, of course, the mental wellbeing of  
9 residents and on the mental health of carers can't be  
10 overstated. In many cases, the restrictions imposed on  
11 visiting were cruel and felt punitive and failed to take  
12 into consideration the real importance of family  
13 relations and social interaction.

14 Sixth, far too many of our families experienced fear  
15 and confusion about medications that were prescribed,  
16 and far too many experienced the trauma of realising  
17 a DNACPR had been imposed or was being imposed on their  
18 loved ones without consultation or any meaningful  
19 agreement.

20 Seventh, far too many of those who died, died alone,  
21 in states of confusion and isolation, and without family  
22 members comforting them in death.

23 Now, my Lady, it is reassuring to see that those  
24 issues which come to the fore within our client group  
25 are either outlined in your provisional scope document  
42

1 clear is that although each was packaged as a health and  
2 social care system review, in fact they were primarily  
3 healthcare-focused, with little detailed consideration  
4 or attention given to the social care sector.

5 We anticipate that you will hear evidence commencing  
6 in Module 2C in a number of weeks that social care  
7 legislation in Northern Ireland is riddled with  
8 disconnected and outdated laws, absent any sense of  
9 coherence and theme, or any joined-up ambition in  
10 outcome. You will certainly hear that when the pandemic  
11 hit care homes in the north were already in a state of  
12 crisis, with long-standing issues of workforce shortages  
13 and long overdue reform.

14 In real terms, social care was and is the poor  
15 relation of our already dntrodden and impoverished  
16 healthcare system. For that reason we say that the  
17 evidence that you hear in Module 1(sic) about the  
18 Northern Ireland adult social care sector shouldn't  
19 simply commence in January or March 2020. If you are to  
20 make meaningful recommendations, you must hear evidence  
21 about why and how it was that the social care sector was  
22 so ill equipped and so unprepared for the pandemic.

23 It's not, of course, an inquiry into austerity or  
24 an inquiry into the adult social care system funding,  
25 but in order to properly consider preparedness for  
44

1 future pandemics, we must understand how it was we were  
2 so ill prepared in 2020.

3 My Lady, it's complicated. In 2020 there were just  
4 shy of 500 care homes registered in Northern Ireland.  
5 Some were run, as you've heard this morning, by one of  
6 the five health and social care trusts, some by  
7 voluntary organisations, but the vast majority, perhaps  
8 as much as 90%, were privately owned.

9 The complicated structure of accountability for  
10 service provision spanning that public and private and  
11 voluntary sphere meant that for many of our families  
12 when they wanted information or when they wanted to  
13 challenge decision-making there was a lack of clarity  
14 about where to go. It was almost impossible to identify  
15 from whom to seek the answers.

16 There lacked clarity in practice over the duties and  
17 responsibilities of various providers. There lacked  
18 clarity on funding, particularly vis-à-vis private  
19 healthcare providers. There lacked clarity on guidance  
20 across health and social care trusts, on patients'  
21 rights and family rights, and there lacked consistency  
22 in the application of such guidance as there was.

23 My Lady, the Inquiry will need to carefully address  
24 against that background how it is that the evidence is  
25 to be gathered in relation to the Northern Ireland

45

1 Perhaps the clearest example we've identified in our  
2 written submissions at paragraph 22 comes in the form of  
3 care partner guidance. Some might say a belated  
4 recognition that those in care, be it older persons,  
5 those with dementia, residents with learning  
6 difficulties, those with Down's Syndrome, required  
7 a care partner not just for support but also for  
8 advocacy, but the reality for many was that care homes  
9 appeared either unaware or unable or unwilling to  
10 implement that guidance, leading to distress and  
11 confusion for residents and families alike.

12 My Lady, touching on experts before I finish, there  
13 is, as you will have gathered, in the Northern Irish  
14 context, a great deal for this module to consider, and  
15 it's for that reason that, whilst we endorse that you've  
16 just heard, and indeed we endorse everything that you've  
17 heard from Ms Morris, but in relation to expert  
18 witnesses we underscore that a "one witness fits all"  
19 approach may not work when it comes to Northern Ireland.  
20 It will be important that the experts that you instruct  
21 have sufficient expertise in our devolved system in  
22 order to meaningfully assist you, and if that cannot be  
23 achieved in a single expert on any topic, we are again  
24 ready to assist you and your team with the  
25 identification of individuals with an appropriate level

47

1 care sector. It has already been recognised that the  
2 local government survey doesn't transpose easily across  
3 on to the Northern Irish system, and in that regard our  
4 client group is a well of information and resource and  
5 suggestions, and we're ready to work with your team in  
6 order to identify the most appropriate recipients of  
7 Rule 9 requests, indeed a process that we have already  
8 commenced in Module 3.

9 My Lady, unregulated.

10 Against a background of that complex system, you  
11 will hear that during the pandemic there lacked  
12 regulatory oversight because regulatory oversight was  
13 withdrawn on the direction of the Department of Health  
14 in March 2020, arguably at a time when residents and  
15 their families needed it most.

16 The Regulation and Quality Improvement Authority  
17 (RQIA), responsible for monitoring and inspecting the  
18 health and social care services, and the promotion of  
19 the quality of those services, it would appear was  
20 directed to suspend routine investigations in  
21 March 2020. The inherent risks, my Lady, of reducing  
22 inspections at the same time as ensuring that visiting  
23 restrictions were imposed on families are obvious.

24 There are a number of issues that we can point to  
25 that really do depict the state of confusion and chaos.

46

1 of Northern Irish expertise.

2 My Lady, this is, of course, an early stage in the  
3 preparation for Module 6. The issues that I have raised  
4 this morning must be explored in the fullness of time,  
5 but we raise them at this early stage to stress that the  
6 social care system in Northern Ireland must receive due  
7 care and attention within Module 6, and whether that is  
8 by way of a sub-module, which we know has been raised by  
9 our colleagues from Wales, or whether it's in a specific  
10 phase of Module 6, sufficient time, resources, adequate  
11 witness evidence, and full attention must be given  
12 within this module to social care in Northern Ireland if  
13 this Inquiry is to properly address and understand the  
14 response of the Northern Ireland adult social care  
15 system to the pandemic, and of course to make meaningful  
16 recommendations for change, should a future pandemic  
17 befall those who are reliant on adult social care.

18 My Lady, those are all the submissions that I make  
19 this morning, unless I can assist you further.

20 **LADY HALLETT:** Thank you very much for your help,  
21 Ms Campbell, very grateful.

22 Shall we hear from Mr Henry before we break?

23 Mr Henry.

24 **Submissions on behalf of Scottish Covid Bereaved by MR HENRY**

25 **MR HENRY:** My Lady, I appear this morning on behalf of the

48

1 Scottish Covid Bereaved as one of the counsel, including  
2 Claire Mitchell King's Counsel, Kevin McCaffery,  
3 advocate, and David Welsh, advocate, instructed by the  
4 Inquiries team at Aamer Anwar & Company.

5 My Lady, Scottish Covid Bereaved have provided  
6 written submissions to the Inquiry and would adopt  
7 those. My submissions this morning, while brief, are in  
8 five parts.

9 Firstly, I will make some general submissions in  
10 relation to this module. I will then address liaison  
11 with the Scottish Inquiry, disclosure, expert reports,  
12 and Every Story Matters.

13 Turning to the first part of my submissions,  
14 my Lady, the Scottish Covid Bereaved are grateful to the  
15 Inquiry for being included as a core participant in this  
16 module. Module 6 is of particular significance to  
17 a number of the bereaved whose loved ones died in  
18 care homes. While they can share with the Inquiry their  
19 own experiences of the care sector, they wish to know  
20 why their loved ones died, they wish to know why certain  
21 decisions were taken by the UK and Scottish Governments,  
22 and whether those decisions led to deaths.

23 They wish to know whether there were failings  
24 relating to decisions to discharge patients from  
25 hospitals into the care sector, whether there was early

49

1 the pandemic. These concerns particularly focus on  
2 issues of communication and ensuring that relatives  
3 clearly understood what DNACPR meant, and that  
4 ultimately this could be a medical decision.

5 There are also concerns around capacity, my Lady,  
6 and what steps were taken to ensure that loved ones were  
7 able to understand and consent to DNACPRs.

8 It's the experience of Scottish Covid Bereaved,  
9 my Lady, that there were differences in how DNACPRs were  
10 recorded in medical notes and communicated to the wider  
11 healthcare team.

12 My Lady, the Scottish Covid Bereaved note and  
13 welcome that the module will focus on infection  
14 prevention and control (IPC) measures. The Covid  
15 bereaved consider that IPC guidance includes not only  
16 PPE but also fundamental aspects of IPC such as hand  
17 hygiene and cleaning regimes in wards, units and  
18 clinical areas, with a particular emphasis on  
19 high-traffic and communal areas such as toilets. It is  
20 understood that ventilation, and in particular HEPA air  
21 filtration and its use in the removal of airborne  
22 contaminants, is an essential element of IPC practice.

23 Given the unique challenges posed by residents  
24 within care homes, such as those suffering from  
25 dementia, the Scottish Covid Bereaved wonder what

51

1 discharge when further hospital treatment was required,  
2 whether GPs were attending care homes, and how staff at  
3 care homes were expected to administer medicines, and  
4 what consideration had been given to those who required  
5 care at home. And, my Lady, perhaps most pertinently,  
6 why Covid-positive patients were discharged from  
7 hospitals.

8 My Lady, Scottish Covid Bereaved are aware from  
9 research published by the Scottish Inquiry that by  
10 mid-2020 care home residents accounted for 50% of all  
11 Covid-19-related deaths in Scotland, a higher percentage  
12 than in both England and in Wales.

13 By early June 2020 more people had died of Covid-19  
14 in Scottish care homes than in hospitals, with  
15 1,818 deaths occurring in care, compared with  
16 1,815 deaths in hospitals.

17 As Counsel to the Inquiry set out this morning,  
18 my Lady, between March 2020 and June 2022 there were  
19 3,592 notifications of deaths related to Covid-19 in  
20 care homes in Scotland.

21 As I hope this illustrates, my Lady, this module is  
22 of significance to the Scottish bereaved. In relation  
23 to the matters in the outline scope of the module,  
24 my Lady, members of Scottish Covid Bereaved have serious  
25 concerns about the use of DNACPRs during the course of

50

1 consideration was given to the movement of residents  
2 within care homes when the IPC guidance was being  
3 prepared. It's hoped, my Lady, that this module can  
4 give the bereaved the answers that they seek.

5 As your Ladyship will be aware, out of all the  
6 hardships suffered by the bereaved throughout the  
7 pandemic, one of the most difficult to deal with has  
8 been being unable to be with loved ones in their final  
9 moments. Scottish Covid Bereaved note that rules around  
10 visiting were not uniformly applied across different  
11 care homes, and even for those who were fortunate enough  
12 to be able to visit their loved ones in their last  
13 hours, their experiences varied.

14 Scottish Covid Bereaved consider that there was  
15 often a lack of communication with relatives about their  
16 loved ones' health, particularly where there was  
17 a deterioration towards the end of life. The bereaved  
18 consider that a lack of testing and PPE meant that they  
19 were unable to visit their loved ones face-to-face.  
20 Though there was the possibility of electronic  
21 communication, this proved difficult for those who were  
22 deaf or hard of hearing or suffering from dementia, and  
23 the Scottish Covid Bereaved welcome this being covered  
24 in Module 6, my Lady.

25 Moving on to liaison with the Scottish Inquiry,

52

1 my Lady, I'm sure your Ladyship will be aware that the  
2 impact hearings for the Scottish Inquiry are under way  
3 in Edinburgh, that those impact hearings have raised  
4 a number of issues which the Scottish Covid Bereaved  
5 consider are relevant to this module of your Ladyship's  
6 Inquiry.

7 It's noted that, from the outline scope of Module 6,  
8 it appears that there will be some overlap with the  
9 Scottish Inquiry's third portfolio, which is examining  
10 the provision of health and social care services. The  
11 Scottish Covid Bereaved are aware that the  
12 Scottish Inquiry intends to examine, amongst other  
13 matters, the provision of social care in care and  
14 nursing homes, issues relating to the transfer of  
15 patients from hospitals, and the testing of patients and  
16 the use of the DNACPR notices.

17 My Lady, the Scottish Covid Bereaved understand that  
18 it's this Inquiry's intention in relation to Scottish  
19 matters to seek to minimise the duplication of  
20 investigation, evidence gathering and reporting with the  
21 Scottish Inquiry. Given that the responsibility for  
22 much of what is to be covered in this module, at least  
23 from a Scottish perspective, was within the Scottish  
24 Government's devolved competency, Scottish Covid  
25 Bereaved look forward to hearing how the two Inquiries

53

1 in Module 2A. This was perhaps the most stark example  
2 of the difficulties the Inquiry can face when attempting  
3 to recover evidence, and a reminder that the process is  
4 often far from straightforward.

5 Scottish Covid Bereaved are sure that the Inquiry  
6 will make every possible effort to ensure that it has  
7 obtained all relevant evidence and it's hoped that there  
8 will be timeous compliance with the Inquiry's Rule 9  
9 procedure from all the core decision-makers across all  
10 four nations.

11 One concern which the Scottish Covid Bereaved have,  
12 my Lady, relates to the timing of disclosure and its  
13 likely availability to core participants.

14 For those core participants who have also been  
15 core participants in other modules, they are now  
16 accustomed to the vast amount of material which is  
17 disclosed and which requires to be considered in each  
18 module. Given the anticipated scope of Module 6,  
19 my Lady, it seems likely once again that there will be  
20 a substantial amount of disclosure. There is, my Lady,  
21 some apprehension that the timing of the disclosure will  
22 leave core participants and their representatives  
23 insufficient time to properly consider all materials.  
24 The preparation for this module will of course overlap  
25 with the preparation and the hearings for other modules,

55

1 intend to co-operate in relation to the subject matter  
2 of this module and any practical implications of this  
3 co-operation.

4 The Scottish Covid Bereaved hope that this Inquiry  
5 will fully consider the matters in the module's outline  
6 of scope as they apply to Scotland. In that regard,  
7 my Lady, Scottish Covid Bereaved note the suggestion of  
8 the Welsh bereaved that the Inquiry adopt a similar  
9 approach in Module 6 as it did in Module 2 and have  
10 Modules 6A, 6B and 6C, looking at Scottish, Welsh and  
11 Northern Irish responses. Scottish Covid Bereaved would  
12 welcome such an approach, my Lady, although we note all  
13 that was said by Counsel to the Inquiry this morning.

14 Moving on to the issue of disclosure, my Lady, we  
15 note all that is said in Counsel to the Inquiry's note  
16 and has been said this morning. The Scottish Covid  
17 Bereaved look forward to the commencement of the  
18 disclosure procedure in the summer of 2024. We are  
19 somewhat limited in the submissions that can be made  
20 this morning until such time as the results of that  
21 disclosure process has been made known and distributed  
22 to the core participants.

23 Scottish Covid Bereaved are mindful, however,  
24 my Lady, of the difficulties faced by the Inquiry in  
25 obtaining certain evidence from the Scottish Government

54

1 and it's hoped that all steps are taken to make sure  
2 that disclosure is made available as quickly as possible  
3 for adequate preparations to be made.

4 In relation to expert reports, my Lady, Scottish  
5 Covid Bereaved understand that, as has been the case in  
6 other modules, the Inquiry intends to instruct a number  
7 of expert reports again, to assist it by providing  
8 written reports and giving oral evidence at the  
9 hearings.

10 Scottish Covid Bereaved will make further  
11 submissions in this regard once the identity of the  
12 experts and the questions and issues they will be asked  
13 to address are disclosed to core participants.

14 At this stage, my Lady, Scottish Covid Bereaved  
15 submit that it's hoped that the experts will be  
16 instructed who will have sufficient and requisite  
17 experience in relation to those matters concerning  
18 Scotland and the Scottish Government, and Scotland's own  
19 set-up of care home and care provision.

20 The Scottish Covid Bereaved note the submissions of  
21 the UK bereaved, my Lady, who have submitted that the  
22 Inquiry should consider the impact of structural and  
23 institutional racism and discrimination, and that the  
24 expert report should consider racism, ageism, ableism  
25 and sexism. The Scottish Covid Bereaved would welcome

56

1 such an approach, my Lady.

2 Finally, my Lady, turning to Every Story Matters,  
3 Scottish Covid Bereaved are aware that the Inquiry's  
4 research specialists are exploring the opportunities to  
5 conduct targeted research in relation to particular  
6 topics based on the key lines of enquiry. We note that  
7 those key lines of enquiry are set out by Counsel to the  
8 Inquiry in her note, and your Ladyship has Scottish  
9 Covid Bereaved's submissions in relation to those key  
10 lines.

11 Scottish Covid Bereaved look forward to positively  
12 engaging with the Inquiry and the research specialists.  
13 It welcomes the proposed research and has suggested to  
14 your Ladyship a number of groups and organisations who  
15 may be able to assist the Inquiry in that regard.

16 My Lady, unless there are any other matters to be  
17 addressed, those are the Scottish Covid Bereaved's  
18 submissions.

19 **LADY HALLETT:** Thank you very much for your help, Mr Henry.

20 **MR HENRY:** Thank you, my Lady.

21 **LADY HALLETT:** Right, we'll take a break now and come back  
22 at 12.05.

23 (11.48 am)

(A short break)

24 (12.05 pm)

57

1 proportionality, but we wish to make the following final  
2 points for your consideration before you make your  
3 determination.

4 As my Lady is acutely aware, health and social care  
5 are devolved competencies, with responsibilities sitting  
6 firmly with the devolved administrations. And as has  
7 been clear in earlier modules, devolution is not  
8 an artificial construct, rather it has resulted in  
9 tangible variations across the four nations in respect  
10 of significant pillars of legislation, political  
11 decision-making, structures and implementation.

12 The Cymru group feels strongly that subdivision of  
13 the modules would not only reflect the constitutional  
14 position but, on a practical basis, it would enable  
15 equal allocation of the Inquiry resources to ensure  
16 a robust investigation of the issues in respect of each  
17 of the four nations making up the UK.

18 If the Inquiry is not minded to subdivide the  
19 modules, we submit that the provisional outline of scope  
20 ought to be slightly revised and, as stressed by  
21 Ms Morris King's Counsel, sufficient time allocated to  
22 allow for the position in Wales, and indeed each of the  
23 devolved administrations, on each of the identified  
24 issues within scope to be thoroughly scrutinised.

25 Turning to the provisional outline of scope, the key

59

1 **LADY HALLETT:** I have caught people by surprise, but not  
2 you, Ms Gowman.

3 **Submissions on behalf of Covid-19 Bereaved Families for  
4 Justice Cymru by MS GOWMAN**

5 **MS GOWMAN:** Thank you, my Lady.

6 Good afternoon. As you know, I represent Covid  
7 Bereaved Families for Justice Cymru, and I will refer to  
8 them as the Cymru group.

9 We firstly wish to thank you, my Lady, for granting  
10 the Cymru group core participant status in this module.  
11 As you know, having met the group, a large proportion of  
12 them lost loved ones after they contracted Covid-19 in  
13 social care settings, and as a result the Cymru group  
14 feels that they have real standing on the issue of the  
15 impact of Covid-19 on the social care sector in Wales.

16 The Inquiry has received written submissions from  
17 the Cymru group, and I don't propose to repeat the same.

18 Turning firstly to my first topic, the structure of  
19 Module 6, as you've heard, my Lady, the group invites  
20 the Inquiry to consider adopting the approach taken in  
21 Module 2 by introducing sub-modules 6A, 6B and 6C to  
22 specifically address the impact of the pandemic on the  
23 devolved administrations.

24 We have listened to what has been said by Counsel to  
25 the Inquiry and of course we understand the need for

58

1 areas of concern for the Cymru group are set out at  
2 paragraph 9 of the submission. Overall, the group  
3 considers that the scope is sufficiently broad to  
4 encompass its key areas of concern, subject to the  
5 following observations.

6 Firstly, the scope identifies that the Inquiry will  
7 not consider the state of adult social care systems in  
8 the UK prior to the pandemic, save where necessary to  
9 understand how the pandemic impacted on adult social  
10 care. We agree with the submission of the Trades Union  
11 Congress that it will inevitably be necessary to  
12 consider to some extent the broader context of the state  
13 of the care sector in each of the four nations at the  
14 outset of the pandemic, because it's only within this  
15 context that the root cause analysis of any negative  
16 impacts of the pandemic can be fully understood to  
17 inform the lessons to be learnt.

18 Secondly, my Lady, the provisional outline of scope  
19 suggests that the ambit will cover "adult care in  
20 residential homes, care provided in the home, but not  
21 care provided within day centres or in supported  
22 housing".

23 The Cymru group agrees with the submissions made  
24 other core participants that clarity surrounding  
25 definitions is required. For example, the Cymru group

60

1 considers that the present outline of scope is in fact  
2 unclear as to whether nursing homes as distinct settings  
3 from residential homes would be included.

4 Similarly, accommodation settings such as sheltered  
5 accommodation, extra care, hospices and shared lives are  
6 not mentioned, and clarity surrounding definitions is  
7 important.

8 The Cymru group agrees with the written submissions  
9 of CBFFJ and Northern Ireland group that the Inquiry's  
10 experts on the structure of adult social care may assist  
11 in further refining the provisional outline of scope and  
12 the list of issues to come.

13 Further, the Cymru group supports the call of other  
14 core participants for the Inquiry to expand its  
15 exploration to a broader range of adult social care  
16 settings, not necessarily all settings but certainly  
17 a broader range. We understand what has been said by  
18 Counsel to the Inquiry on the need for proportionality,  
19 but we agree in particular with the submission of  
20 National Care Forum, Homecare Association and  
21 Care England, that the Inquiry's intended narrower focus  
22 risks neglecting a large cohort of individuals whose  
23 needs and circumstances during the pandemic were  
24 distinct from those residing in care homes, and at homes  
25 that are equally meritorious of consideration.

61

1 in essence had the effect of absolving the local  
2 authorities from the requirement to carry out needs  
3 assessments of adults with social care needs but also  
4 adult carers, and also of its duty to meet eligible care  
5 and support needs arising.

6 Fourth, on the issue of the provisional scope, is  
7 the management of the pandemic on the ground, and the  
8 Cymru group invites confirmation to be provided that  
9 this will include, firstly, how infection control was  
10 managed prior to individuals entering the broad range of  
11 social care settings, secondly, how it was managed in  
12 a broader range of care settings once arrived, including  
13 testing, segregation and PPE, and, finally, how  
14 infection control was managed between settings and, in  
15 particular, the movement of staff.

16 This topic should also include whether sufficient  
17 regard was had on the ground to the risk of asymptomatic  
18 transmission and airborne transmission. And if regard  
19 was not had, why not.

20 Fifth, on the issue of the provisional scope, Do Not  
21 Attempt Cardiopulmonary Resuscitation notices. You will  
22 know, my Lady, that most members of the Cymru group's  
23 loved ones were placed on DNACPRs as soon as they tested  
24 positive for Covid, without due process. Often neither  
25 the deceased nor family were consulted over the

63

1 Third, on the issue of the decision-making by the  
2 UK Government and devolved administrations, this is  
3 issue 3 of the scope, the group welcomes the Inquiry's  
4 intention to further explore the decision to discharge  
5 people from hospitals into the care sector. As you will  
6 recall, this was a significant concern for the Cymru  
7 group in Module 2B, the Welsh Government having  
8 recklessly endorsed and exposed those in care homes by  
9 discharging hospital patients without testing, against  
10 the context of inadequate and insufficient PPE and  
11 inadequate testing of staff more broadly.

12 In addition to hospital discharge, the Cymru group  
13 seeks confirmation that the Inquiry will explore under  
14 this heading: firstly, the impact of any inadequacies in  
15 the Welsh Government's engagement with the sector;  
16 secondly, the impact of deficiencies in a co-produced  
17 approach to response planning; thirdly, whether  
18 sufficient regard was paid to early warning signs and  
19 vulnerabilities emanating from within the social care  
20 sector; fourthly, the impact of delayed introduction of  
21 testing for all staff and residents; and fifthly, the  
22 impact of inadequacies in PPE.

23 Finally, the Cymru group invites the Inquiry to  
24 consider under this heading the impact of social care  
25 legislation easements under the Coronavirus Act, which

62

1 decision, and many members, some of whom held a power of  
2 attorney or a deputyship over health and welfare, only  
3 discovered that a DNACPR was in place after records were  
4 requested. And even where patients had been informed,  
5 many simply did not understand the implications of being  
6 under such an order.

7 The final point I make on the provisional scope,  
8 my Lady, is in respect of bereavement support.

9 The impact films and evidence given by the bereaved  
10 in modules to date has served as tangible heartbreaking  
11 reminders of the tremendous loss of life but also the  
12 trauma experienced by the bereaved. Against this  
13 context, it's understood that none of the Cymru group  
14 bereaved members were made aware of any bereavement  
15 support offered by the social care sector during the  
16 pandemic, and we say that this should be explored to  
17 some extent in this module.

18 Now, within the context, my Lady, of the provisional  
19 scope, I turn to evidence gathering and disclosure. The  
20 Cymru group submits that in order to properly examine  
21 the Module 6 issues in Wales, Rule 9 statements should  
22 be requested and received from relevant individuals and  
23 organisations in Wales.

24 The group notes that requests have been sent to  
25 various recipients and we seek confirmation for the

64



1 avoidance of doubt that this includes organisations and  
 2 institutions whose members work within the social care  
 3 sector in Wales: the Welsh divisions of the Welsh  
 4 colleges, and charities, groups and non-governmental  
 5 organisations operating in Wales, for example the WLGA,  
 6 local authorities, health boards, Care Inspectorate  
 7 Wales, the Older People's Commissioner for Wales, the  
 8 Equality and Human Rights Commissioner for Wales, Care  
 9 Forum Wales, Social Care Wales, Public Health Wales, and  
 10 finally, the Welsh Institute for Health and Social Care.

11 We also consider that it would be of assistance to  
 12 obtain evidence from frontline staff in Wales in order  
 13 to understand how policies, procedures and guidance were  
 14 implemented on the ground, and the Cymru group is happy  
 15 to write to the ILT with further specific suggestions if  
 16 this would assist.

17 The same point, my Lady, applies to disclosure  
 18 insofar as the Cymru group maintains that disclosure  
 19 needs to be requested from and received from key Welsh  
 20 bodies who are relevant to decision-making on this topic  
 21 in Wales.

22 Moving on to the instruction of expert witnesses, in  
 23 a similar vein to submissions made in respect of Rule 9,  
 24 the Cymru group submits that in order to properly  
 25 examine the Module 6 issues in Wales, experts must be

65

1 broadly mirrored the issues of particular concern for  
 2 the group. The key lines of enquiry, however, should,  
 3 we say, be expanded to cover provision other than  
 4 care homes and domiciliary care in order to ensure that  
 5 a whole raft of evidence is captured in that means.

6 The Cymru group again will work with the CTI to  
 7 identify specific lines of enquiry as required.

8 What's clear, my Lady, from previous modules is that  
 9 the bereaved families have and will continue to provide  
 10 powerful and valuable information regarding their  
 11 experiences, as they ultimately witnessed first-hand the  
 12 devastating consequences of the pandemic on the care  
 13 sent in Wales, and to this end we echo the requests made  
 14 on behalf of other core participants that the bereaved  
 15 be given a further opportunity to give oral evidence in  
 16 this module. Some of the issues that the Cymru group  
 17 members can provide helpful evidence on involve PPE,  
 18 testing, segregation, DNACPR and, perhaps more  
 19 harrowing, end-of-life care.

20 Turning to my concluding remarks, my Lady, the Cymru  
 21 group's members experienced and continue to experience  
 22 suffering and trauma due to the devastation caused by  
 23 Covid-19, and to provide one account for one of our  
 24 members, she says that her father died from Covid whilst  
 25 living in a care home. She states that within four days

67

1 instructed who have sufficient expertise to be able to  
 2 provide evidence dealing with Wales specifically, and in  
 3 that regard we adopt the submission made by Ms Campbell  
 4 King's Counsel in the context of Northern Ireland.

5 In addition to the experts having sufficient  
 6 expertise, they must also search for, document and  
 7 analyse the Welsh data in order to scrutinise the  
 8 position in Wales. The Cymru group invites the Inquiry  
 9 to consider providing the core participants with  
 10 confirmation of the identity of experts in advance so  
 11 that any potential pitfalls can be identified at  
 12 an early stage and any representations can be made as  
 13 appropriate.

14 Insofar as Rule 9s, disclosure and expert evidence  
 15 is concerned, the Cymru group reiterates its request for  
 16 such documents to be disclosed to the core participants  
 17 as soon as reasonably practicable in order to allow for  
 18 sufficient preparation time ahead of a substantive  
 19 hearing.

20 Turning to my final topic, my Lady, Every Story  
 21 Matters and the participation of the bereaved in  
 22 Module 6.

23 The Cymru group has considered the key lines of  
 24 enquiry for Every Story Matters as outlined at  
 25 paragraph 41 of CTI's note, and considers that they

66

1 of being informed of a staff-induced outbreak at the  
 2 home, her father contracted the virus and passed away.  
 3 And she says this:

4 "Although we knew it was inevitable that my dad  
 5 would pass at some point due to the cruel disease of  
 6 dementia, at no point did we ever imagine that we  
 7 wouldn't see him for 11 months, that not one of the  
 8 family members could be there when he died, and that he  
 9 wouldn't get the dignified funeral that he so much  
 10 deserved. We have been left devastated. Mum's life  
 11 isn't the same; she seems lost, demotivated and no  
 12 longer has a sense of purpose. She visits the grave one  
 13 to two times weekly and this has now become her main  
 14 focus, to make sure Dad's grave is clean. We find it  
 15 hard to even think about what happened without reliving  
 16 the horror and trauma all over again. I know that in my  
 17 lifetime I'll never be able to truly get over this and  
 18 wouldn't wish this to happen to anybody else."

19 And it's on that basis that the Cymru group  
 20 continues to seek truth, justice and accountability for  
 21 all those bereaved in Wales, and for those additional  
 22 reasons the Cymru group will continue to work  
 23 proactively with the Inquiry to robustly explore the  
 24 evidence, to understand what went wrong and why, so that  
 25 lessons can be truly learned to minimise the potential

68

1 for future suffering.  
 2 Diolch yn fawr, thank you for listening, my Lady.  
 3 **LADY HALLETT:** Thank you very much, Ms Gowman.  
 4 Mr Friedman.  
 5 **MR FRIEDMAN:** My Lady, before I begin, I hope you don't mind  
 6 if in front of you I congratulate Joanne Cecil  
 7 King's Counsel, who we know was elevated yesterday.  
 8 For those watching, it's a tradition, at least at  
 9 the Bar, to do that, but it's also important, when we  
 10 thank Ms Carey King's Counsel and all of her team for  
 11 preparing this module, that she has the benefit of  
 12 having Ms Cecil King's Counsel working with her and for  
 13 this process.  
 14 **LADY HALLETT:** Very nice thought, Mr Friedman, thank you.  
 15 And I think it must be the first time Ms Cecil has been  
 16 referred to as Ms Cecil KC in a hearing, so thank you  
 17 very much.  
 18 **Submissions on behalf of Disabled People's Organisations by**  
 19 **MR FRIEDMAN KC**  
 20 **MR FRIEDMAN:** My Lady, as you know, we act for four disabled  
 21 people's organisations across the UK. They are  
 22 Disability Rights UK, Inclusion Scotland,  
 23 Disability Wales and Disability Action Northern Ireland.  
 24 Disabled people's organisations, or DPO, are  
 25 organisations that are run by and for disabled people.

69

1 describe a system profoundly lacking in resilience. It  
 2 is wrong to interpret the source of that vulnerability  
 3 as lying with disabled people or the frontline  
 4 workforce. To adopt the analogy used by Mr Jacobs on  
 5 behalf of the Welsh TUC last week, that is to look  
 6 through the wrong end of the telescope.  
 7 On the way forward for this part of this Inquiry,  
 8 can we therefore make five short points.  
 9 The first, this module, like health and vaccines, is  
 10 going to involve a whole-system investigation. It will  
 11 combine in one module the evidence of politicians,  
 12 technicians, service providers, managers, workers and  
 13 those individuals, families and communities who were  
 14 both in need of care and assistance and provided it  
 15 unpaid.  
 16 When the Inquiry thinks about experts and other  
 17 witnesses, as well as reading already available reports  
 18 and studies, it will be important to seek a descriptive  
 19 map of the whole system. That includes describing the  
 20 sector's fragmentation, complexity and fragility, and  
 21 high turnover of staff who were themselves in vulnerable  
 22 states of employment and protection.  
 23 Our sense is that when you do that, especially  
 24 through the lens of the four nations and not just  
 25 England, you will do something that has never been done

71

1 They are to be distinguished from charities that  
 2 represent disabled people, however well, rather than  
 3 enabling them to represent themselves.  
 4 The DPO thank you in recognising them as  
 5 core participants in this module. It is a module of  
 6 great importance to them and the people they work with.  
 7 That is because when government, bureaucracy and science  
 8 responded during the pandemic, the care sector is where  
 9 the most immediate humanitarian consequences of that  
 10 response came to bear, where disabled people suffered  
 11 the most disproportionate fatalities and other harms,  
 12 and where the likelihood that such would be the case was  
 13 considerably foretold by the state of the sector when  
 14 the pandemic began.  
 15 That being the case, my Lady knows the DPO have  
 16 a single starting point for all your modules. It was  
 17 the system that was vulnerable, not people. Forgive me  
 18 repeating an observation in the presence of new teams,  
 19 but overlooking this as a starting point enables  
 20 individualising the problem, overestimating that  
 21 something will happen without intervention or, worse,  
 22 accepting that nothing can be done.  
 23 On that basis, can we express gratitude for work  
 24 already done by the Inquiry team but also the  
 25 submissions of core participants for today. They all

70

1 before, and in the process enable the different parts of  
 2 the system to learn many things that it does not yet  
 3 properly know about itself.  
 4 My Lady, given that, the DPO support the important  
 5 submissions of the National Care Forum,  
 6 Homecare Association and Care England that if your  
 7 definition of "care provided in the home" does not  
 8 include the various supported and independent ways that  
 9 disabled people live at home and receive care, then you  
 10 deny yourself a sizeable part of the map.  
 11 By design, the experience particularly of younger  
 12 disabled people and those with learning disabilities  
 13 will be left out. That would be wrong in itself. It  
 14 would also leave out the lessons to be learned about  
 15 smarter and more targeted NPIs, including how disabled  
 16 people with state assistance could set up supported  
 17 living networks in the pandemics and emergencies to  
 18 come.  
 19 Of course, the level of detail in which these  
 20 matters are gone into will be a matter for time  
 21 management. We have already seen you do that in the  
 22 curation of the live witnesses in previous modules,  
 23 combined with the written statements and exhibits. With  
 24 that approach, and the careful choice of case studies  
 25 and what we've now heard the bereaved families refer to

72

1 as spotlighting, a lot of ground can be proportionately  
2 covered. Alongside other core participants, we simply  
3 do not want you to cut out completely a central category  
4 of the care sector which would have the consequence of  
5 distorting the population profile of the whole module.  
6 That does not mean the Inquiry has to deep dive into  
7 every home setting in the same way.

8 Our second point concerns context. As your counsel  
9 team apprehend, we do say that, without repeating  
10 itself, the Inquiry needs to consider the pre-pandemic  
11 situation of the sector in order to understand why the  
12 system buckled once the crisis began. We agree with,  
13 amongst others, the Covid Bereaved Families for Justice  
14 UK and the Northern Ireland bereaved families that part  
15 of that consideration should include a renewed and  
16 targeted focus on how structural inequality and  
17 discrimination specifically impacted this care sector  
18 part of state and society. I hope my Lady already  
19 appreciates that the effort is critical to scene setting  
20 and identifying where the vulnerabilities of the system  
21 lay and indeed how those vulnerabilities should have  
22 been foreseen.

23 How that can be done proportionately includes, as  
24 my Lady has been doing, disclosing into this module the  
25 various expert reports and other publications that have

73

1 are already making.

2 In three nations, the very first thing the Covid  
3 emergency state did in law to protect the so-called  
4 vulnerable was to ease its duties in relation to them.  
5 The fact that it was the very first thing is  
6 an important indication of how vulnerable the state knew  
7 the system was. Easement rendered people in need of  
8 care more vulnerable, but nevertheless was something  
9 done, what lawyers call, in accordance with law. In lay  
10 persons' terms, it legalised it and licensed it.

11 The fact, as we understand it, no local authority in  
12 Wales notified its use of the easement and only a few  
13 local authorities in England said they might is not good  
14 news, especially when DPO and others report such  
15 a massive decline of services and there was no  
16 independent auditing then or now to establish what truly  
17 went on.

18 My Lady, this is a question that should be inserted  
19 into relevant Rule 9 requests.

20 Our fourth point is human rights, and especially the  
21 human rights of disabled people. I can take this very  
22 shortly.

23 Firstly, the four nations are absolutely not in the  
24 same boat about what they say they want to do about  
25 rights. However, their delivery on such aspirations as

75

1 been adduced in previous modules. On this, CPs could  
2 make suggestions as to what should go into a core file  
3 of materials. Equally, there is benefit in asking  
4 experts on the care sector to consider the implications  
5 on(?) budgeting and reforms in the immediate  
6 pre-pandemic period.

7 My Lady has already heard from DPO witnesses that it  
8 produced a state of emergency for them before the  
9 pandemic began. Finally, as suggested by others, those  
10 who provided reports on structural inequality at the  
11 beginning of Module 2 should be asked to provide either  
12 a group or individual updates, applying their minds  
13 specifically to the care sector.

14 Our third point is the statutory easements. As the  
15 Cymru group has just outlined, these were provisions  
16 contained in the Coronavirus Act to allow local  
17 authorities to suspend their care services and  
18 assessments when staffing and other activities required.

19 For England and Wales, these were contained in  
20 schedule 12 of the Act and for Scotland they were  
21 contained in sections 16 and 17. These provisions have  
22 not been mentioned yet in the CP submissions other than  
23 by the National Care Forum, and we just heard them  
24 mentioned now, and we respectfully think they are  
25 important in this module, given the other points the DPO

74

1 they do have will be sorely compromised if we do not  
2 have a United Kingdom approach to the issue.

3 Secondly, a major cause of the flaws in the system  
4 you will study in Module 6 derived from non-compliance  
5 with the human rights of disabled people, in terms of  
6 planning, consultation and data collection.

7 Our final point concerns recommendations. Your  
8 counsel's note for today reminds us of one of my Lady's  
9 core values, which is the imperative to make  
10 recommendations as the Inquiry goes along.

11 It follows that CPs have to learn to participate  
12 that way too, to make our suggestions as we go along,  
13 which is obviously only for intermittent parts of the  
14 Inquiry's journey. We suggest for this module that  
15 my Lady more specifically asks the witnesses in the  
16 Rule 9 questionnaires: what would you particularly  
17 recommend for future pandemic preparation, and why? And  
18 that witnesses come to the Inquiry prepared to discuss.

19 That may be happening generally, but the Inquiry is  
20 now entering the sharp end of the system, and it's all  
21 very well to want to make meaningful and effective  
22 recommendations, but the Inquiry and all its CPs will  
23 need help.

24 The DPO say now that part of the change required is  
25 for the views and agency of disabled people to become

76

1 far more valued in their own right, but also for  
 2 disabled people to stop being analysed as passive  
 3 recipients of care or mere dependents.  
 4 They want the Inquiry to examine and consider  
 5 recommendations that would enable the care system to  
 6 empower disabled people as individuals and groups within  
 7 that system. They also want the system to become more  
 8 resilient in terms of including them in the  
 9 co-production and co-design of its future. They  
 10 therefore thank the Inquiry again for making this module  
 11 and their involvement in it with others one of the  
 12 places to start that task.

13 **LADY HALLETT:** Thank you very much indeed, Mr Friedman, very  
 14 grateful.

15 I think we have a slight change of order, I think  
 16 Dr Townson, are you going next?

17 **Submissions on behalf of National Care Forum, Homecare  
 18 Association and Care England by DR TOWNSON**

19 **DR TOWNSON:** Thank you, my Lady.

20 My name is Jane Townson and I'm CEO of the Homecare  
 21 Association, making this statement on behalf of the  
 22 National Care Forum, Care England and the Homecare  
 23 Association.

24 The National Care Forum is a membership body for not  
 25 for profit care and support organisations in England,

77

1 our written submission about the general neglect and  
 2 misunderstanding shown towards the social care sector  
 3 and the risks that may arise if the scope of the module  
 4 is drawn too narrowly.

5 In our closing statement as core participants for  
 6 Module 2, we drew attention to three concerns. First,  
 7 decision-makers continually overlooked and sidelined  
 8 social care at critical points. Second, they  
 9 misunderstood its scope and diversity. Third, they  
 10 placed it at a disadvantage compared to the NHS.  
 11 Indeed, the focus of decision-making appeared to be  
 12 protecting the NHS rather than citizens in all  
 13 communities. They saw social care mainly as care homes  
 14 for older adults rather than as a diverse system of care  
 15 and support services for people of all ages and  
 16 abilities, who depend on these essential services to  
 17 live with dignity and autonomy, with a workforce of  
 18 1.6 million, larger than the NHS.

19 Repeatedly we saw decisions and guidance that failed  
 20 to consider their needs. For example, initial  
 21 government guidance stated that face masks were  
 22 unnecessary because it was "very unlikely that people  
 23 receiving care in a care home or the community would  
 24 become infected". Guidance was developed with  
 25 healthcare settings in mind, with little or no

79

1 although its members have services in all parts of  
 2 the UK.

3 Care England is a representative body for  
 4 independent adult social care providers in England,  
 5 including single care homes, small local groups,  
 6 national providers and not for profit voluntary  
 7 organisations and associations as well as private  
 8 providers.

9 The Homecare Association is the UK's only membership  
 10 body exclusively for home care providers.

11 We are pleased to have been designated as  
 12 core participants in Module 6 of the Covid Inquiry,  
 13 having also been granted core participant status for  
 14 Module 2. We look forward to assisting the Inquiry with  
 15 its critically important work, in particular helping  
 16 the Inquiry to understand the social care sector and the  
 17 impact the pandemic had upon it.

18 However, we note with some concern that those  
 19 granted core participant status do not include a wider  
 20 range of organisations who might also be able to assist  
 21 the Inquiry in ensuring that the voices of all those  
 22 providing and drawing on support in the sector are  
 23 heard.

24 We are grateful for the opportunity to make this  
 25 opening statement, to highlight key concerns outlined in

78

1 consideration for the practical realities of delivering  
 2 social care in people's homes and communities.

3 The flow and communication of guidance from  
 4 government and key stakeholders was poor and chaotic.

5 PPE supply and guidance for the social care sector  
 6 was also shambolic during the first wave, with little  
 7 understanding of the pre-existing usage of PPE in the  
 8 care sector and the needs of those working in and being  
 9 supported by the sector.

10 A prolonged lack of prioritisation of testing in  
 11 social care settings, particularly those beyond  
 12 care homes, allowed the virus to spread unchecked with  
 13 devastating consequences.

14 Wider community settings and home care could not  
 15 regularly test until 2021. Implementation of key  
 16 policies related to hospital discharges and the  
 17 withdrawal of community health support and visiting  
 18 restrictions without proper consultation with the  
 19 social care sector and the people they support led to  
 20 confusion, anxiety, inconsistency and harm.

21 The glaring absence of social care expertise in the  
 22 main SAGE advisory group meant they did not adequately  
 23 consider the unique challenges and needs of the sector  
 24 in the scientific advice informing policy decisions.

25 The roll-out of vaccines was initially disorganised

80

1 and inconsistent for social care workers and people  
2 drawing on care in community settings, leaving them at  
3 heightened risk.

4 Decision-makers frequently disregarded and  
5 undervalued the dedicated professionals working in  
6 social care, who put their own health and wellbeing on  
7 the line to continue providing care and support in the  
8 most challenging of circumstances.

9 Implementation of vaccination as a condition of  
10 deployment for those working in care homes was against  
11 the advice and guidance of senior leaders in  
12 social care. It is noticeable that once the policy was  
13 to be applied to the NHS it was quickly withdrawn.

14 Application of blanket Do Not Attempt Resuscitation  
15 orders without due consideration of individual  
16 circumstances and without conversations with individuals  
17 and family caused immense distress and a fundamental  
18 breach of human rights.

19 Visiting guidance showed a lack of understanding of  
20 the needs of people with learning disabilities, dementia  
21 and other conditions, causing untold anguish and  
22 deterioration in mental and physical wellbeing.

23 The sudden withdrawal of vital community services  
24 such as day centres and respite care left many  
25 individuals and families struggling to cope without

81

1 stenographer will be struggling. Thank you.

2 **DR TOWNSON:** In considering these important issues, it is  
3 essential that the Inquiry truly listens, values and  
4 acts on the voices and experiences of the entire  
5 social care sector, including those drawing on services  
6 and professional care experts.

7 Turning to our submissions on the proposed scope for  
8 Module 6, we are concerned that the Inquiry risks  
9 inadvertently perpetuating some of the same mistakes and  
10 erroneous assumptions that undermined the pandemic  
11 response.

12 In the note from Counsel to the Inquiry dated  
13 1 March 2024 it was suggested that, although there are  
14 a number of different settings in which adult social  
15 care is provided, it will not be possible or  
16 proportionate to examine all the settings. The Inquiry  
17 considers that by focusing on adult care and residential  
18 homes and care provided in the home, the Inquiry will  
19 have a sufficiently broad evidence base upon which to  
20 make meaningful recommendations.

21 By focusing narrowly on care homes and a restrictive  
22 definition of care in the home, the Inquiry would be  
23 overlooking a significant portion of social care  
24 including populations most severely affected by  
25 Covid-19. It is crucial for the Inquiry to recognise

83

1 essential support. The extended isolation of those  
2 drawing on support and care services, even when society  
3 re-opened, exacerbated feelings of loneliness,  
4 abandonment and despair.

5 While care providers appreciated the emergency  
6 funding provided by the government, it often arrived too  
7 late, focused on short-term fixes rather than long-term  
8 sustainability and came with burdensome bureaucratic  
9 requirements that diverted precious time and resources  
10 away from direct care delivery. Data collection systems  
11 were cumbersome, duplicative and provided little  
12 tangible benefit to the providers tasked with submitting  
13 information, while offering few meaningful insights to  
14 inform real-time decision-making.

15 The Care Quality Commission, like many agencies,  
16 changed the way it worked. Whilst CQC remained the  
17 central point for providers to raise concerns and to  
18 provide data on the safeguarding and operational impacts  
19 of Covid-19 within care, the data they held needed to be  
20 more clearly articulated at the outset of the pandemic.

21 Further down the line, their focus on risk drove  
22 a series of behaviours from which we are yet to recover.

23 **LADY HALLETT:** Could you just slow down a little?

24 I appreciate you've got limited time, but if you could  
25 just slow down a little, I think, otherwise the

82

1 that social care extends far beyond the confines of  
2 residential care homes for older people: it encompasses  
3 a broad and complex spectrum of community-based  
4 services, supported housing, assisted living and home  
5 care for individuals of all ages, with a wide range of  
6 needs, including physical disabilities, learning  
7 disabilities, autism, mental health conditions, brain  
8 injuries and more.

9 These various models of care often overlap and  
10 intersect, with support being delivered in people's own  
11 homes and communities, tailored to their individual  
12 circumstances and aspirations. Focusing only on the  
13 subset of services would be a gross oversimplification  
14 and cannot catch the true scope and impact of the  
15 pandemic on social care. We urge the Inquiry to  
16 acknowledge that people with learning disabilities and  
17 autism were among the most disproportionately affected  
18 by the pandemic, with mortality rates a staggering three  
19 to four times higher than the general population.

20 Most of these individuals receive care and support  
21 outside of residential care homes, though often through  
22 supported living arrangements that enabled them to lead  
23 fulfilling lives in their own homes. Failing to  
24 investigate their experiences along with the experiences  
25 of the skilled and compassionate workforce that supports

84

1 them would be a grave oversight, undermining the very  
2 purpose of this Inquiry.

3 By expanding the scope of Module 6 beyond  
4 residential care homes and a limited view of home care,  
5 the Inquiry can avoid perpetuating the same  
6 misunderstandings and oversights that hindered the  
7 pandemic response and instead put forward well informed  
8 recommendations to improve policy, practice and  
9 preparedness for the future.

10 In summing up, the social care sector showed  
11 incredible dedication, composition and resilience  
12 throughout the pandemic. We have, though, also faced  
13 enormous challenges, heartbreaking losses and  
14 a persistent lack of recognition and support.  
15 Policymakers neglected social care before the pandemic,  
16 during the pandemic and after the pandemic. We trust  
17 the Inquiry to give voice to our experiences, to  
18 scrutinise the systemic issues that affected the  
19 pandemic response, and to pave the way for meaningful  
20 change that ensures the sector and those it supports  
21 will never be left behind or forgotten again.

22 We are committed to working closely with the Inquiry  
23 team, providing the evidence, insights and expertise  
24 necessary to paint a comprehensive and nuanced picture  
25 of social care. Together we have an opportunity to

85

1 issues relating to expert evidence.

2 We continue it to rely in full on the detail in our  
3 written submissions for this hearing.

4 In our written submissions we have identified  
5 several key areas of concern relevant to this module.  
6 I will highlight seven of these today.

7 First, the Inquiry has suggested that it does not  
8 intend to consider settings beyond residential  
9 care homes or care provided in domestic homes.

10 Our core participant group urge the Inquiry to also  
11 consider supported or assisted living settings.

12 Those in supported living settings are an important  
13 cross-section of people in care for three reasons.  
14 People in these settings are particularly vulnerable;  
15 a Mencap report found that 78% of people living in  
16 specialist supported housing are people who have  
17 learning disabilities and/or autism as their primary  
18 support need.

19 The needs of and particular obstacles faced by those  
20 receiving and providing care in supported living  
21 facilities are different to other care settings and are  
22 equally worthy of investigation.

23 People in these settings were treated differently to  
24 people in care homes and those receiving domiciliary  
25 care in many aspects. For example, the UK Government

87

1 honour the sacrifices made, to learn from the hardships  
2 endured, and to build a stronger, fairer and more  
3 resilient social care system for the future, one that  
4 truly values and supports the millions of people who  
5 depend on it and the dedicated workforce that makes it  
6 possible.

7 Those are our opening submissions, my Lady.

8 **LADY HALLETT:** Thank you very much, Dr Townson.

9 Next I think it's Ms Morgan.

10 **Submissions on behalf of John's Campaign, the Patients  
11 Association and Care Rights UK by MS MORGAN**

12 **MS MORGAN:** Good afternoon, my Lady.

13 I appear on behalf of John's Campaign, the Patients  
14 Association and Care Rights UK.

15 Each of these organisations has expertise in the  
16 individual experience of social care during the  
17 pandemic. They are representative of individuals who  
18 were and continue to be deeply affected by Covid-19 and  
19 the response to it. They include social care users in  
20 a variety of settings and people providing care,  
21 including unpaid carers.

22 These submissions will first highlight some of our  
23 core participants' key areas of concern for this module,  
24 outline proposals for key groups to focus on for  
25 research and Rule 9 evidence, and mention some key

86

1 produced distinct guidance for supported living  
2 facilities.

3 We agree with the National Care Forum submissions  
4 that through the pandemic there was little consideration  
5 of the breadth and diversity of care and support  
6 settings and services, and we wish to emphasise that the  
7 needs of those receiving care are also broad and  
8 diverse.

9 Our core participant group are keen to stress how  
10 important it is that the Inquiry focus on people, rather  
11 than institutions.

12 Our second key area of concern is consideration of  
13 whether legislative duties were overlooked. The  
14 evidence available so far, particularly as considered in  
15 Module 2B, indicates that those in care were valued less  
16 than others, their lives were considered to be worth  
17 less than those of other people. This is an issue of  
18 serious public concern which should be examined.

19 The evidence indicates that duties in the  
20 Equality Act 2010, whether the equality duty in  
21 section 149 or the reasonable adjustment duty or  
22 otherwise, were ignored.

23 Similarly, there is considerable evidence that the  
24 human rights and autonomy of those needing care were  
25 abandoned. The need to seek consent was often ignored,

88

1 whether in making decisions about DNACPRs or deprivation  
2 of liberty. Duties in the Medical Capacity Act and  
3 deprivation of liberty safeguards were overlooked.

4 Other related concerns including the increased use  
5 of sedation and antipsychotic drugs to manage distressed  
6 behaviour and a deterioration in quality of care without  
7 consent, use of restraint and enforced isolation without  
8 consent, the disregard of the legal responsibilities of  
9 people with guardianship duties or powers of attorney,  
10 and blanket approaches to restrictions on access to  
11 family and friends, who often provide essential care,  
12 without taking into account the harm that this may  
13 cause.

14 An important more general issue of principle is that  
15 while it may be easy to dispense with these duties at  
16 a time of crisis, they are even more important than  
17 in normal times, particularly when oversight and  
18 regulation is reduced, and they should be fiercely  
19 protected.

20 Third, a particularly stark example of poor  
21 decision-making relevant to this module is the impact of  
22 discharge from hospitals into care homes. This  
23 particularly concerns the policy in March and April 2020  
24 to discharge patients from hospital into care homes  
25 without comprehensive prior testing. Our

89

1 and complaints mechanisms were needed most, particularly  
2 as loved ones were also shut out and unable to observe  
3 the care being provided.

4 There is considerable evidence of a substantial  
5 increase in the abuse of vulnerable people in need of  
6 care during the pandemic, which proper oversight was in  
7 place to prevent, and these matters ought to be  
8 investigated.

9 Fifth, our core participant group ask the Inquiry to  
10 consider the indirect harm caused by NPIs to people  
11 living in care homes and supported living facilities,  
12 particularly the management of outbreaks, restrictions  
13 on visits and movement. In many ways, indirect harm was  
14 considerably worse than the harm caused by Covid-19.  
15 Indirect harm includes the huge number of excess deaths  
16 from causes other than Covid-19 during the first wave of  
17 the pandemic, the number of additional physical and  
18 mental illnesses, the ninefold increase in people  
19 waiting for medical treatment, including for serious  
20 conditions such as cancer, the severe deteriorations in  
21 physical or mental health, the number of people who died  
22 alone and the ongoing distress and trauma this caused to  
23 bereaved loved ones.

24 Crucially, a death caused by dementia was just as  
25 important as a death caused by Covid-19. There was

91

1 core participant group in particular invite the Inquiry  
2 to consider the number of Covid-19 cases or deaths that  
3 this policy caused, and the impact in terms of how it  
4 affected future decision-making.

5 We have detailed in our written submissions why,  
6 particularly in light of the evidence in Module 2B, it  
7 is necessary to instruct an independent expert on these  
8 matters.

9 Fourth, our core participant group are concerned  
10 about regulation and oversight, or the lack thereof,  
11 during the pandemic. It appears that regulatory  
12 functions were suspended at the outset.

13 For example, on March 16, 2020, the CQC announced  
14 that it would be ceasing its routine inspections of  
15 care homes. The CQC observed a sharp fall in  
16 notifications by providers about the outcomes of  
17 applications to deprive a person of their liberty. The  
18 Local Government and Social Care Ombudsman, in their  
19 words, suspended "all casework activity that demands  
20 information from or action by local authorities and care  
21 providers in light of the coronavirus outbreak". That  
22 was during -- from 26 March to 29 June 2020. The same  
23 was true of a number of other regulators and complaints  
24 mechanisms relating to those needing care.

25 This was not appropriate at a time when regulators

90

1 widespread failure to measure indirect harms,  
2 for example to obtain data on what indirect harm would  
3 be caused by a particular restriction, to understand and  
4 take into account indirect harms, to make decisions by  
5 balancing the benefit of a particular measure in terms  
6 of the Covid-19 harm it would prevent against the  
7 indirect harm it would cause, and to achieve  
8 an appropriate balance between protecting people from  
9 the harm of Covid-19 and protecting wider health and  
10 wellbeing.

11 We welcome, as have Covid Bereaved Families for  
12 Justice UK, the inclusion of visits from loved ones in  
13 the provisional outline of scope for Module 6. However,  
14 we agree that the Inquiry should consider this as  
15 a distinct issue and not only as an aspect of infection  
16 prevention and control.

17 The sixth area of concern I wish to highlight today  
18 is the recording of deaths in care homes during the  
19 early part of the pandemic, and the need to investigate  
20 whether Covid-19 was under-reported. This is important  
21 because it may have affected the pandemic response in  
22 care homes.

23 Finally, we consider it important for this module to  
24 take into account unpaid carers across the range of  
25 settings in which they provide care. That is because

92

1 unpaid carers are an invaluable group. In England and  
2 Wales they contribute £162 billion to the economy every  
3 year, meaning that the value of unpaid care provision is  
4 broadly equivalent to the annual budget of the NHS  
5 itself, which received £164 billion in funding in 2020  
6 to 2021.

7 There were specific obstacles faced by unpaid  
8 carers, including: not being recognised as carers in the  
9 same way as a paid carer, a significant increase in  
10 caring responsibilities during the pandemic, where the  
11 person they cared for lived in the community; and  
12 restrictions preventing them from carrying out their  
13 caring responsibilities where the person they cared for  
14 lived in a care setting.

15 Those obstacles are important, far-reaching and  
16 should not be overlooked by this module.

17 As set out in our written submissions, we refer to  
18 several potential audience groups. We put these forward  
19 as proposed populations for targeted research and for  
20 the Inquiry to take into account when considering  
21 organisations and witnesses which to issue Rule 9  
22 requests.

23 We consider that those living with dementia,  
24 including Alzheimer's, should be a key group for  
25 the Inquiry's consideration. This is because dementia

93

1 the pandemic in care homes which concerned people living  
2 with dementia. An obvious example is how to balance the  
3 need to limit the spread of Covid with the need for  
4 a person with dementia to have sustained contact with  
5 their essential carer. Too often, family members were  
6 treated as visitors rather than an essential part of the  
7 care team. These issues are also relevant to people  
8 with similar cognitive impairments.

9 Another focus group that our core participant group  
10 recommend is people with highly complex disabilities,  
11 for example severe global developmental delay and  
12 profound and multiple learning difficulties. This may  
13 cover a range of disabilities, and often involves people  
14 living with a combination of different conditions. It's  
15 important for the Inquiry to consider the most  
16 vulnerable people in need of care, who are most  
17 dependent on their closest and most familiar carers.  
18 This group was particularly badly affected by the  
19 restrictions on visiting and their separation from  
20 family members and essential caregivers.

21 In relation to expert evidence, our core participant  
22 group welcome and endorse the proposed topics for expert  
23 evidence identified by the Inquiry. We have also  
24 suggested some additional topics in our written  
25 submissions which broadly track some of the themes

95

1 is the leading cause of death in the UK. Around  
2 1 million people live with it. Dementia and Alzheimer's  
3 remained the leading cause of death in the UK in care  
4 homes throughout the pandemic, higher than Covid-19.

5 People living with dementia suffered particularly  
6 badly from indirect harms arising from the restrictions.  
7 People living with dementia often depend very heavily on  
8 essential and family carers for their physical and  
9 mental wellbeing. During the pandemic, they were, in  
10 many cases, separated from that critical source of care  
11 by the NPIs. This caused very serious harm.

12 For example, the Alzheimer's Society report  
13 concluded that lockdown isolation caused shocking levels  
14 of decline for people with dementia. Person-centred  
15 care is the only treatment known to improve dementia and  
16 by removing family or family carers, this form of  
17 treatment was denied.

18 An equality impact assessment on 27 August 2020  
19 identified, in respect of those with dementia,  
20 a worsening functional independence and cognitive  
21 symptoms during the first month of lockdown in 31% of  
22 people surveyed, exasperated agitation, apathy and  
23 depression in 54% of those surveyed, and a deterioration  
24 of health status in 40%.

25 There are particular issues as to the response to

94

1 I have highlighted today. For example, it is necessary  
2 to obtain expert evidence on the indirect harms of the  
3 pandemic as this appears not to have been done at the  
4 time.

5 One particular topic I'd like to highlight is  
6 employment arrangements and staffing in care homes.  
7 Staffing arrangements is an important issue that had  
8 a huge impact on the safe and proper operation of  
9 care homes during the pandemic. In particular, that  
10 includes low wages, zero-hours contracts, the lack of  
11 statutory sick pay, staff shortages and agency workers  
12 being used across multiple settings.

13 All of these issues are relevant to the ability of  
14 care homes to properly protect people living in them and  
15 made it difficult for care staff to isolate where  
16 necessary.

17 Also relevant to this is the impact of care home  
18 insurance and high premiums on the decisions made by  
19 care homes relating to restrictions. In contrast to  
20 hospitals, which were given an indemnity against  
21 liability for infection transmitted on their premises,  
22 care homes were faced with the additional concern about  
23 employer/employee liability which made it even more  
24 difficult for them to facilitate family member or  
25 essential carer visits. As care home insurance is only

96



1 provided by a limited number of companies, providers had  
2 very little option.

3 As the Inquiry will have seen, our core participant  
4 group have made various suggestions in our written  
5 submissions about potential experts to assist with this  
6 module. This includes experts in the care sector,  
7 experts in specific conditions such as dementia and  
8 expert consultants.

9 The proposed individuals are all experts with strong  
10 reputations in their fields and with relevant expertise  
11 that is likely to be hugely beneficial to the Inquiry  
12 for this module.

13 In conclusion, our core participant group are  
14 grateful for the continued opportunity to participate in  
15 the Inquiry. They wish to emphasise the importance of  
16 considering the individual needs of the people they  
17 represent, who were too often treated as a homogeneous  
18 group to which blanket policies could be easily applied.

19 Unless there is anything else you would like me to  
20 address, my Lady, those are my submissions.

21 **LADY HALLETT:** Thank you very much, Ms Morgan, for your  
22 help.

23 I think it's time to break now. I shall return at  
24 2 o'clock.

25 (1.00 pm)

97

1 interests of migrants, refugees and diaspora communities  
2 from South East Asia in the UK. Their members work  
3 across the care sector, including nurses, non-clinical  
4 staff and home carers.

5 IWGB and UVW are non-TUC-affiliated trade unions  
6 with membership in several sectors, including the  
7 social care sector. Their members works as care  
8 workers, cleaners and kitchen staff, often in outsourced  
9 gig economy positions. Group members are overwhelmingly  
10 working class, in low paid and precarious employment.

11 The majority are women and migrant and/or ethnic  
12 minority workers. As such they fall within the  
13 protected characteristics of the Equality Act.

14 However, the group wishes to emphasise at the outset  
15 that systemic issues such as outsourced employment are  
16 applicable across the working class, regardless of  
17 ethnicity and gender.

18 Most members work outside the NHS and local  
19 authority care homes in the privatised care sector.  
20 Many work in the informal care sector, in private homes.  
21 In the first months of the pandemic, as government tried  
22 to free up capacity, hospitals were forced to discharge  
23 patients into the care sector. The government's  
24 policies ensured that patients were discharged without  
25 testing or isolation into care homes that were populated

99

(The short adjournment)

2 (2.00 pm)

3 **LADY HALLETT:** Is it Mr Marquis? Marquis. I'm sorry,  
4 Mr Marquis. I bet it was Marquis once.

5 **Submissions on behalf of Frontline Migrant Health Workers**  
6 **Group by MR MARQUIS**

7 **MR MARQUIS:** It was once.

8 Thank you very much, my Lady. Along with  
9 Katharine Newton KC, I represent the Frontline Migrant  
10 Health Workers Group, we are instructed by the Public  
11 Interest Law Centre.

12 I propose to summarise our written submissions, to  
13 give an overview of the group's work in the care sector  
14 and then make some submissions on scope that follow on  
15 from their experience.

16 First of all, the group would like to thank  
17 the Inquiry for including them in this module, but also  
18 for the particular inclusion of home care within the  
19 module's scope.

20 The group is a collective of two trade unions, the  
21 United Voices of the World and the Independent Workers  
22 Union of Great Britain, and a community consortium,  
23 Kanlungan. Kanlungan is a charitable organisation  
24 consisting of several Filipino and Southeast Asian  
25 community groups. They work for the welfare and

98

1 by the clinically vulnerable and staffed by the most  
2 disadvantaged of workers.

3 An underfunded NHS was effectively told to shunt the  
4 problem elsewhere. Care workers were placed under  
5 immense pressure to meet the needs that the healthcare  
6 system could not meet.

7 Pre-pandemic, 61% of care sector workers were  
8 employed by private providers, with just 7% by local  
9 authorities and 6% by the NHS. The average public  
10 sector pay was around £10 an hour, the average private  
11 sector pay was around £8.40, which is below the living  
12 wage. There is a heavy reliance on outsourced workers,  
13 particularly in the private sector, where a full third  
14 of social care jobs were classified as insecure. Home  
15 care workers, that figure was 56%, on zero-hours  
16 contracts.

17 Almost a quarter of the national care sector  
18 workforce are from ethnic minority backgrounds, rising  
19 to 70% in London, and 82% nationally of social care  
20 workers are women.

21 It cannot have come as a surprise to anyone that in  
22 May 2020 the ONS were reporting that care workers were  
23 among the occupations at the highest risk of death.  
24 Historically, the main social determinant of health  
25 inequality is income: the poorer you are, the more

100

1 precarious your employment, the more exposed you are and  
2 the more likely you are to die.

3 Care sector workers are some of the lowest paid  
4 workers in the country, even when they have the benefit  
5 of an employment contract. Outsourced workers, without  
6 the contractual protection needed to demand safer  
7 conditions from their employers, were at even greater  
8 risk.

9 Migrant care workers were all the more vulnerable.  
10 When immigration status is tied to employment, you  
11 cannot refuse unreasonable demands from employers  
12 without losing both your job and your home.

13 Migrant workers who were undocumented had no  
14 protection at all.

15 In care homes, the two major pandemic issues were  
16 understaffing and PPE. Understaffing was chronic  
17 pre-pandemic, and evidently a lack of sufficient staff  
18 leads to unsafe workplaces, and this was inevitably  
19 exacerbated when the virus ripped through the care  
20 sector.

21 A key feature of the gig economy is that workers had  
22 to work in multiple care homes, filling gaps caused by  
23 understaffing and sickness. The very nature of their  
24 employment made them vectors of the virus.

25 The causes of understaffing are multifaceted. Low  
101

1 I'm afraid you are, I'm afraid, trespassing on areas  
2 where I cannot go. The other area I cannot go are party  
3 politics. So if you could please just focus on the  
4 issues that I'm addressing this module, I would be  
5 extremely grateful.

6 **MR MARQUIS:** My Lady, these workers that I'm just referring  
7 to were disproportionately allocated to higher risk  
8 environments, and there --

9 **LADY HALLETT:** That I understand, but if you could make sure  
10 it is related to the care sector and the pandemic. Some  
11 of your remarks sounded a bit more general. Maybe  
12 I misunderstood, I'm sorry if I did.

13 **MR MARQUIS:** I'm trying to set the scene, my Lady. But I'll  
14 continue and I'll endeavour to stay as close to the  
15 scope as possible.

16 Workers in the care sector who had "no recourse to  
17 public funds" conditions applied to their visas found  
18 themselves destitute in the event of sickness and  
19 fearful of seeking medical treatment, including testing  
20 and vaccination, due to the risk of medical charges and  
21 immigration consequences.

22 Sick workers with work-dependent immigration  
23 statuses were often pressured to return to work in order  
24 to cover staff shortages.

25 On PPE, group members report a total lack of PPE in  
103

1 pay and insecure employment are plainly major  
2 considerations. Outsourced workers in the private  
3 sector often put pre-Covid understaffing down to profit  
4 margins. As one member put it, it's about profit rather  
5 than proper care.

6 Whatever the reasons, an understaffed sector cannot  
7 be resilient to a pandemic. The government's  
8 post-pandemic response to understaffing was to issue  
9 employment-linked visas to 70,000 overseas workers in  
10 2023, in effect outsourcing the problem internationally  
11 and subsidising the cost of care in the UK through low  
12 wages.

13 This doesn't address the problem and, in the context  
14 of the government's hostile environment policies, it  
15 creates precisely the subclass of worker that group  
16 members have reported. And some examples: migrant  
17 workers being disproportionately allocated to higher  
18 risk environments, unable to object because of their  
19 immigration status being dependent on --

20 **LADY HALLETT:** I'm sorry to interrupt, Mr Marquis, but I've  
21 got to be really careful in what I'm addressing. I have  
22 terms of reference -- I cannot change the whole of  
23 society. My terms of reference relate to the pandemic  
24 and the response -- the preparedness for, which we've  
25 done in Module 1 to a large extent, and response to.  
102

1 care homes at the outset of the pandemic, leaving them  
2 unprotected when hospital patients were discharged into  
3 their care. A single example: at a nursing home in  
4 North London, UVW workers took to making their own masks  
5 by laminating pieces of plastic and fixing them around  
6 their heads with elastic sourced from their leggings.  
7 When employed staff were provided with PPE, outsourced  
8 staff were often forced to work without the same  
9 protection. When PPE was provided, it was frequently in  
10 the face of employer intransigence, often of a lower  
11 standard, ill fitting and provided without guidance on  
12 use.

13 There are frequent examples, which I've put within  
14 our written submissions, of care staff raising concerns  
15 about mismanagement that in part came about as a result  
16 of infrastructure issues and in part came about as  
17 a result of accountability issues.

18 We also have examples of outsourced workers  
19 reporting employers refusing to pay sick pay. The  
20 inadequacy of statutory sick pay led to sick workers  
21 facing destitution or, in some cases, facing no option  
22 but to continue to work even whilst they were ill.

23 Home care workers make up a large cohort of  
24 Kanlungan's members. Many have employment-dependent  
25 immigration status. A large proportion have irregular  
104

1 immigration status and are informally employed without  
2 contracts. Their roles often involve giving complex  
3 care to vulnerable people.

4 During the pandemic, home care workers were  
5 overexposed through a lack of PPE but also through  
6 an expectation to continue working and to continue  
7 caring when either they or their employers were infected  
8 with the virus.

9 These workers were invisible to national statistics  
10 and so did not inform the significantly higher infection  
11 and subsequently mortality rates in ethnic minority  
12 communities. They faced the same issues as their  
13 outsourced and documented colleagues, but with the  
14 additional burden of the immigration policies that I was  
15 referring to earlier.

16 Some examples, because they are important, my Lady:  
17 the wages of the outsourced staff were significantly  
18 lower than that I've referred to -- of the undocumented  
19 staff, sorry, than that I've referred to previously; the  
20 effectively undocumented workers working in "no work and  
21 no pay" positions; transient and crowded housing, making  
22 it all the more difficult stay safe from the virus.

23 The group's members experienced the strain, grief  
24 and fear of their colleagues and patients. They cared  
25 for residents who should have been in hospital, and they

105

1 these positions of precarious employment.

2 The structural analysis should examine the  
3 percentage of staff from migrant backgrounds with visas  
4 linked to their employment, and in respect of the home  
5 care sector, an analysis of the extent to which that is  
6 regulated and, where possible, estimates of the  
7 contribution of undocumented workers to the sector over  
8 the pandemic period.

9 Finally, my Lady, point 3, the scope's point 3. We  
10 say that this analysis must include the consideration  
11 given to the impact on staff and the particular need to  
12 protect them, given that they were in the most deprived  
13 quintiles of the working population. That evaluation  
14 should extend to specific categories of staff who were  
15 all the more vulnerable due to precarious employment and  
16 their immigration statuses. Bearing in mind the  
17 proportion of care staff from ethnic minority  
18 backgrounds, the analysis must include the consideration  
19 of staff who had been made vulnerable by hostile  
20 environment policies.

21 Lastly, on points 4 and 8, when expert evidence is  
22 sought in respect of infection control, we ask for it to  
23 include two things: first, evidence on the surface  
24 transmission time of the virus and the impact of that on  
25 the cleaning staff, given that they were the first line

107

1 were with them, of course, when they died. They did so  
2 whilst exposed and unprotected themselves, taking the  
3 virus back home to their own families when they finished  
4 work, and they did that on a wage that cannot be lived  
5 on, in work that is wrongly considered to be menial.

6 In the words of one member, "I don't need claps,  
7 I need proper PPE and dignified pay."

8 So, my Lady, in terms of the scope, we appreciate  
9 that the scope is provisional and dependent on the  
10 Rule 9 requests. We ask when making those requests that  
11 the Inquiry consider the experience of the group's  
12 membership and ensure that that informs the subsequent  
13 list of issues.

14 We endorse what many others have said this morning  
15 on the pre-pandemic period in respect of understaffing.  
16 This aspect of the pre-pandemic state of social care is  
17 fundamental to understanding the impact on the sector.  
18 Understaffing, pay, conditions and underfunding are  
19 historic problems and the analysis has to be able to  
20 explore that history.

21 The point 2 analysis must look at pay and conditions  
22 and the percentage of workers in precarious employment  
23 across the whole sector and as a comparison between the  
24 public and private sectors, and should, we say, look at  
25 the rationale for placing key workers such as these in

106

1 of infection control and the last in line for PPE; and,  
2 secondly, an analysis of the failure of PPE supply  
3 chains and an exploration as to why PPE was not  
4 available for care sector staff.

5 So those, my Lady, are our preliminary submissions.

6 **LADY HALLETT:** Thank you very much, Mr Marquis, and I'm  
7 sorry for interrupting you, I may have misunderstood  
8 you, as I said.

9 Thank you.

10 Right, Mr Payter.

11 **Submissions on behalf of National Association of Care and  
12 Support Workers by MR PAYTER**

13 **MR PAYTER:** My Lady, I represent the National Association of  
14 Care and Support Workers, or NACAS for short. I'm here  
15 today with Paul Featherstone, who is NACAS's founder and  
16 sits to my right.

17 This is the first module in which NACAS has sought  
18 to participate in your Inquiry as a core participant.  
19 With that in mind, and for the unfamiliar, NACAS is  
20 an independent professional body that advocates for care  
21 and support workers, promotes the recognition and value  
22 of their work, and provides its members with support,  
23 education and other resources, as it did during the  
24 pandemic.

25 It is the only such organisation dedicated

108

1 exclusively to care workers. It has an ethnically  
2 diverse membership, which consists of those working in  
3 the full range of adult social care roles, including  
4 within care homes and in home care, and the employed,  
5 self-employed and those engaged on zero-hours contracts.

6 NACAS is proud to be a core participant in this  
7 module and is grateful to your Ladyship for giving care  
8 workers a distinct voice in Module 6. As a group, care  
9 workers are so often underrepresented in public life,  
10 and NACAS is committed to contributing to  
11 your Ladyship's investigation.

12 Care workers suffered the devastating impact of the  
13 pandemic acutely. The available data suggests that the  
14 mortality rates for those employed in social care were  
15 among if not the highest by occupation in the  
16 United Kingdom. That death rate was contributed to by  
17 a number of factors that make care workers generally  
18 more vulnerable, including their socioeconomic status,  
19 immigration status, gender and race. Indeed, as  
20 compared to the general population, care workers are  
21 disproportionately from a black and minority ethnic  
22 background and the vast majority are women.

23 As the pandemic took hold, the conditions in which  
24 care workers worked, often to the point of exhaustion,  
25 to deliver vital services, deteriorated from what was

109

1 different places, which in turn contributed to the  
2 response of the sector to the pandemic.

3 We are confident the Inquiry will investigate all of  
4 the issues relevant to the impact of the pandemic on  
5 care workers, including what we think may prove to be  
6 uneven impacts depending on factors such as employment  
7 status.

8 My Lady, our written submissions focused on the  
9 proposed scope of Module 6 and we adopt those  
10 submissions and indeed the submissions of the  
11 core participants that have gone before us.

12 From a care workers' perspective we would encourage  
13 your Ladyship to consider the pre-pandemic state of  
14 adult social care in a number of areas because, in  
15 NACAS's experience, and as the available research  
16 suggests, the dire state of many of the systems  
17 underpinning the adult social care sector had  
18 a significant bearing on the response of that sector to  
19 the pandemic.

20 We think such consideration will be of critical  
21 importance to your Ladyship's recommendations to  
22 strengthen the response of the sector to a future  
23 pandemic and, simply put, the position of the sector the  
24 day before the pandemic struck cannot be disentangled  
25 from what happened on the day when it began.

111

1 already a parlous state. With little or no training,  
2 care workers were required to adapt their heavy and  
3 emotionally challenging workloads to respond to those  
4 for whom they cared who may or were suffering from the  
5 virus.

6 They often did so with no or limited access to PPE  
7 or testing, inadequate and ever-changing guidance on  
8 infection prevention and control, difficulties in  
9 evidencing their key worker status, and without access  
10 to sick pay. That work also involved implementing what  
11 were heartbreaking do not resuscitate instructions and  
12 limitations on family visits. Such was the commitment  
13 to those for whom they cared, some carers took the  
14 extraordinary step of separating themselves from their  
15 own families and moving into their places of work.

16 My Lady, considering the essential and difficult  
17 nature of their role, as recognised by so many of us as  
18 we clapped on our doorsteps, it is striking that care  
19 workers are not only overburdened in their tasks but  
20 some of the most poorly paid in society.

21 The low value put on care work, at least by  
22 reference to its apparent financial worth, is important  
23 we say to this Inquiry, because the available research  
24 suggests it contributed to, for example, understaffing  
25 and the need for carers to hold multiple jobs in

110

1 Many of the points have already been made by others  
2 before me, but may I just highlight five key points  
3 affecting care workers that we would invite the Inquiry  
4 to explore.

5 The first is structure and whether the structure of  
6 the adult social care sector affected the response.  
7 This includes whether sporadic funding arrangements  
8 impacted on strategic planning and robustness of the  
9 sector, including capacity. It also includes whether  
10 different business models, including publicly funded,  
11 small-scale, large-scale, private funding and highly  
12 financialised care home providers led to variable  
13 investment in staff and infrastructure, and whether that  
14 had an impact, and we adopt the submission made by the  
15 Covid-19 Bereaved Families for Justice about  
16 spotlighting different settings. We suggest that could  
17 include private and public settings. There is evidence  
18 to suggest that where there is better investment, that  
19 may have led to better outcomes during the pandemic.

20 It also includes consideration of whether the  
21 fragmented nature of services had an impact,  
22 particularly in England and Wales where health and  
23 social care sectors are not integrated as they are in  
24 Scotland and Northern Ireland.

25 The second point is systemic issues affecting care

112

1 workers, some of which I have touched upon and which may  
2 have contributed to the pandemic response, including  
3 pay, working conditions, workloads, the insecurity of  
4 employment, the lack of training, low staff retention,  
5 high turnover rates, the absence of profession  
6 regulation and the low status attributed by some to the  
7 work of caring.

8 The third point is the position of care workers in  
9 relation to policies and guidance and whether their  
10 position was given adequate and timely consideration  
11 when policies such as the one to discharge untested  
12 patients from hospitals into care settings and guidance  
13 such as in relation to testing and infection prevention  
14 and control, whether the position of care workers was  
15 considered when they were being developed, communicated  
16 and implemented.

17 That includes consideration of whether any such  
18 consideration and the resultant policies and guidance  
19 took into account the diverse range of roles fulfilled  
20 by care workers, including the position of the employed  
21 and self-employed, the latter of whom were less able to  
22 access PPE, testing and financial support.

23 It also includes consideration of whether those  
24 determining policy and guidance took into account the  
25 complexity of the sector, including its infrastructure

113

1 you today. We are grateful for the indication from your  
2 team about it. We would be grateful to have that as  
3 soon as possible so we can get up to speed as soon as  
4 possible.

5 Thank you very much.

6 **LADY HALLETT:** Thank you very much, Mr Payter, very  
7 grateful.

8 Ms Morris.

9 **Submissions on behalf of the Royal College of Nursing by**  
10 **MS FENELLA MORRIS KC**

11 **MS MORRIS:** My Lady, on behalf of the Royal College of  
12 Nursing, may I make first some submissions on the issue  
13 of scope which are intended to be focused.

14 We submit that the issue of what aspects of the  
15 social care sector require to be considered by the  
16 Inquiry are essential, require to be addressed at this  
17 stage.

18 The College submits that the question "What was the  
19 impact on the social care sector?" can only be addressed  
20 in the light of the characteristics of the sector at the  
21 time. So, to adopt and build on the submissions of  
22 Mr Friedman KC that the system buckled when the crisis  
23 began, we say that the appropriate analogy is perhaps of  
24 a hammer hitting a wall. A weak structure, which we say  
25 was the case with the social care sector at the

115

1 and the ability of smaller organisations to implement  
2 ever-evolving requirements.

3 The fourth point is the support that was available  
4 to care workers of all statuses and whether it was  
5 adequate, bearing in mind the obvious risks of  
6 transmission to those for whom they cared.

7 The fifth point, and I'm grateful for the indication  
8 from your counsel this morning on this topic, whether  
9 appropriate consideration was given to the impact on  
10 care workers of the mandatory nature of vaccination  
11 requirements and what alternative approaches might work  
12 in a future pandemic.

13 My Lady, as to experts, we think the Inquiry may  
14 benefit from expert evidence on a number of the issues  
15 we have identified. We adopt what has been said before.  
16 We would be grateful, as others have suggested, to be  
17 told who the Inquiry proposes to instruct so we may  
18 contribute to that discussion.

19 Disclosure, finally, my Lady. Like other CPs, we  
20 invite disclosure as early as possible to assist us to  
21 prepare. As a new core participant in your Ladyship's  
22 Inquiry, we have asked your team to assist us with what  
23 evidence from other earlier modules, including oral  
24 evidence, we should be familiar with. We note a number  
25 of CPs have cited such evidence in their submissions to

114

1 beginning of the pandemic, will buckle, but a robust one  
2 will not.

3 In that case, what characteristics of the  
4 social care sector made it weak so that it buckled under  
5 the impact of the pandemic and require further  
6 investigation by the Inquiry?

7 First of all, we echo the submissions of many of the  
8 core participants that it was a lack of adequate  
9 staffing.

10 Secondly, another key characteristic was the poor  
11 relation status of the social care sector as against the  
12 healthcare, and we say that affected outcomes in  
13 a number of critical domains.

14 First of all, there was a lack of access to adequate  
15 equipment such as PPE and testing, and, secondly, the  
16 decision to move patients from hospitals to social care  
17 without due regard for the effects of that. Thus, we  
18 say what requires to be investigated is that lack of  
19 adequate staffing, lack of adequate equipment, and the  
20 inflexion of the decision-making process.

21 Staying with the issue of staffing, almost 7% of  
22 nursing posts in the social care sector were unfilled at  
23 the start of the pandemic. Of those who were working,  
24 their ability to work was affected by their own Covid  
25 infection and a need to shield. That meant that

116

1 pressures on those working were intensified, ultimately  
2 leading to moral distress and sometimes psychological  
3 injury. In consequence, there are ongoing shortages in  
4 nursing provision, particularly in the social care  
5 sector, and that is increasing that sector's  
6 vulnerability to a future pandemic.

7 One solution which this Inquiry is invited to  
8 consider by the College is that there is legislation in  
9 this country that imposes accountability on central  
10 government for workforce planning and supply as a key  
11 recommendation of the Inquiry, and we submit that that  
12 should form part of Module 6.

13 Thirdly, since infection was so poorly controlled in  
14 social care settings, the Royal College of Nursing  
15 reminds the Inquiry of its request in the preliminary  
16 hearing for Module 3 that the Inquiry seek from all the  
17 relevant bodies a full suite of infection prevention and  
18 control guidance for the period, a chronology of when it  
19 was issued, by whom, and how it was disseminated.  
20 Because that, the College submits, is a further key  
21 aspect of how, as it's been put today, Covid ripped  
22 through the social care sector.

23 Finally, and in addition to its written submissions,  
24 having heard the submissions of Mr Friedman KC, the  
25 College also adopts his submission that Rule 9

117

1 The challenges faced by those working in the sector  
2 were obviously significant and some of the fault lines  
3 have already been canvassed in Modules 1 and 2 and in  
4 submissions of others before you today, which I will not  
5 repeat.

6 We were grateful to hear Counsel to the Inquiry in  
7 opening to note the 1.5 million who work in the sector  
8 in England alone and some of the characteristics of the  
9 workforce.

10 These summary submissions will focus, my Lady, on  
11 one point. It is the extent to which this module will  
12 need to consider, in the discharge of your terms of  
13 reference, some of the structural challenges facing the  
14 sector which pre-existed the pandemic.

15 My Lady, perhaps something of a theme in some of the  
16 submissions before you today.

17 Counsel to the Inquiry in their written note, and  
18 again in submissions today, describe that it is not part  
19 of the Inquiry's terms of reference to consider the  
20 state of adult social care systems in the United Kingdom  
21 prior to the pandemic, save where necessary to  
22 understand how the pandemic impacted on adult social  
23 care.

24 As a matter of principle, that is no doubt correct,  
25 but it begs an important question: to what extent is it

119

1 questionnaires include the question: what would you  
2 recommend for future pandemic planning? And that  
3 witnesses attend prepared to answer that key question,  
4 given the vital purpose of the Inquiry.

5 That concludes my submissions.

6 **LADY HALLETT:** Thank you very much, Ms Morris.

7 Mr Jacobs.

8 **Submissions on behalf of the Trades Union Congress by**

9 **MR JACOBS**

10 **MR JACOBS:** Good afternoon, my Lady. These are the  
11 submissions of the Trades Union Congress.

12 The TUC brings together over 5 million working  
13 people who make up its 48 member unions. Those  
14 affiliated unions with a particular interest in Module 6  
15 include Unison, GMB and Unite, each of which represent  
16 a substantial number of those who work in the sector.

17 The experiences of those who work in the sector and  
18 the experiences of those who rely on residential or  
19 domiciliary care are, my Lady, two sides of the same  
20 coin. One depends on the other, and in that sense the  
21 TUC has an interest in the array of issues to be  
22 considered in this module.

23 But of course it is the experiences of those who  
24 work in the sector upon which the TUC's input will be  
25 particularly focused.

118

1 necessary in order to understand how the pandemic  
2 impacted on adult social care to consider the state of  
3 adult social care systems prior to the pandemic?

4 The TUC says that the inescapable reality, however  
5 messy and difficult it may be, is that the impact of the  
6 pandemic is a function of the state of the adult social  
7 care system going into it.

8 The extraordinary challenges of the pandemic met  
9 with the challenges of a chronically underfunded and  
10 fragmented social care sector, delivered by many  
11 thousands of local authority and private care providers  
12 with little central strategic direction, oversight and  
13 data, served by an understaffed, underpaid and  
14 undervalued workforce, many in insecure work.

15 In an echo, I think, of an observation made by  
16 Ms Campbell on behalf of the Northern Ireland Covid  
17 Bereaved this morning, these matters will be relevant  
18 not only to understanding the impact of the pandemic,  
19 but also to the making of meaningful recommendations.  
20 That is because, my Lady, change cannot be achieved in  
21 a vacuum from the structural challenges.

22 Your Counsel to the Inquiry addressed this issue  
23 this morning and said this:

24 "... [that] it may be that the pandemic threw  
25 a harsh and painful light on issues such as pre-pandemic

120

1 underfunding and the undervaluing of the adult social  
2 care sector, but Module 6 is focused on the impact of  
3 the pandemic, not on those wide-reaching and historic  
4 concerns and problems, and so, in [Counsel to the  
5 Inquiry's] submission, it is not, therefore, within  
6 Module 6's remit or scope to seek to fix or address  
7 those long-standing issues ..."

8 My Lady, that was a submission made, entirely  
9 properly, of course, in recognition of the need to  
10 adhere carefully to your terms of reference, but,  
11 respectfully, we say that it is mistaken. The place to  
12 which it may inadvertently lead is that it is not the  
13 function of this Inquiry to fix the roof but to focus on  
14 where best to place the buckets that catch the dropping  
15 water. That, my Lady, would be a mistake.

16 At the very least, we urge this module to gather the  
17 evidence and for you, my Lady, to proceed with an open  
18 mind. The conclusion of a full and fearless Inquiry  
19 might ultimately be that the roof needs to be fixed.

20 That a problem is historic does not mean that it is not  
21 relevant to pandemic response, and it may mean that  
22 a recommendation addressing it is desperately needed.

23 You cannot, my Lady, as you observed just a few  
24 moments ago, fix all of society, but we do invite the  
25 funnel of your investigations to start broadly and not

121

1 stand behind our written submissions and do not repeat  
2 them here.

3 My Lady, unless I can assist further.

4 **LADY HALLETT:** No, thank you very much, Mr Jacobs.

5 Ms Curtain, I think you complete the submissions.

6 **Submissions on behalf of the Welsh Government by MS CURTAIN**

7 **LADY HALLETT:** Have you got a green light?

8 (Pause)

9 **MS CURTAIN:** It's on, thank you.

10 **LADY HALLETT:** Got you.

11 **MS CURTAIN:** My Lady, prynhawn da, good afternoon,  
12 Hannah Curtain on behalf of the Welsh Government.

13 The Welsh Government is grateful for the opportunity  
14 to participate in Module 6 and grateful for the  
15 opportunity to make these brief oral submissions. As in  
16 all other modules, the Welsh Government offers its full  
17 co-operation and support for your Inquiry's work in  
18 examining the impact of the pandemic on the adult social  
19 care sector in Wales.

20 My Lady, the Welsh Government recognises that  
21 Module 6 will require the investigation of difficult  
22 questions. Service users of the care sector include  
23 some of the most vulnerable individuals in society and  
24 the Welsh Government recognises the particular suffering  
25 and loss that was experienced by those individuals and

123

1 to cast some of the broader structural issues to one  
2 side for fear of them being too broad or having  
3 a political hue. They may prove to be centrally  
4 relevant.

5 In a related point, it was observed by Counsel to  
6 the Inquiry that this module does not intend to repeat  
7 Module 1, clearly it should not, but Module 1 considered  
8 resilience and preparedness up to the start of the  
9 pandemic, including in the social care sector. That  
10 leads to what is perhaps the most important and relevant  
11 of questions: how did those features of resilience and  
12 preparedness play out during the pandemic? In that  
13 sense, Module 1 must be a platform for this module,  
14 Module 1 need not be repeated but its evidence and  
15 findings should be of core relevance, and we hope that  
16 that is what is envisaged.

17 My Lady, the structural challenges to which we  
18 invite your focus are set out in more detail at  
19 paragraphs 9(a) to 9(j) of our written submission. I do  
20 not repeat the detail of those matters here, but we  
21 invite careful consideration of them.

22 In our written submissions, we do also make  
23 observations in respect of expert evidence, Every Story  
24 Matters, and the important role of the evidence of  
25 frontline staff to this module, but on those matters we

122

1 by their loved ones during the pandemic.

2 The Welsh Government would restate its deep sympathy  
3 to those who lost loved ones or who otherwise suffered  
4 during the pandemic.

5 Similarly, the care sector was supported during the  
6 pandemic by the individuals who worked tirelessly and  
7 with great courage and dedication to continue to provide  
8 care to those who needed it, and that includes those  
9 individuals who were employed in the sector and unpaid  
10 carers and volunteers.

11 The Welsh Government would restate its profound  
12 gratitude to those individuals for their committed  
13 service and for the many personal sacrifices that were  
14 required to continue to work under that exceptional  
15 strain.

16 It is entirely right that Module 6 should examine  
17 both the experience of those individuals and the broad  
18 range of decisions that were taken by the Welsh  
19 Government and by others in relation to the management  
20 of the pandemic in the care sector.

21 The Welsh Government would emphasise that it fully  
22 recognises the importance of that scrutiny and, indeed,  
23 it welcomes that scrutiny, which will enable lessons to  
24 be learned for the future.

25 The Welsh Government is committed to providing every

124

1 assistance that it can to the Inquiry to allow for that  
 2 investigation to take place.  
 3 My Lady, diolch, thank you.  
 4 **LADY HALLETT:** Thank you, Ms Curtain.  
 5 Anything by way of response?  
 6 **MS CAREY:** Only this, my Lady: whether it's a leaky roof or  
 7 a structurally weak wall, the scale of the Module 6  
 8 task, listening to today's submissions, is unenviable,  
 9 and I know that you will want to consider the eloquent  
 10 and thoughtful submissions you heard with real care.  
 11 All raise important matters and provide you with  
 12 much to think about, but that must be balanced as  
 13 against the very real need to focus on the key issues  
 14 and the key recommendations and the competing demands  
 15 not just within Module 6 but across the Inquiry as  
 16 a whole, and so I have no doubt that you will in due  
 17 course issue a determination to the core participants  
 18 once you have had a chance to think about all that's  
 19 been said today and written.  
 20 **LADY HALLETT:** Thank you very much, Ms Carey. I think no  
 21 more construction analogies.  
 22 **MS CAREY:** No.  
 23 **LADY HALLETT:** Thank you all very much indeed.  
 24 I want to repeat my thanks: the submissions today  
 25 have been very constructive and instructive and, as  
 125

1 Ms Carey says, I shall consider them all with great  
 2 care.  
 3 I should also like to commend the entire team for  
 4 their timekeeping. I think you are the first module  
 5 list of participants who have managed to come in under  
 6 time rather than over time.  
 7 So thank you all very much for being so efficient  
 8 and focused and, as I say, as Ms Carey says, I shall  
 9 issue a determination once I've had a chance to consider  
 10 all the matters that you've raised.  
 11 Thank you very much. I think the next substantive  
 12 hearing is Belfast on April 30, but I think I may have  
 13 another preliminary hearing before then.  
 14 Thank you all.  
 15 **(2.40 pm)**  
 16 **(The hearing concluded)**  
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 19  
 20  
 21  
 22  
 23  
 24  
 25  
 126

1	INDEX	PAGE
2		
3	Introductory remarks by THE CHAIR .....	1
4		
5	Statement by LEAD COUNSEL TO THE INQUIRY for .....	1
6	MODULE 6	
7		
8	Submissions on behalf of Covid Bereaved .....	29
9	Families for Justice UK by MS ANNA MORRIS KC	
10		
11	Submissions on behalf of the Northern .....	38
12	Ireland Covid-19 Bereaved Families for	
13	Justice by MS CAMPBELL KC	
14		
15	Submissions on behalf of Scottish Covid .....	48
16	Bereaved by MR HENRY	
17		
18	Submissions on behalf of Covid-19 Bereaved .....	58
19	Families for Justice Cymru by MS GOWMAN	
20		
21	Submissions on behalf of Disabled People's .....	69
22	Organisations by MR FRIEDMAN KC	
23		
24		
25		

127

1	Submissions on behalf of National Care .....	77
2	Forum, Homecare Association and Care England	
3	by DR TOWNSON	
4		
5	Submissions on behalf of John's Campaign, .....	86
6	the Patients Association and Care Rights UK	
7	by MS MORGAN	
8		
9	Submissions on behalf of Frontline Migrant .....	98
10	Health Workers Group by MR MARQUIS	
11		
12	Submissions on behalf of National .....	108
13	Association of Care and Support Workers by	
14	MR PAYTER	
15		
16	Submissions on behalf of the Royal College .....	115
17	of Nursing by MS FENELLA MORRIS KC	
18		
19	Submissions on behalf of the Trades Union .....	118
20	Congress by MR JACOBS	
21		
22	Submissions on behalf of the Welsh .....	123
23	Government by MS CURTAIN	
24		
25		

128



<b>DR TOWNSON: [2]</b> 77/19 83/2	<b>17 [1]</b> 74/21	<b>45,632 [1]</b> 2/7	28/18 34/8 34/15	74/18
<b>LADY HALLETT:</b> <b>[25]</b> 1/4 29/2 38/10 48/20 57/19 57/21 58/1 69/3 69/14 77/13 82/23 86/8 97/21 98/3 102/20 103/9 108/6 115/6 118/6 123/4 123/7 123/10 125/4 125/20 125/23	<b>18 [1]</b> 3/10	<b>48 [1]</b> 118/13	37/18 37/20 38/24 42/15 43/6 43/17 43/22 43/23 44/17 44/21 45/14 50/25 52/15 68/15 71/16 72/3 72/14 75/24 75/24 79/1 89/1 90/10 90/16 96/22 97/5 102/4 104/15 104/15 104/16 112/15 115/2 125/12 125/18	<b>activity [1]</b> 90/19 <b>acts [1]</b> 83/4 <b>actual [1]</b> 33/17 <b>acute [1]</b> 18/19 <b>acutely [4]</b> 40/11 40/21 59/4 109/13 <b>adapt [1]</b> 110/2 <b>adapted [1]</b> 17/21 <b>addition [10]</b> 3/15 11/25 12/16 21/6 27/13 28/22 30/9 62/12 66/5 117/23 <b>additional [9]</b> 20/14 26/4 26/6 34/15 68/21 91/17 95/24 96/22 105/14 <b>address [17]</b> 8/7 10/7 11/14 11/23 14/16 16/10 25/16 28/24 29/11 45/23 48/13 49/10 56/13 58/22 97/20 102/13 121/6 <b>addressed [5]</b> 30/8 57/17 115/16 115/19 120/22 <b>addressing [3]</b> 102/21 103/4 121/22 <b>adduced [1]</b> 74/1 <b>adequacy [1]</b> 9/14 <b>adequate [9]</b> 40/25 48/10 56/3 113/10 114/5 116/8 116/14 116/19 116/19 <b>adequately [3]</b> 41/8 41/18 80/22 <b>adhere [1]</b> 121/10 <b>adjournment [1]</b> 98/1 <b>adjustment [1]</b> 88/21 <b>administer [1]</b> 50/3 <b>administrations [6]</b> 8/24 9/4 58/23 59/6 59/23 62/2 <b>adopt [9]</b> 21/22 49/6 54/8 66/3 71/4 111/9 112/14 114/15 115/21 <b>adopting [1]</b> 58/20 <b>adopts [1]</b> 117/25 <b>adult [57]</b> 2/1 3/4 3/5 3/18 4/5 6/12 7/22 8/2 8/6 8/8 8/9 9/7 9/10 10/18 13/1 13/23 14/22 15/23 16/1 16/6 16/21 23/8 23/12 27/1 27/4 29/16 29/20 29/24 31/4 32/3 33/10 35/5 43/6 44/18 44/24 48/14 48/17 60/7 60/9 60/19 61/10 61/15 63/4 78/4 83/14 83/17 109/3 111/14 111/17 112/6 119/20 119/22 120/2 120/3 120/6 121/1 123/18
<b>MR FRIEDMAN: [2]</b> 69/5 69/20	<b>19 [39]</b> 1/25 2/11 2/14 4/3 5/20 8/9 9/11 9/13 9/24 14/17 18/22 18/24 19/1 19/14 19/15 23/21 34/19 38/12 40/3 50/13 50/19 58/3 58/12 58/15 67/23 82/19 83/25 86/18 90/2 91/14 91/16 91/25 92/6 92/9 92/20 94/4 112/15 127/12 127/18	<b>5</b>	<b>above [1]</b> 34/20 <b>absence [3]</b> 30/12 80/21 113/5 <b>absent [1]</b> 44/8 <b>absolutely [1]</b> 75/23 <b>absolving [1]</b> 63/1 <b>abuse [1]</b> 91/5 <b>accept [1]</b> 20/6 <b>accepting [1]</b> 70/22 <b>access [7]</b> 9/15 27/20 89/10 110/6 110/9 113/22 116/14 <b>accessing [1]</b> 3/11 <b>accommodate [1]</b> 10/9 <b>accommodation [6]</b> 13/6 13/18 13/25 32/14 61/4 61/5 <b>accompanied [1]</b> 2/21 <b>accordance [2]</b> 22/2 75/9 <b>according [1]</b> 2/12 <b>account [8]</b> 12/11 67/23 89/12 92/4 92/24 93/20 113/19 113/24 <b>accountability [4]</b> 45/9 68/20 104/17 117/9 <b>accounted [2]</b> 39/6 50/10 <b>accustomed [1]</b> 55/16 <b>achieve [1]</b> 92/7 <b>achieved [4]</b> 30/22 30/23 47/23 120/20 <b>acknowledge [1]</b> 84/16 <b>across [21]</b> 3/4 14/9 20/12 23/9 23/11 29/21 31/5 32/7 35/5 45/20 46/2 52/10 55/9 59/9 69/21 92/24 96/12 99/3 99/16 106/23 125/15 <b>act [8]</b> 4/15 62/25 69/20 74/16 74/20 88/20 89/2 99/13 <b>action [3]</b> 5/25 69/23 90/20 <b>activities [2]</b> 17/25	<b>56 [1]</b> 100/15
<b>MR HENRY: [2]</b> 48/25 57/20	<b>19 March 2024 [1]</b> 1/1	<b>6</b>	<b>6's [2]</b> 16/9 121/6 <b>61 [1]</b> 100/7 <b>64 [1]</b> 3/10 <b>6A [3]</b> 11/25 54/10 58/21 <b>6B [3]</b> 12/1 54/10 58/21 <b>6C [3]</b> 12/1 54/10 58/21	<b>6</b>
<b>MR JACOBS: [1]</b> 118/10	<b>2</b>	<b>7</b>	<b>70 [1]</b> 100/19 <b>70,000 [1]</b> 102/9 <b>74 [1]</b> 39/6 <b>75 [2]</b> 39/5 39/6 <b>78 [1]</b> 87/15	<b>7</b>
<b>MR MARQUIS: [3]</b> 98/7 103/6 103/13	<b>2 o'clock [1]</b> 97/24	<b>8</b>	<b>8.40 [1]</b> 100/11 <b>82 [1]</b> 100/19	<b>8</b>
<b>MR PAYTER: [1]</b> 108/13	<b>2.00 pm [1]</b> 98/2	<b>9</b>	<b>90 [3]</b> 38/23 39/1 45/8 <b>95 [1]</b> 19/12 <b>953 [1]</b> 2/14 <b>9s [1]</b> 66/14	<b>9</b>
<b>MR JACOBS: [1]</b> 118/10	<b>2.40 pm [1]</b> 126/15	<b>A</b>	<b>Aamer [1]</b> 49/4 <b>Aamer Anwar [1]</b> 49/4 <b>abandoned [1]</b> 88/25 <b>abandonment [1]</b> 82/4 <b>abilities [1]</b> 79/16 <b>ability [4]</b> 36/23 96/13 114/1 116/24 <b>able [15]</b> 4/16 11/6 19/13 19/24 24/13 25/18 31/12 51/7 52/12 57/15 66/1 68/17 78/20 106/19 113/21 <b>ableism [4]</b> 32/20 33/3 39/24 56/24 <b>about [48]</b> 3/8 7/19 9/20 9/21 10/17 11/22 15/11 18/24 26/5 27/14 27/19 28/7	<b>A</b>
<b>MS CAMPBELL: [1]</b> 38/14	<b>2010 [1]</b> 88/20	<b>2021 [2]</b> 80/15 93/6		
<b>MS CAREY: [3]</b> 1/24	<b>2020 [21]</b> 2/6 2/9 2/12 16/1 31/24 39/5 39/8 44/19 45/2 45/3 46/14 46/21 50/10 50/13 50/18 89/23 90/13 90/22 93/5 94/18 100/22	<b>2022 [7]</b> 2/6 2/9 2/12 16/2 39/5 39/9 50/18		
<b>MS CURTAIN: [2]</b> 123/9 123/11	<b>2023 [2]</b> 17/12 102/10	<b>2024 [5]</b> 1/1 22/16 37/12 54/18 83/13		
<b>MS GOWMAN: [1]</b> 58/5	<b>2025 [1]</b> 28/13	<b>21 January 2022 [1]</b> 2/6		
<b>MS MORGAN: [1]</b> 86/12	<b>2021 [2]</b> 80/15 93/6	<b>22 [1]</b> 47/2		
<b>MS MORRIS: [2]</b> 29/7 115/11	<b>2022 [7]</b> 2/6 2/9 2/12 16/2 39/5 39/9 50/18	<b>26 March [1]</b> 90/22		
<b>1</b>	<b>2023 [2]</b> 17/12 102/10	<b>27 [1]</b> 5/14		
<b>1 March 2024 [1]</b> 83/13	<b>2024 [5]</b> 1/1 22/16 37/12 54/18 83/13	<b>27 August 2020 [1]</b> 94/18		
<b>1 million [1]</b> 94/2	<b>2025 [1]</b> 28/13	<b>29 June 2020 [1]</b> 90/22		
<b>1,284 [1]</b> 39/9	<b>21 January 2022 [1]</b> 2/6	<b>2A [1]</b> 55/1		
<b>1,815 deaths [1]</b> 50/16	<b>22 [1]</b> 47/2	<b>2B [3]</b> 62/7 88/15 90/6		
<b>1,818 deaths [1]</b> 50/15	<b>26 March [1]</b> 90/22	<b>2C [1]</b> 44/6		
<b>1.00 pm [1]</b> 97/25	<b>27 [1]</b> 5/14	<b>3</b>		
<b>1.5 million [2]</b> 3/20 119/7	<b>27 August 2020 [1]</b> 94/18	<b>3,592 [1]</b> 2/10		
<b>1.6 million [1]</b> 79/18	<b>29 June 2020 [1]</b> 90/22	<b>3,592 notifications</b> <b>[1]</b> 50/19		
<b>10 [1]</b> 100/10	<b>2A [1]</b> 55/1	<b>30 [1]</b> 126/12		
<b>10.30 am [1]</b> 1/2	<b>2B [3]</b> 62/7 88/15 90/6	<b>31 [1]</b> 94/21		
<b>11 months [1]</b> 68/7	<b>2C [1]</b> 44/6	<b>337 [1]</b> 17/14		
<b>11.48 am [1]</b> 57/23	<b>3</b>			
<b>12 [1]</b> 74/20	<b>3,592 [1]</b> 2/10			
<b>12 core participants</b> <b>[1]</b> 28/23	<b>3,592 notifications</b> <b>[1]</b> 50/19			
<b>12.05 [1]</b> 57/22	<b>30 [1]</b> 126/12			
<b>12.05 pm [1]</b> 57/25	<b>31 [1]</b> 94/21			
<b>13 [1]</b> 29/17	<b>337 [1]</b> 17/14			
<b>14 [1]</b> 5/17	<b>4</b>			
<b>149 [1]</b> 88/21	<b>4,500 [1]</b> 31/21			
<b>16 [2]</b> 74/21 90/13	<b>40 [1]</b> 94/24			
<b>162 billion [1]</b> 93/2	<b>41 [2]</b> 34/5 66/25			
<b>164 billion [1]</b> 93/5	<b>42 [1]</b> 34/14			

<p><b>A</b></p> <p><b>adult's [1]</b> 25/7</p> <p><b>adults [7]</b> 3/9 3/14 10/24 15/6 33/12 63/3 79/14</p> <p><b>advance [2]</b> 14/15 66/10</p> <p><b>advice [2]</b> 80/24 81/11</p> <p><b>advisable [1]</b> 10/5</p> <p><b>advisory [1]</b> 80/22</p> <p><b>advocacy [1]</b> 47/8</p> <p><b>advocate [3]</b> 42/3 49/3 49/3</p> <p><b>advocates [1]</b> 108/20</p> <p><b>affected [16]</b> 7/12 10/18 16/1 24/11 26/11 36/15 83/24 84/17 85/18 86/18 90/4 92/21 95/18 112/6 116/12 116/24</p> <p><b>affecting [2]</b> 112/3 112/25</p> <p><b>affiliated [2]</b> 99/5 118/14</p> <p><b>afield [1]</b> 5/5</p> <p><b>afraid [3]</b> 24/22 103/1 103/1</p> <p><b>after [4]</b> 1/11 58/12 64/3 85/16</p> <p><b>afternoon [4]</b> 58/6 86/12 118/10 123/11</p> <p><b>afterthought [1]</b> 18/3</p> <p><b>again [11]</b> 16/11 25/11 28/2 47/23 55/19 56/7 67/6 68/16 77/10 85/21 119/18</p> <p><b>against [11]</b> 31/10 35/4 45/24 46/10 62/9 64/12 81/10 92/6 96/20 116/11 125/13</p> <p><b>age [2]</b> 3/9 14/9</p> <p><b>aged [2]</b> 39/5 39/6</p> <p><b>ageism [6]</b> 32/20 33/3 33/17 33/19 39/24 56/24</p> <p><b>agencies [3]</b> 16/21 19/8 82/15</p> <p><b>agency [6]</b> 2/13 6/24 32/8 39/4 76/25 96/11</p> <p><b>agenda [6]</b> 5/7 7/15 16/14 21/20 26/8 28/8</p> <p><b>ages [2]</b> 79/15 84/5</p> <p><b>agitation [1]</b> 94/22</p> <p><b>ago [1]</b> 121/24</p> <p><b>agree [5]</b> 60/10 61/19 73/12 88/3 92/14</p> <p><b>agreeing [1]</b> 33/25</p> <p><b>agreement [1]</b> 42/19</p> <p><b>agrees [2]</b> 60/23 61/8</p> <p><b>ahead [1]</b> 66/18</p> <p><b>aim [1]</b> 1/17</p> <p><b>aims [1]</b> 26/20</p>	<p><b>air [1]</b> 51/20</p> <p><b>airborne [2]</b> 51/21 63/18</p> <p><b>aired [1]</b> 5/2</p> <p><b>albeit [1]</b> 11/19</p> <p><b>alike [1]</b> 47/11</p> <p><b>all [74]</b> 1/16 1/19 6/25 10/6 10/23 11/14 11/14 13/22 14/9 14/21 17/1 17/14 17/14 19/11 21/23 21/23 23/17 24/14 28/3 28/5 28/15 30/18 34/9 35/20 38/2 41/23 47/18 48/18 50/10 52/5 54/12 54/15 55/7 55/9 55/9 55/23 56/1 61/16 62/21 68/16 68/21 69/10 70/16 70/25 76/20 76/22 78/1 78/21 79/12 79/15 83/16 84/5 90/19 96/13 97/9 98/16 101/9 101/14 105/22 107/15 111/3 114/4 116/7 116/14 117/16 121/24 123/16 125/11 125/18 125/23 126/1 126/7 126/10 126/14</p> <p><b>Allied [1]</b> 22/25</p> <p><b>allocate [1]</b> 43/11</p> <p><b>allocated [3]</b> 59/21 102/17 103/7</p> <p><b>allocation [1]</b> 59/15</p> <p><b>allow [4]</b> 59/22 66/17 74/16 125/1</p> <p><b>allowed [1]</b> 80/12</p> <p><b>allowing [1]</b> 22/19</p> <p><b>allows [1]</b> 4/18</p> <p><b>almost [7]</b> 18/20 39/6 39/8 39/16 45/14 100/17 116/21</p> <p><b>alone [5]</b> 3/19 39/21 42/20 91/22 119/8</p> <p><b>along [6]</b> 5/23 27/25 76/10 76/12 84/24 98/8</p> <p><b>Alongside [1]</b> 73/2</p> <p><b>already [23]</b> 11/19 17/3 21/7 22/5 22/12 23/6 24/6 26/1 28/20 43/23 44/11 44/15 46/1 46/7 70/24 71/17 72/21 73/18 74/7 75/1 110/1 112/1 119/3</p> <p><b>also [52]</b> 1/15 3/4 3/13 4/18 9/12 12/5 13/15 22/8 23/18 23/24 24/2 32/11 33/6 34/2 36/19 40/4 47/7 51/5 51/16 55/14 63/3 63/4 63/16 64/11 65/11 66/6 69/9 70/24</p>	<p>72/14 77/1 77/7 78/13 78/20 80/6 85/12 87/10 88/7 91/2 95/7 95/23 96/17 98/17 104/18 105/5 110/10 112/9 112/20 113/23 117/25 120/19 122/22 126/3</p> <p><b>alternative [1]</b> 114/11</p> <p><b>although [14]</b> 4/21 10/4 13/20 15/19 16/11 19/12 25/25 32/23 39/1 44/1 54/12 68/4 78/1 83/13</p> <p><b>Alzheimer's [3]</b> 93/24 94/2 94/12</p> <p><b>Alzheimer's Society [1]</b> 94/12</p> <p><b>am [2]</b> 1/2 57/23</p> <p><b>ambit [1]</b> 60/19</p> <p><b>ambition [1]</b> 44/9</p> <p><b>amendment [1]</b> 12/23</p> <p><b>among [3]</b> 84/17 100/23 109/15</p> <p><b>amongst [5]</b> 25/21 31/22 33/14 53/12 73/13</p> <p><b>amount [4]</b> 13/9 37/25 55/16 55/20</p> <p><b>analogies [1]</b> 125/21</p> <p><b>analogy [2]</b> 71/4 115/23</p> <p><b>analyse [2]</b> 26/11 66/7</p> <p><b>analysed [1]</b> 77/2</p> <p><b>analysis [9]</b> 37/21 60/15 106/19 106/21 107/2 107/5 107/10 107/18 108/2</p> <p><b>anguish [1]</b> 81/21</p> <p><b>ANNA [2]</b> 29/6 127/9</p> <p><b>announced [1]</b> 90/13</p> <p><b>annual [1]</b> 93/4</p> <p><b>anonymised [1]</b> 26/15</p> <p><b>another [4]</b> 33/23 95/9 116/10 126/13</p> <p><b>answer [1]</b> 118/3</p> <p><b>answered [1]</b> 37/23</p> <p><b>answers [2]</b> 45/15 52/4</p> <p><b>anticipate [5]</b> 4/21 5/4 25/20 28/11 44/5</p> <p><b>anticipated [1]</b> 55/18</p> <p><b>anticipates [1]</b> 19/24</p> <p><b>antipsychotic [1]</b> 89/5</p> <p><b>Anwar [1]</b> 49/4</p> <p><b>anxiety [1]</b> 80/20</p> <p><b>any [26]</b> 7/7 7/8 8/16 10/22 12/12 14/16 15/21 23/11 25/13</p>	<p>26/6 28/6 29/23 32/4 35/21 42/18 44/8 44/9 47/23 54/2 57/16 60/15 62/14 64/14 66/11 66/12 113/17 <b>anybody [1]</b> 68/18</p> <p><b>anyone [4]</b> 26/21 26/22 27/11 100/21</p> <p><b>anything [3]</b> 5/1 97/19 125/5</p> <p><b>apathy [1]</b> 94/22</p> <p><b>appalled [1]</b> 33/17</p> <p><b>appalling [1]</b> 39/1</p> <p><b>apparent [1]</b> 110/22</p> <p><b>appear [5]</b> 29/7 37/6 46/19 48/25 86/13</p> <p><b>appeared [2]</b> 47/9 79/11</p> <p><b>appears [3]</b> 53/8 90/11 96/3</p> <p><b>applicable [1]</b> 99/16</p> <p><b>application [2]</b> 45/22 81/14</p> <p><b>applications [3]</b> 5/12 5/13 90/17</p> <p><b>applied [4]</b> 52/10 81/13 97/18 103/17</p> <p><b>applies [1]</b> 65/17</p> <p><b>apply [2]</b> 7/4 54/6</p> <p><b>applying [2]</b> 7/7 74/12</p> <p><b>appointed [1]</b> 26/2</p> <p><b>appointment [1]</b> 25/24</p> <p><b>appreciate [2]</b> 82/24 106/8</p> <p><b>appreciated [2]</b> 15/7 82/5</p> <p><b>appreciates [1]</b> 73/19</p> <p><b>apprehend [1]</b> 73/9</p> <p><b>apprehension [1]</b> 55/21</p> <p><b>approach [12]</b> 21/21 21/22 30/24 31/2 47/19 54/9 54/12 57/1 58/20 62/17 72/24 76/2</p> <p><b>approaches [3]</b> 31/10 89/10 114/11</p> <p><b>appropriate [11]</b> 5/16 7/10 30/7 43/9 46/6 47/25 66/13 90/25 92/8 114/9 115/23</p> <p><b>appropriately [1]</b> 41/8</p> <p><b>April [2]</b> 89/23 126/12</p> <p><b>April 2020 [1]</b> 89/23</p> <p><b>April 30 [1]</b> 126/12</p> <p><b>are [163]</b></p> <p><b>area [9]</b> 15/8 18/21 19/13 19/20 24/2 25/14 88/12 92/17</p>	<p>103/2</p> <p><b>areas [16]</b> 11/16 23/3 23/5 25/13 26/4 26/6 31/16 34/15 51/18 51/19 60/1 60/4 86/23 87/5 103/1 111/14</p> <p><b>arguably [1]</b> 46/14</p> <p><b>arise [4]</b> 4/21 25/8 40/9 79/3</p> <p><b>arises [1]</b> 5/1</p> <p><b>arising [5]</b> 5/4 10/12 14/21 63/5 94/6</p> <p><b>around [9]</b> 7/17 38/2 38/6 51/5 52/9 94/1 100/10 100/11 104/5</p> <p><b>arrangements [6]</b> 17/8 20/7 84/22 96/6 96/7 112/7</p> <p><b>array [1]</b> 118/21</p> <p><b>arrived [2]</b> 63/12 82/6</p> <p><b>articulated [1]</b> 82/20</p> <p><b>artificial [1]</b> 59/8</p> <p><b>as [192]</b></p> <p><b>ASC [2]</b> 34/19 34/22</p> <p><b>Asia [1]</b> 99/2</p> <p><b>Asian [2]</b> 3/23 98/24</p> <p><b>aside [1]</b> 30/18</p> <p><b>ask [6]</b> 32/11 34/2 37/19 91/9 106/10 107/22</p> <p><b>asked [8]</b> 7/16 17/12 18/24 25/16 28/13 56/12 74/11 114/22</p> <p><b>asking [1]</b> 74/3</p> <p><b>asks [1]</b> 76/15</p> <p><b>aspect [5]</b> 17/5 36/11 92/15 106/16 117/21</p> <p><b>aspects [6]</b> 8/14 10/20 32/19 51/16 87/25 115/14</p> <p><b>aspirations [2]</b> 75/25 84/12</p> <p><b>assessment [1]</b> 94/18</p> <p><b>assessments [2]</b> 63/3 74/18</p> <p><b>assist [20]</b> 23/3 35/21 35/22 36/24 37/7 38/3 38/9 43/13 47/22 47/24 48/19 56/7 57/15 61/10 65/16 78/20 97/5 114/20 114/22 123/3</p> <p><b>assistance [6]</b> 20/4 35/13 65/11 71/14 72/16 125/1</p> <p><b>assisted [5]</b> 13/7 34/16 35/7 84/4 87/11</p> <p><b>assisting [1]</b> 78/14</p> <p><b>Association [21]</b> 5/25 6/6 6/7 6/10 6/12 6/13 6/14 17/13 61/20 72/6 77/18 77/21</p>
---	---	---	--	---

<b>A</b>	<b>autonomy [2]</b> 79/17 88/24	55/14 56/5 58/24 59/7 61/17 64/4 64/24	48/24 49/1 49/5 49/14 49/17 50/8 50/22	88/7 122/2 124/17	
<b>Association... [9]</b> 77/23 78/9 86/11 86/14 108/11 108/13 128/2 128/6 128/13	<b>availability [2]</b> 9/14 55/13	68/10 69/15 71/25 73/22 73/24 74/1	50/24 51/8 51/12 51/15 51/25 52/4 52/6	<b>broadcasting [1]</b> 4/24	
<b>associations [1]</b> 78/7	<b>available [10]</b> 19/22 39/3 56/2 71/17 88/14 108/4 109/13 110/23 111/15 114/3	74/22 78/11 78/13 96/3 105/25 107/19 112/1 114/15 117/21 119/3 125/19 125/25	52/9 52/14 52/17 52/23 53/4 53/11 53/17 53/25 54/4 54/7 54/8 54/11 54/17 54/23 55/5 55/11 56/5	<b>broader [6]</b> 32/25 60/12 61/15 61/17 63/12 122/1	
<b>assumptions [1]</b> 83/10	<b>average [2]</b> 100/9 100/10	<b>befall [1]</b> 48/17	56/10 56/14 56/20 56/21 56/25 57/3	<b>broadly [6]</b> 36/12 62/11 67/1 93/4 95/25 121/25	
<b>asymptomatic [1]</b> 63/17	<b>avoid [1]</b> 85/5	<b>before [18]</b> 25/17 26/6 35/14 37/12 47/12 48/22 59/2 69/5 72/1 74/8 85/15 111/11 111/24 112/2 114/15 119/4 119/16 126/13	57/11 58/3 58/7 64/9 64/12 64/14 66/21 67/9 67/14 68/21 72/25 73/13 73/14 91/23 92/11 112/15 120/17 127/8 127/12 127/16 127/18	<b>brought [1]</b> 41/16	
<b>at [92]</b> 2/21 4/2 4/8 4/20 5/9 7/11 8/17 8/25 8/25 9/3 9/13 9/22 10/5 10/16 12/1 12/8 17/9 18/10 19/11 19/14 23/13 23/14 23/15 23/23 23/24 24/3 24/17 25/7 27/2 27/6 27/9 27/17 27/21 28/10 29/15 29/17 32/1 33/17 34/14 35/24 36/3 39/15 39/19 39/20 46/14 46/22 47/2 48/5 49/4 50/2 50/5 53/22 54/10 56/8 56/14 57/22 60/1 60/13 61/24 66/11 66/24 68/1 68/5 68/6 69/8 69/8 72/9 74/10 79/8 79/10 81/2 82/20 89/15 90/12 90/25 96/3 97/23 99/14 100/23 101/7 101/14 104/1 104/3 106/21 106/24 110/21 115/16 115/20 115/25 116/22 121/16 122/18	<b>avoidance [1]</b> 65/1	<b>begin [1]</b> 69/5	67/9 67/14 68/21 72/25 73/13 73/14 91/23 92/11 112/15 120/17 127/8 127/12 127/16 127/18	<b>buckets [1]</b> 121/14	
<b>attempts [3]</b> 9/17 63/21 81/14	<b>aware [7]</b> 50/8 52/5 53/1 53/11 57/3 59/4 64/14	<b>beginning [2]</b> 74/11 116/1	112/18 112/19	<b>buckle [1]</b> 116/1	
<b>attempting [1]</b> 55/2	<b>away [3]</b> 35/14 68/2 82/10	<b>begs [1]</b> 119/25	<b>between [10]</b> 2/9 2/12 3/10 18/9 35/18 39/5 50/18 63/14 92/8 106/23	<b>buckled [3]</b> 73/12 115/22 116/4	
<b>attend [2]</b> 4/17 118/3	<b>back [2]</b> 57/21 106/3	<b>behalf [36]</b> 28/25 29/5 29/7 38/12 40/7 42/3 48/24 48/25 58/3 67/14 69/18 71/5 77/17 77/21 86/10 86/13 98/5 108/11 115/9 115/11 118/8 120/16 123/6 123/12 127/8 127/11 127/15 127/18 127/21 128/1 128/5 128/9 128/12 128/16 128/19 128/22	2/12 3/10 18/9 35/18 39/5 50/18 63/14 92/8 106/23	<b>budget [1]</b> 93/4	
<b>attending [1]</b> 50/2	<b>background [3]</b> 45/24 46/10 109/22	<b>behaviour [1]</b> 89/6	<b>best [2]</b> 20/10 121/14	<b>budgeting [1]</b> 74/5	
<b>attention [6]</b> 7/8 40/8 44/4 48/7 48/11 79/6	<b>backgrounds [3]</b> 100/18 107/3 107/18	<b>behaviours [1]</b> 82/22	<b>bet [1]</b> 98/4	<b>build [2]</b> 86/2 115/21	
<b>attorney [2]</b> 64/2 89/9	<b>badly [2]</b> 94/6 95/18	<b>behind [2]</b> 85/21 123/1	<b>better [3]</b> 35/7 112/18 112/19	<b>burden [1]</b> 105/14	
<b>attributed [1]</b> 113/6	<b>balance [2]</b> 92/8 95/2	<b>being [32]</b> 4/10 7/6 13/10 17/5 18/16 18/17 19/24 20/13 21/5 27/19 31/17 37/15 39/8 42/17 49/15 52/2 52/8 52/23 64/5 68/1 70/15 77/2 80/8 84/10 91/3 93/8 96/12 102/17 102/19 113/15 122/2 126/7	<b>bit [1]</b> 103/11	<b>burdensome [1]</b> 82/8	
<b>audience [2]</b> 27/25 93/18	<b>balanced [1]</b> 125/12	<b>belated [1]</b> 47/3	<b>black [2]</b> 3/23 109/21	<b>bureaucracy [1]</b> 70/7	
<b>auditing [1]</b> 75/16	<b>balancing [1]</b> 92/5	<b>Belfast [1]</b> 126/12	<b>blanket [3]</b> 81/14 89/10 97/18	<b>bureaucratic [1]</b> 82/8	
<b>August [1]</b> 94/18	<b>Bar [1]</b> 69/9	<b>believe [1]</b> 40/18	<b>boards [2]</b> 6/19 65/6	<b>business [1]</b> 112/10	
<b>austerity [1]</b> 44/23	<b>barristers [1]</b> 22/4	<b>below [2]</b> 8/14 100/11	<b>boat [1]</b> 75/24	<b>but [84]</b> 2/4 2/17 2/22 3/3 3/6 3/13 5/4 8/3 8/17 12/5 13/14 14/14 15/3 15/6 16/6 17/16 20/23 22/18 24/10 24/14 24/23 25/3 25/6 25/11 26/15 27/10 30/5 31/2 33/6 34/10 35/20 37/4 38/2 39/15 41/10 43/25 43/25 44/25 45/7 47/7 47/8 47/17 48/5 51/16 58/1 59/1 59/14 60/20 61/16 61/19 63/3 64/11 69/9 70/19 70/24 75/8 76/19 76/22 77/1 82/24 98/17 102/20 103/9 103/13 104/22 105/5 105/13 110/19 112/2 116/1 118/23 119/25 120/19 121/2 121/10 121/13 121/24 122/7 122/14 122/20 122/25 125/12 125/15 126/12	<b>can [43]</b> 4/19 7/5 7/13 7/24 10/10 16/25 22/18 25/23 26/16
<b>authorities [11]</b> 6/20 6/22 17/6 17/10 20/3 63/2 65/6 74/17 75/13 90/20 100/9	<b>base [2]</b> 14/4 83/19	<b>beneficial [1]</b> 97/11	<b>bodies [4]</b> 8/23 16/24 65/20 117/17		
<b>authority [5]</b> 6/15 46/16 75/11 99/19 120/11	<b>based [3]</b> 25/3 57/6 84/3	<b>benefit [6]</b> 69/11 74/3 82/12 92/5 101/4 114/14	<b>body [4]</b> 77/24 78/3 78/10 108/20		
<b>autism [3]</b> 84/7 84/17 87/17	<b>basis [7]</b> 20/14 20/18 22/8 35/9 59/14 68/19 70/23	<b>bereaved [77]</b> 5/19 5/20 5/22 5/23 11/23 28/25 29/5 29/8 33/16 36/14 37/14 37/19 38/13 38/18 38/21 40/2 40/8 43/5 43/13	<b>both [8]</b> 29/22 31/5 31/6 35/12 50/12 71/14 101/12 124/17		
<b>autoimmune [1]</b> 34/12	<b>be [201]</b>		<b>bracket [1]</b> 39/13		
	<b>bear [1]</b> 70/10		<b>brain [1]</b> 84/7		
	<b>bearing [3]</b> 107/16 111/18 114/5		<b>breach [1]</b> 81/18		
	<b>became [1]</b> 40/4		<b>breadth [2]</b> 4/5 88/5		
	<b>because [22]</b> 5/3 7/18 20/8 31/3 31/20 39/13 40/11 40/21 43/3 46/12 60/14 70/7 79/22 92/21 92/25 93/25 102/18 105/16 110/23 111/14 117/20 120/20		<b>break [5]</b> 5/6 48/22 57/21 57/24 97/23		
	<b>becomes [1]</b> 39/2		<b>breaks [1]</b> 37/11		
	<b>bed [1]</b> 9/1		<b>brief [3]</b> 4/4 49/7 123/15		
	<b>bedsides [1]</b> 2/22		<b>bring [1]</b> 40/8		
	<b>been [56]</b> 5/8 5/14 6/2 10/8 10/24 11/10 11/20 15/20 21/16 22/6 22/11 22/13 23/6 26/10 26/21 27/9 27/24 28/3 30/2 37/22 42/17 43/1 43/7 43/24 43/25 46/1 48/8 50/4 52/8 54/16 54/21		<b>bringing [1]</b> 7/8		
			<b>brings [2]</b> 21/19 118/12		
			<b>Britain [1]</b> 98/22		
			<b>British [2]</b> 6/6 28/14		
			<b>broad [9]</b> 14/4 32/24 60/3 63/10 83/19 84/3		

C				
<p><b>can...</b> [34] 26/22 27/10 28/18 30/21 30/23 32/16 34/16 35/20 36/16 38/4 38/8 43/13 46/24 48/19 49/18 52/3 54/19 55/2 60/16 66/11 66/12 67/17 68/25 70/22 70/23 71/8 73/1 73/23 75/21 85/5 115/3 115/19 123/3 125/1</p> <p><b>can't</b> [1] 42/9</p> <p><b>cancer</b> [1] 91/20</p> <p><b>cannot</b> [15] 22/17 32/22 34/9 47/22 84/14 100/21 101/11 102/6 102/22 103/2 103/2 106/4 111/24 120/20 121/23</p> <p><b>canvassed</b> [1] 119/3</p> <p><b>capacity</b> [10] 8/5 8/9 9/1 18/8 23/8 23/15 51/5 89/2 99/22 112/9</p> <p><b>captured</b> [1] 67/5</p> <p><b>Cardiopulmonary</b> [2] 9/18 63/21</p> <p><b>care</b> [438]</p> <p><b>Care England</b> [5] 6/9 61/21 72/6 77/22 78/3</p> <p><b>care home</b> [6] 39/10 39/17 41/13 50/10 56/19 96/25</p> <p><b>care homes</b> [57] 2/8 2/11 2/14 3/1 3/3 3/6 14/7 18/19 18/21 19/12 23/14 27/4 27/10 27/21 31/25 40/16 40/23 41/21 44/11 47/8 49/18 50/2 50/3 50/14 50/20 51/24 52/2 52/11 61/24 62/8 67/4 78/5 79/13 80/12 81/10 83/21 84/2 84/21 85/4 87/9 87/24 89/22 89/24 90/15 91/11 92/18 92/22 95/1 96/6 96/9 96/22 99/19 99/25 101/15 101/22 104/1 109/4</p> <p><b>Care Inspectorate</b> [3] 2/9 6/16 65/6</p> <p><b>care sector</b> [34] 1/6 7/23 8/2 8/10 8/13 8/19 8/21 8/23 9/5 9/23 23/10 23/25 24/1 26/25 27/8 38/25 39/20 40/6 40/15 46/1 49/19 49/25 60/13 62/5 70/8 73/4 73/17 74/4 74/13 80/8 97/6 99/19 103/10 107/5</p>	<p><b>cared</b> [8] 19/18 27/2 93/11 93/13 105/24 110/4 110/13 114/6</p> <p><b>careful</b> [4] 11/15 72/24 102/21 122/21</p> <p><b>carefully</b> [3] 16/12 45/23 121/10</p> <p><b>caregivers</b> [1] 95/20</p> <p><b>carer</b> [4] 13/11 93/9 95/5 96/25</p> <p><b>carers</b> [19] 10/2 14/1 19/17 19/20 32/2 42/9 63/4 86/21 92/24 93/1 93/8 93/8 94/8 94/16 95/17 99/4 110/13 110/25 124/10</p> <p><b>Carey</b> [11] 1/8 1/11 1/22 29/2 30/3 34/8 39/12 69/10 125/20 126/1 126/8</p> <p><b>caring</b> [4] 93/10 93/13 105/7 113/7</p> <p><b>carried</b> [1] 41/6</p> <p><b>carry</b> [2] 33/5 63/2</p> <p><b>carrying</b> [1] 93/12</p> <p><b>case</b> [8] 26/18 31/15 56/5 70/12 70/15 72/24 115/25 116/3</p> <p><b>cases</b> [5] 41/5 42/10 90/2 94/10 104/21</p> <p><b>casework</b> [1] 90/19</p> <p><b>cast</b> [1] 122/1</p> <p><b>catch</b> [2] 84/14 121/14</p> <p><b>catchment</b> [1] 31/16</p> <p><b>categories</b> [3] 21/16 27/25 107/14</p> <p><b>category</b> [1] 73/3</p> <p><b>caught</b> [1] 58/1</p> <p><b>cause</b> [6] 60/15 76/3 89/13 92/7 94/1 94/3</p> <p><b>caused</b> [14] 19/4 36/23 67/22 81/17 90/3 91/10 91/14 91/22 91/24 91/25 92/3 94/11 94/13 101/22</p> <p><b>causes</b> [2] 91/16 101/25</p> <p><b>causing</b> [1] 81/21</p> <p><b>CBFFJ</b> [1] 61/9</p> <p><b>ceasing</b> [1] 90/14</p> <p><b>Cecil</b> [4] 69/6 69/12 69/15 69/16</p> <p><b>central</b> [5] 19/8 73/3 82/17 117/9 120/12</p> <p><b>centrally</b> [1] 122/3</p> <p><b>Centre</b> [1] 98/11</p> <p><b>centred</b> [1] 94/14</p> <p><b>centres</b> [3] 8/4 60/21 81/24</p> <p><b>CEO</b> [1] 77/20</p> <p><b>certain</b> [3] 34/7 49/20 54/25</p>	<p><b>certainly</b> [4] 2/3 41/22 44/10 61/16</p> <p><b>certainty</b> [1] 38/6</p> <p><b>chains</b> [1] 108/3</p> <p><b>CHAIR</b> [2] 1/3 127/3</p> <p><b>Chair's</b> [1] 35/22</p> <p><b>challenge</b> [1] 45/13</p> <p><b>challenges</b> [10] 14/10 51/23 80/23 85/13 119/1 119/13 120/8 120/9 120/21 122/17</p> <p><b>challenging</b> [2] 81/8 110/3</p> <p><b>chance</b> [3] 28/5 125/18 126/9</p> <p><b>change</b> [7] 17/22 48/16 76/24 77/15 85/20 102/22 120/20</p> <p><b>changed</b> [1] 82/16</p> <p><b>changes</b> [1] 9/22</p> <p><b>changing</b> [1] 110/7</p> <p><b>chaos</b> [1] 46/25</p> <p><b>chaotic</b> [1] 80/4</p> <p><b>characteristic</b> [1] 116/10</p> <p><b>characteristics</b> [4] 99/13 115/20 116/3 119/8</p> <p><b>charges</b> [1] 103/20</p> <p><b>charitable</b> [1] 98/23</p> <p><b>charities</b> [3] 16/23 65/4 70/1</p> <p><b>children</b> [2] 10/20 10/21</p> <p><b>choice</b> [2] 41/10 72/24</p> <p><b>chronic</b> [1] 101/16</p> <p><b>chronically</b> [1] 120/9</p> <p><b>chronology</b> [1] 117/18</p> <p><b>circulate</b> [1] 10/11</p> <p><b>circulated</b> [1] 5/8</p> <p><b>circumstances</b> [5] 2/20 61/23 81/8 81/16 84/12</p> <p><b>cited</b> [1] 114/25</p> <p><b>citizens</b> [1] 79/12</p> <p><b>Claire</b> [1] 49/2</p> <p><b>Claire Mitchell</b> [1] 49/2</p> <p><b>clapped</b> [1] 110/18</p> <p><b>claps</b> [1] 106/6</p> <p><b>clarify</b> [1] 32/11</p> <p><b>clarity</b> [7] 38/5 45/13 45/16 45/18 45/19 60/24 61/6</p> <p><b>class</b> [2] 99/10 99/16</p> <p><b>classified</b> [1] 100/14</p> <p><b>clean</b> [1] 68/14</p> <p><b>cleaners</b> [1] 99/8</p> <p><b>cleaning</b> [2] 51/17 107/25</p> <p><b>clear</b> [10] 8/16 10/19</p>	<p>12/17 12/24 25/21 29/18 33/6 44/1 59/7 67/8</p> <p><b>clearest</b> [1] 47/1</p> <p><b>clearly</b> [4] 36/1 51/3 82/20 122/7</p> <p><b>client</b> [5] 38/23 41/21 42/24 43/4 46/4</p> <p><b>clients</b> [1] 40/18</p> <p><b>clinical</b> [2] 51/18 99/3</p> <p><b>clinically</b> [1] 100/1</p> <p><b>close</b> [1] 103/14</p> <p><b>closely</b> [1] 85/22</p> <p><b>closest</b> [1] 95/17</p> <p><b>closing</b> [1] 79/5</p> <p><b>co</b> [6] 54/1 54/3 62/16 77/9 77/9 123/17</p> <p><b>co-design</b> [1] 77/9</p> <p><b>co-operate</b> [1] 54/1</p> <p><b>co-operation</b> [2] 54/3 123/17</p> <p><b>co-production</b> [1] 77/9</p> <p><b>cognitive</b> [2] 94/20 95/8</p> <p><b>coherence</b> [1] 44/9</p> <p><b>cohort</b> [2] 61/22 104/23</p> <p><b>coin</b> [2] 25/11 118/20</p> <p><b>colleagues</b> [5] 38/15 38/22 48/9 105/13 105/24</p> <p><b>collection</b> [2] 76/6 82/10</p> <p><b>collective</b> [1] 98/20</p> <p><b>College</b> [9] 6/8 115/9 115/11 115/18 117/8 117/14 117/20 117/25 128/16</p> <p><b>colleges</b> [1] 65/4</p> <p><b>colloquially</b> [1] 6/20</p> <p><b>combination</b> [1] 95/14</p> <p><b>combine</b> [1] 71/11</p> <p><b>combined</b> [1] 72/23</p> <p><b>come</b> [9] 20/19 42/24 43/10 57/21 61/12 72/18 76/18 100/21 126/5</p> <p><b>comes</b> [2] 47/2 47/19</p> <p><b>comforting</b> [1] 42/22</p> <p><b>commence</b> [2] 11/7 44/19</p> <p><b>commenced</b> [1] 46/8</p> <p><b>commencement</b> [1] 54/17</p> <p><b>commences</b> [1] 37/12</p> <p><b>commencing</b> [1] 44/5</p> <p><b>commend</b> [1] 126/3</p> <p><b>commented</b> [1]</p>	<p>18/11</p> <p><b>commission</b> [4] 6/14 27/14 35/11 82/15</p> <p><b>commissioned</b> [1] 29/20</p> <p><b>Commissioner</b> [2] 65/7 65/8</p> <p><b>Commissioner for</b> [1] 65/7</p> <p><b>commitment</b> [2] 37/15 110/12</p> <p><b>committed</b> [4] 85/22 109/10 124/12 124/25</p> <p><b>common</b> [1] 21/21</p> <p><b>commonly</b> [1] 24/5</p> <p><b>communal</b> [1] 51/19</p> <p><b>communicate</b> [1] 42/2</p> <p><b>communicated</b> [3] 28/18 51/10 113/15</p> <p><b>communication</b> [4] 51/2 52/15 52/21 80/3</p> <p><b>communications</b> [1] 9/19</p> <p><b>communities</b> [6] 71/13 79/13 80/2 84/11 99/1 105/12</p> <p><b>community</b> [11] 31/5 36/4 79/23 80/14 80/17 81/2 81/23 84/3 93/11 98/22 98/25</p> <p><b>community-based</b> [1] 84/3</p> <p><b>companies</b> [1] 97/1</p> <p><b>company</b> [2] 2/24 49/4</p> <p><b>comparative</b> [2] 35/2 35/10</p> <p><b>comparators</b> [1] 35/4</p> <p><b>compare</b> [2] 31/9 34/23</p> <p><b>compared</b> [4] 18/3 50/15 79/10 109/20</p> <p><b>comparison</b> [1] 106/23</p> <p><b>compassionate</b> [1] 84/25</p> <p><b>competencies</b> [1] 59/5</p> <p><b>competency</b> [1] 53/24</p> <p><b>competing</b> [1] 125/14</p> <p><b>complaints</b> [2] 90/23 91/1</p> <p><b>complemented</b> [1] 24/15</p> <p><b>complete</b> [1] 123/5</p> <p><b>completely</b> [1] 73/3</p> <p><b>complex</b> [5] 24/20 46/10 84/3 95/10 105/2</p> <p><b>complexity</b> [2] 71/20 113/25</p>

<p><b>C</b></p> <p><b>compliance [2]</b> 55/8 76/4</p> <p><b>complicated [3]</b> 43/19 45/3 45/9</p> <p><b>composition [1]</b> 85/11</p> <p><b>compounded [1]</b> 19/4</p> <p><b>comprehensive [2]</b> 85/24 89/25</p> <p><b>compromised [1]</b> 76/1</p> <p><b>concern [18]</b> 10/16 15/8 30/17 35/15 36/1 36/2 55/11 60/1 60/4 62/6 67/1 78/18 86/23 87/5 88/12 88/18 92/17 96/22</p> <p><b>concerned [4]</b> 66/15 83/8 90/9 95/1</p> <p><b>concerning [3]</b> 33/19 41/20 56/17</p> <p><b>concerns [14]</b> 16/8 38/24 50/25 51/1 51/5 73/8 76/7 78/25 79/6 82/17 89/4 89/23 104/14 121/4</p> <p><b>concluded [2]</b> 94/13 126/16</p> <p><b>concludes [1]</b> 118/5</p> <p><b>concluding [1]</b> 67/20</p> <p><b>conclusion [2]</b> 97/13 121/18</p> <p><b>concurrently [1]</b> 37/13</p> <p><b>condition [5]</b> 9/20 11/17 24/7 25/3 81/9</p> <p><b>conditions [18]</b> 24/4 24/7 24/14 24/22 34/7 34/10 34/11 81/21 84/7 91/20 95/14 97/7 101/7 103/17 106/18 106/21 109/23 113/3</p> <p><b>conduct [2]</b> 17/13 57/5</p> <p><b>conducted [1]</b> 12/16</p> <p><b>confidence [1]</b> 37/24</p> <p><b>confident [1]</b> 111/3</p> <p><b>confines [1]</b> 84/1</p> <p><b>confirm [1]</b> 21/8</p> <p><b>confirmation [4]</b> 62/13 63/8 64/25 66/10</p> <p><b>confusing [1]</b> 19/7</p> <p><b>confusion [5]</b> 42/15 42/21 46/25 47/11 80/20</p> <p><b>congratulate [1]</b> 69/6</p> <p><b>Congress [5]</b> 6/8 60/11 118/8 118/11 128/20</p> <p><b>consent [4]</b> 51/7</p>	<p>88/25 89/7 89/8</p> <p><b>consequence [2]</b> 73/4 117/3</p> <p><b>consequences [5]</b> 7/25 67/12 70/9 80/13 103/21</p> <p><b>consider [55]</b> 1/10 4/15 7/25 8/11 9/17 12/24 15/10 15/23 16/12 17/4 23/17 25/5 26/3 28/5 28/14 34/3 34/9 44/25 47/14 51/15 52/14 52/18 53/5 54/5 55/23 56/22 56/24 58/20 60/7 60/12 62/24 65/11 66/9 73/10 74/4 77/4 79/20 80/23 87/8 87/11 90/2 91/10 92/14 92/23 93/23 95/15 106/11 111/13 117/8 119/12 119/19 120/2 125/9 126/1 126/9</p> <p><b>considerable [2]</b> 88/23 91/4</p> <p><b>considerably [2]</b> 70/13 91/14</p> <p><b>consideration [27]</b> 5/10 8/21 11/15 30/6 34/11 42/12 44/3 50/4 52/1 59/2 61/25 73/15 80/1 81/15 88/4 88/12 93/25 107/10 107/18 111/20 112/20 113/10 113/17 113/18 113/23 114/9 122/21</p> <p><b>considerations [1]</b> 102/2</p> <p><b>considered [12]</b> 10/22 15/14 39/4 55/17 66/23 88/14 88/16 106/5 113/15 115/15 118/22 122/7</p> <p><b>considering [9]</b> 3/12 20/10 24/6 24/17 25/11 83/2 93/20 97/16 110/16</p> <p><b>considers [7]</b> 11/1 13/23 26/8 60/3 61/1 66/25 83/17</p> <p><b>consistency [1]</b> 45/21</p> <p><b>consistently [1]</b> 19/6</p> <p><b>consisting [1]</b> 98/24</p> <p><b>consists [1]</b> 109/2</p> <p><b>consortium [1]</b> 98/22</p> <p><b>constitutional [2]</b> 12/4 59/13</p> <p><b>construct [1]</b> 59/8</p> <p><b>construction [1]</b> 125/21</p> <p><b>constructive [1]</b> 125/25</p>	<p><b>consultants [1]</b> 97/8</p> <p><b>consultation [3]</b> 42/18 76/6 80/18</p> <p><b>consulted [1]</b> 63/25</p> <p><b>contact [3]</b> 40/5 42/6 95/4</p> <p><b>contained [3]</b> 74/16 74/19 74/21</p> <p><b>contaminants [1]</b> 51/22</p> <p><b>contemplation [1]</b> 11/19</p> <p><b>context [11]</b> 2/5 32/14 47/14 60/12 60/15 62/10 64/13 64/18 66/4 73/8 102/13</p> <p><b>continually [1]</b> 79/7</p> <p><b>continue [15]</b> 36/22 37/19 41/11 67/9 67/21 68/22 81/7 86/18 87/2 103/14 104/22 105/6 105/6 124/7 124/14</p> <p><b>continued [1]</b> 97/14</p> <p><b>continues [1]</b> 68/20</p> <p><b>contract [1]</b> 101/5</p> <p><b>contracted [2]</b> 58/12 68/2</p> <p><b>contracting [3]</b> 40/3 40/11 40/21</p> <p><b>contracts [6]</b> 32/9 41/10 96/10 100/16 105/2 109/5</p> <p><b>contractual [1]</b> 101/6</p> <p><b>contrary [1]</b> 12/17</p> <p><b>contrast [1]</b> 96/19</p> <p><b>contribute [4]</b> 26/21 26/22 93/2 114/18</p> <p><b>contributed [5]</b> 2/16 109/16 110/24 111/1 113/2</p> <p><b>contributing [1]</b> 109/10</p> <p><b>contribution [1]</b> 107/7</p> <p><b>control [18]</b> 9/12 10/1 19/1 19/3 19/10 23/19 32/6 36/11 40/22 51/14 63/9 63/14 92/16 107/22 108/1 110/8 113/14 117/18</p> <p><b>controlled [1]</b> 117/13</p> <p><b>Convention [2]</b> 6/19 20/3</p> <p><b>conversations [2]</b> 38/22 81/16</p> <p><b>conversely [1]</b> 18/16</p> <p><b>COPD [1]</b> 34/11</p> <p><b>cope [1]</b> 81/25</p> <p><b>copies [1]</b> 20/22</p> <p><b>core [78]</b> 1/12 1/17 4/12 5/11 5/13 5/17</p>	<p>5/23 6/10 6/11 6/25 7/4 7/5 7/6 10/25 11/6 11/11 13/3 15/1 16/25 20/22 20/24 21/10 21/13 21/19 21/23 22/10 22/16 25/17 25/18 26/2 26/15 27/24 28/19 28/23 29/16 30/21 35/16 38/3 49/15 54/22 55/9 55/13 55/14 55/15 55/22 56/13 58/10 60/24 61/14 66/9 66/16 67/14 70/5 70/25 73/2 74/2 76/9 78/12 78/13 78/19 79/5 86/23 87/10 88/9 90/1 90/9 91/9 95/9 95/21 97/3 97/13 108/18 109/6 111/11 114/21 116/8 122/15 125/17</p> <p><b>core participant [18]</b> 5/13 5/23 6/11 7/4 10/25 58/10 78/13 78/19 87/10 88/9 90/1 90/9 91/9 95/9 95/21 97/3 97/13 114/21</p> <p><b>core participants [47]</b> 1/12 1/17 4/12 5/11 5/17 6/25 11/6 11/11 13/3 15/1 16/25 20/22 20/24 21/10 21/13 21/19 21/23 22/10 22/16 25/17 25/18 26/2 26/15 27/24 28/19 30/21 35/16 38/3 54/22 55/13 55/14 55/15 55/22 56/13 60/24 61/14 66/9 66/16 67/14 70/5 70/25 73/2 78/12 79/5 111/11 116/8 125/17</p> <p><b>core participants' [1]</b> 86/23</p> <p><b>coronavirus [3]</b> 62/25 74/16 90/21</p> <p><b>correct [1]</b> 119/24</p> <p><b>COSLA [2]</b> 6/20 20/3</p> <p><b>cost [2]</b> 28/16 102/11</p> <p><b>could [15]</b> 28/15 31/7 35/22 51/4 68/8 72/16 74/1 80/14 82/23 82/24 97/18 100/6 103/3 103/9 112/16</p> <p><b>councils [7]</b> 17/20 17/22 17/24 18/5 18/18 19/2 19/17</p> <p><b>counsel [29]</b> 1/7 1/8 1/23 28/25 30/4 39/12 43/1 49/1 49/2 50/17 54/13 54/15 57/7 58/24 59/21 61/18</p>	<p>66/4 69/7 69/10 69/12 73/8 83/12 114/8 119/6 119/17 120/22 121/4 122/5 127/5</p> <p><b>counsel's [1]</b> 76/8</p> <p><b>countries [2]</b> 12/8 34/21</p> <p><b>country [3]</b> 12/7 101/4 117/9</p> <p><b>country's [1]</b> 12/12</p> <p><b>courage [1]</b> 124/7</p> <p><b>course [28]</b> 3/15 4/10 10/11 15/19 20/16 20/19 25/22 25/22 28/10 28/19 30/5 30/15 38/25 39/21 41/5 42/8 43/15 44/23 48/2 48/15 50/25 55/24 58/25 72/19 106/1 118/23 121/9 125/17</p> <p><b>court [1]</b> 38/16</p> <p><b>cover [6]</b> 21/15 32/24 60/19 67/3 95/13 103/24</p> <p><b>covered [6]</b> 11/18 17/15 24/7 52/23 53/22 73/2</p> <p><b>covering [1]</b> 26/13</p> <p><b>Covid [111]</b> 1/25 2/7 2/11 2/14 4/3 5/19 5/20 5/21 5/22 8/9 9/11 9/13 9/24 11/23 14/17 18/22 18/24 19/1 19/14 19/15 23/21 28/25 29/5 29/7 33/16 34/19 38/12 38/17 38/20 39/7 39/9 39/17 40/2 40/3 40/7 40/10 40/11 40/14 40/16 40/21 41/13 41/16 48/24 49/1 49/5 49/14 50/6 50/8 50/11 50/13 50/19 50/24 51/8 51/12 51/14 51/25 52/9 52/14 52/23 53/4 53/11 53/17 53/24 54/4 54/7 54/11 54/16 54/23 55/5 55/11 56/5 56/10 56/14 56/20 56/25 57/3 57/9 57/11 57/17 58/3 58/6 58/12 58/15 63/24 67/23 67/24 73/13 75/2 78/12 82/19 83/25 86/18 90/2 91/14 91/16 91/25 92/6 92/9 92/11 92/20 94/4 95/3 102/3 112/15 116/24 117/21 120/16 127/8 127/12 127/15 127/18</p> <p><b>Covid Inquiry [1]</b> 78/12</p>
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<p><b>C</b></p> <p><b>Covid-19 [39]</b> 1/25 2/11 2/14 4/3 5/20 8/9 9/11 9/13 9/24 14/17 18/22 18/24 19/1 19/14 19/15 23/21 34/19 38/12 40/3 50/13 50/19 58/3 58/12 58/15 67/23 82/19 83/25 86/18 90/2 91/14 91/16 91/25 92/6 92/9 92/20 94/4 112/15 127/12 127/18</p> <p><b>Covid-19-related [2]</b> 2/7 50/11</p> <p><b>Covid-positive [1]</b> 50/6</p> <p><b>Covid-related [2]</b> 39/7 39/9</p> <p><b>CP [1]</b> 74/22</p> <p><b>CPs [5]</b> 74/1 76/11 76/22 114/19 114/25</p> <p><b>CQC [3]</b> 82/16 90/13 90/15</p> <p><b>creates [1]</b> 102/15</p> <p><b>cries [1]</b> 36/13</p> <p><b>crisis [4]</b> 44/12 73/12 89/16 115/22</p> <p><b>criteria [2]</b> 25/4 25/7</p> <p><b>critical [7]</b> 14/5 14/20 73/19 79/8 94/10 111/20 116/13</p> <p><b>critically [1]</b> 78/15</p> <p><b>cross [2]</b> 32/8 87/13</p> <p><b>cross-section [1]</b> 87/13</p> <p><b>cross-sector [1]</b> 32/8</p> <p><b>crowded [1]</b> 105/21</p> <p><b>crucial [1]</b> 83/25</p> <p><b>Crucially [1]</b> 91/24</p> <p><b>cruel [2]</b> 42/11 68/5</p> <p><b>CTI [1]</b> 67/6</p> <p><b>CTI's [1]</b> 66/25</p> <p><b>cumbersome [1]</b> 82/11</p> <p><b>curation [1]</b> 72/22</p> <p><b>Curtain [5]</b> 123/5 123/6 123/12 125/4 128/23</p> <p><b>cut [2]</b> 41/25 73/3</p> <p><b>Cymru [34]</b> 5/21 11/24 58/4 58/7 58/8 58/10 58/13 58/17 59/12 60/1 60/23 60/25 61/8 61/13 62/6 62/12 62/23 63/8 63/22 64/13 64/20 65/14 65/18 65/24 66/8 66/15 66/23 67/6 67/16 67/20 68/19 68/22 74/15 127/19</p>	<p><b>D</b></p> <p><b>da [1]</b> 123/11</p> <p><b>dad [1]</b> 68/4</p> <p><b>Dad's [1]</b> 68/14</p> <p><b>data [9]</b> 2/18 66/7 76/6 82/10 82/18 82/19 92/2 109/13 120/13</p> <p><b>date [4]</b> 22/24 27/7 38/6 64/10</p> <p><b>dated [1]</b> 83/12</p> <p><b>David [1]</b> 49/3</p> <p><b>David Welsh [1]</b> 49/3</p> <p><b>day [5]</b> 7/20 60/21 81/24 111/24 111/25</p> <p><b>daycare [1]</b> 8/4</p> <p><b>days [1]</b> 67/25</p> <p><b>de [1]</b> 22/2</p> <p><b>deaf [1]</b> 52/22</p> <p><b>deal [5]</b> 30/18 43/4 43/14 47/14 52/7</p> <p><b>dealing [2]</b> 21/6 66/2</p> <p><b>death [9]</b> 4/3 36/4 42/22 91/24 91/25 94/1 94/3 100/23 109/16</p> <p><b>deaths [19]</b> 2/7 2/10 2/14 2/15 9/23 9/24 14/18 31/22 39/7 39/9 39/18 49/22 50/11 50/15 50/16 50/19 90/2 91/15 92/18</p> <p><b>deceased [1]</b> 63/25</p> <p><b>deciding [1]</b> 26/6</p> <p><b>decision [19]</b> 8/1 17/23 28/18 45/13 51/4 55/9 59/11 62/1 62/4 64/1 65/20 79/7 79/11 81/4 82/14 89/21 90/4 116/16 116/20</p> <p><b>decision-makers [3]</b> 55/9 79/7 81/4</p> <p><b>decision-making [11]</b> 8/1 17/23 45/13 59/11 62/1 65/20 79/11 82/14 89/21 90/4 116/20</p> <p><b>decisions [18]</b> 2/16 8/5 9/3 9/5 9/21 10/17 12/7 27/18 28/6 49/21 49/22 49/24 79/19 80/24 89/1 92/4 96/18 124/18</p> <p><b>decline [2]</b> 75/15 94/14</p> <p><b>dedicated [3]</b> 81/5 86/5 108/25</p> <p><b>dedication [2]</b> 85/11 124/7</p> <p><b>deep [2]</b> 73/6 124/2</p> <p><b>deep dive [1]</b> 73/6</p> <p><b>deeply [2]</b> 33/18</p>	<p>86/18</p> <p><b>deferred [1]</b> 18/6</p> <p><b>deficiencies [1]</b> 62/16</p> <p><b>definition [2]</b> 72/7 83/22</p> <p><b>definitions [2]</b> 60/25 61/6</p> <p><b>degree [1]</b> 33/5</p> <p><b>delay [2]</b> 4/25 95/11</p> <p><b>delayed [1]</b> 62/20</p> <p><b>delays [5]</b> 18/24 18/25 19/2 41/12 41/14</p> <p><b>deliver [1]</b> 109/25</p> <p><b>delivered [3]</b> 32/5 84/10 120/10</p> <p><b>delivering [1]</b> 80/1</p> <p><b>delivery [2]</b> 75/25 82/10</p> <p><b>demand [1]</b> 101/6</p> <p><b>demands [4]</b> 19/21 90/19 101/11 125/14</p> <p><b>dementia [20]</b> 24/19 34/2 36/8 47/5 51/25 52/22 68/6 81/20 91/24 93/23 93/25 94/2 94/5 94/7 94/14 94/15 94/19 95/2 95/4 97/7</p> <p><b>demographics [1]</b> 14/9</p> <p><b>demonstrate [1]</b> 26/19</p> <p><b>demotivated [1]</b> 68/11</p> <p><b>denied [1]</b> 94/17</p> <p><b>deny [1]</b> 72/10</p> <p><b>Department [3]</b> 6/17 6/17 46/13</p> <p><b>departments [1]</b> 16/20</p> <p><b>departure [1]</b> 35/15</p> <p><b>depend [3]</b> 79/16 86/5 94/7</p> <p><b>dependent [5]</b> 95/17 102/19 103/22 104/24 106/9</p> <p><b>dependents [1]</b> 77/3</p> <p><b>depending [1]</b> 111/6</p> <p><b>depends [1]</b> 118/20</p> <p><b>depict [1]</b> 46/25</p> <p><b>deployment [2]</b> 11/17 81/10</p> <p><b>depression [1]</b> 94/23</p> <p><b>deprivation [2]</b> 89/1 89/3</p> <p><b>deprive [1]</b> 90/17</p> <p><b>deprived [1]</b> 107/12</p> <p><b>deputyship [1]</b> 64/2</p> <p><b>derived [1]</b> 76/4</p> <p><b>describe [2]</b> 71/1 119/18</p> <p><b>describing [1]</b> 71/19</p>	<p><b>descriptive [1]</b> 71/18</p> <p><b>deserved [1]</b> 68/10</p> <p><b>design [2]</b> 72/11 77/9</p> <p><b>designated [3]</b> 7/1 7/5 78/11</p> <p><b>designation [1]</b> 5/10</p> <p><b>designed [2]</b> 10/8 26/21</p> <p><b>despair [1]</b> 82/4</p> <p><b>desperately [1]</b> 121/22</p> <p><b>destitute [1]</b> 103/18</p> <p><b>destitution [1]</b> 104/21</p> <p><b>detail [4]</b> 72/19 87/2 122/18 122/20</p> <p><b>detailed [3]</b> 21/4 44/3 90/5</p> <p><b>deteriorated [1]</b> 109/25</p> <p><b>deterioration [4]</b> 52/17 81/22 89/6 94/23</p> <p><b>deteriorations [1]</b> 91/20</p> <p><b>determinant [1]</b> 100/24</p> <p><b>determination [4]</b> 20/21 59/3 125/17 126/9</p> <p><b>determined [1]</b> 21/7</p> <p><b>determining [1]</b> 113/24</p> <p><b>devastated [1]</b> 68/10</p> <p><b>devastating [5]</b> 1/25 40/17 67/12 80/13 109/12</p> <p><b>devastation [1]</b> 67/22</p> <p><b>developed [4]</b> 11/8 34/22 79/24 113/15</p> <p><b>development [1]</b> 23/20</p> <p><b>developmental [1]</b> 95/11</p> <p><b>devolution [1]</b> 59/7</p> <p><b>devolved [10]</b> 8/24 9/4 12/5 47/21 53/24 58/23 59/5 59/6 59/23 62/2</p> <p><b>diabetes [1]</b> 34/12</p> <p><b>diagnosis [1]</b> 41/13</p> <p><b>diaspora [1]</b> 99/1</p> <p><b>did [13]</b> 7/4 54/9 64/5 68/6 75/3 80/22 103/12 105/10 106/1 106/4 108/23 110/6 122/11</p> <p><b>didn't [1]</b> 41/23</p> <p><b>die [1]</b> 101/2</p> <p><b>died [17]</b> 2/22 32/1 39/16 39/20 39/24 40/10 41/2 41/25 42/20 42/20 49/17 49/20 50/13 67/24</p>	<p>68/8 91/21 106/1</p> <p><b>differences [6]</b> 12/12 18/8 23/11 25/20 30/19 51/9</p> <p><b>different [17]</b> 12/6 12/7 12/8 13/20 17/7 20/8 23/12 30/4 32/4 52/10 72/1 83/14 87/21 95/14 111/1 112/10 112/16</p> <p><b>differently [1]</b> 87/23</p> <p><b>difficult [11]</b> 19/3 35/19 38/19 52/7 52/21 96/15 96/24 105/22 110/16 120/5 123/21</p> <p><b>difficulties [11]</b> 19/4 24/18 24/19 24/20 24/25 36/23 47/6 54/24 55/2 95/12 110/8</p> <p><b>dignified [2]</b> 68/9 106/7</p> <p><b>dignity [2]</b> 36/4 79/17</p> <p><b>diminish [1]</b> 14/13</p> <p><b>diolch [2]</b> 69/2 125/3</p> <p><b>Diolch yn [1]</b> 69/2</p> <p><b>dire [2]</b> 43/22 111/16</p> <p><b>direct [2]</b> 40/19 82/10</p> <p><b>directed [1]</b> 46/20</p> <p><b>direction [2]</b> 46/13 120/12</p> <p><b>Directors [1]</b> 6/12</p> <p><b>disabilities [11]</b> 33/13 34/5 36/9 72/12 81/20 84/6 84/7 84/16 87/17 95/10 95/13</p> <p><b>Disability [6]</b> 5/25 5/25 6/1 69/22 69/23 69/23</p> <p><b>Disability Wales [2]</b> 6/1 69/23</p> <p><b>disabled [20]</b> 6/3 25/1 28/13 36/20 69/18 69/20 69/24 69/25 70/2 70/10 71/3 72/9 72/12 72/15 75/21 76/5 76/25 77/2 77/6 127/21</p> <p><b>disadvantage [2]</b> 18/10 79/10</p> <p><b>disadvantaged [1]</b> 100/2</p> <p><b>discharge [12]</b> 9/6 10/17 40/16 49/24 50/1 62/4 62/12 89/22 89/24 99/22 113/11 119/12</p> <p><b>discharged [5]</b> 18/19 27/19 50/6 99/24 104/2</p> <p><b>discharges [1]</b> 80/16</p> <p><b>discharging [3]</b> 8/6 40/14 62/9</p>
--	---	--	--	---

<b>D</b>	88/8 109/2 113/19 <b>diversity [2]</b> 79/9 88/5 <b>diverted [1]</b> 82/9 <b>division [1]</b> 12/9 <b>divisions [1]</b> 65/3 <b>DNACPR [6]</b> 27/17 42/17 51/3 53/16 64/3 67/18 <b>DNACPRs [7]</b> 9/18 9/21 50/25 51/7 51/9 63/23 89/1 <b>do [26]</b> 7/13 9/17 14/1 15/9 15/25 26/23 35/14 39/21 46/25 63/20 69/9 71/23 71/25 72/21 73/3 73/9 75/24 76/1 76/1 78/19 81/14 110/11 121/24 122/19 122/22 123/1 <b>document [4]</b> 7/18 7/19 42/25 66/6 <b>documentation [2]</b> 10/9 20/13 <b>documented [1]</b> 105/13 <b>documents [6]</b> 20/25 21/16 21/24 21/25 22/11 66/16 <b>does [10]</b> 10/19 15/18 36/25 37/5 72/2 72/7 73/6 87/7 121/20 122/6 <b>doesn't [4]</b> 14/2 39/18 46/2 102/13 <b>doing [3]</b> 34/20 37/20 73/24 <b>domains [1]</b> 116/13 <b>domestic [1]</b> 87/9 <b>domiciliary [8]</b> 3/7 30/25 31/20 31/22 41/3 67/4 87/24 118/19 <b>don't [5]</b> 4/21 24/21 58/17 69/5 106/6 <b>done [7]</b> 70/22 70/24 71/25 73/23 75/9 96/3 102/25 <b>doorsteps [1]</b> 110/18 <b>Dorland [3]</b> 4/20 5/9 28/11 <b>Dorland House [3]</b> 4/20 5/9 28/11 <b>doubt [6]</b> 20/19 26/4 26/6 65/1 119/24 125/16 <b>doubtless [2]</b> 2/17 15/10 <b>down [4]</b> 82/21 82/23 82/25 102/3 <b>Down's [1]</b> 47/6 <b>Down's Syndrome [1]</b> 47/6 <b>downtrodden [1]</b>	44/15 <b>DPO [8]</b> 69/24 70/4 70/15 72/4 74/7 74/25 75/14 76/24 <b>Dr [4]</b> 77/16 77/18 86/8 128/3 <b>Dr Townson [2]</b> 77/16 86/8 <b>draft [2]</b> 22/20 25/19 <b>drafting [1]</b> 22/18 <b>drawing [4]</b> 78/22 81/2 82/2 83/5 <b>drawn [1]</b> 79/4 <b>dress [1]</b> 13/14 <b>drew [1]</b> 79/6 <b>dropping [1]</b> 121/14 <b>drove [1]</b> 82/21 <b>drugs [1]</b> 89/5 <b>due [21]</b> 10/11 14/7 15/19 20/16 25/22 28/10 28/19 30/15 40/24 40/25 41/4 43/15 48/6 63/24 67/22 68/5 81/15 103/20 107/15 116/17 125/16 <b>duplication [2]</b> 22/2 53/19 <b>duplicative [1]</b> 82/11 <b>during [39]</b> 8/25 16/1 18/6 18/13 20/19 23/16 25/23 27/5 31/23 31/25 33/20 36/2 36/5 42/1 43/19 46/11 50/25 61/23 64/15 70/8 80/6 85/16 86/16 90/11 90/22 91/6 91/16 92/18 93/10 94/9 94/21 96/9 105/4 108/23 112/19 122/12 124/1 124/4 124/5 <b>duties [7]</b> 45/16 75/4 88/13 88/19 89/2 89/9 89/15 <b>duty [3]</b> 63/4 88/20 88/21 <b>dying [1]</b> 2/24	<b>easement [2]</b> 75/7 75/12 <b>easements [2]</b> 62/25 74/14 <b>easily [2]</b> 46/2 97/18 <b>East [1]</b> 99/2 <b>easy [1]</b> 89/15 <b>echo [3]</b> 67/13 116/7 120/15 <b>echoed [1]</b> 36/20 <b>economy [3]</b> 93/2 99/9 101/21 <b>Edinburgh [1]</b> 53/3 <b>education [1]</b> 108/23 <b>effect [5]</b> 13/8 23/12 42/7 63/1 102/10 <b>effective [2]</b> 14/10 76/21 <b>effectively [6]</b> 36/24 38/3 38/4 41/24 100/3 105/20 <b>effects [1]</b> 116/17 <b>efficient [1]</b> 126/7 <b>efficiently [1]</b> 12/16 <b>effort [2]</b> 55/6 73/19 <b>eight [3]</b> 8/15 18/18 39/14 <b>eight weeks [1]</b> 39/14 <b>either [5]</b> 19/11 42/25 47/9 74/11 105/7 <b>elastic [1]</b> 104/6 <b>elderly [2]</b> 3/13 10/25 <b>electronic [1]</b> 52/20 <b>element [1]</b> 51/22 <b>elevated [1]</b> 69/7 <b>eligibility [2]</b> 25/4 25/6 <b>eligible [1]</b> 63/4 <b>eloquent [1]</b> 125/9 <b>else [3]</b> 27/11 68/18 97/19 <b>elsewhere [1]</b> 100/4 <b>emanating [1]</b> 62/19 <b>emergencies [1]</b> 72/17 <b>emergency [4]</b> 27/20 74/8 75/3 82/5 <b>emerges [1]</b> 15/13 <b>eminent [1]</b> 35/10 <b>emotionally [1]</b> 110/3 <b>emphasis [2]</b> 14/20 51/18 <b>emphasise [4]</b> 88/6 97/15 99/14 124/21 <b>emphasised [1]</b> 19/6 <b>employed [9]</b> 100/8 104/7 105/1 109/4 109/5 109/14 113/20 113/21 124/9 <b>employee [1]</b> 96/23 <b>employer [2]</b> 96/23 104/10 <b>employer/employee [1]</b> 96/23	<b>employers [4]</b> 101/7 101/11 104/19 105/7 <b>employment [17]</b> 71/22 96/6 99/10 99/15 101/1 101/5 101/10 101/24 102/1 102/9 104/24 106/22 107/1 107/4 107/15 111/6 113/4 <b>employment-depend ent [1]</b> 104/24 <b>employment-linked [1]</b> 102/9 <b>empower [1]</b> 77/6 <b>enable [5]</b> 12/11 59/14 72/1 77/5 124/23 <b>enabled [1]</b> 84/22 <b>enables [1]</b> 70/19 <b>enabling [1]</b> 70/3 <b>enacted [1]</b> 43/25 <b>encompass [1]</b> 60/4 <b>encompasses [3]</b> 10/23 13/11 84/2 <b>encourage [1]</b> 111/12 <b>encourages [1]</b> 27/11 <b>end [6]</b> 27/17 52/17 67/13 67/19 71/6 76/20 <b>endeavour [1]</b> 103/14 <b>ending [1]</b> 2/6 <b>endorse [4]</b> 47/15 47/16 95/22 106/14 <b>endorsed [1]</b> 62/8 <b>endured [1]</b> 86/2 <b>enforced [1]</b> 89/7 <b>engage [1]</b> 36/24 <b>engaged [1]</b> 109/5 <b>engagement [1]</b> 62/15 <b>engaging [1]</b> 57/12 <b>England [27]</b> 2/8 3/19 6/9 7/23 11/18 13/1 17/7 17/9 17/14 19/9 30/6 31/23 50/12 61/21 71/25 72/6 74/19 75/13 77/18 77/22 77/25 78/3 78/4 93/1 112/22 119/8 128/2 <b>English [2]</b> 18/5 18/18 <b>enormous [1]</b> 85/13 <b>enough [2]</b> 32/24 52/11 <b>enquire [1]</b> 11/3 <b>enquiry [7]</b> 27/24 28/4 57/6 57/7 66/24 67/2 67/7 <b>ensure [9]</b> 4/16 21/10 21/11 38/4 51/6 55/6
----------	--	--	---	---

<b>E</b>	114/2	96/1 104/3 110/24	56/12 56/15 61/10	37/14 37/19 38/13
<b>ensure... [3]</b> 59/15 67/4 106/12	<b>ever-changing [1]</b> 110/7	<b>examples [5]</b> 31/13 102/16 104/13 104/18 105/16	65/25 66/5 66/10 71/16 74/4 83/6 97/5 97/6 97/7 97/9 114/13	38/18 42/1 42/14 43/5 45/11 46/15 46/23 47/11 58/3 58/7 67/9 71/13 72/25 73/13 73/14 81/25 92/11 106/3 110/15 112/15 127/9 127/12 127/19
<b>ensured [1]</b> 99/24	<b>ever-evolving [1]</b> 114/2	<b>exasperated [1]</b> 94/22	<b>explains [1]</b> 4/6	<b>families' [2]</b> 32/1 37/23
<b>ensures [1]</b> 85/20	<b>every [18]</b> 7/14 15/8 26/9 26/10 26/13 26/20 27/8 27/13 37/17 49/12 55/6 57/2 66/20 66/24 73/7 93/2 122/23 124/25	<b>exceptional [1]</b> 124/14	<b>exploration [3]</b> 35/22 61/15 108/3	<b>family [19]</b> 2/21 36/4 36/17 42/2 42/6 42/12 42/21 45/21 63/25 68/8 81/17 89/11 94/8 94/16 94/16 95/5 95/20 96/24 110/12
<b>ensuring [3]</b> 46/22 51/2 78/21	<b>everyone [3]</b> 1/4 1/14 26/22	<b>exceptionally [2]</b> 31/14 31/14	<b>explore [6]</b> 30/9 62/4 62/13 68/23 106/20 112/4	<b>far [15]</b> 32/12 40/10 40/17 40/20 41/2 41/25 41/25 42/14 42/16 42/20 55/4 77/1 84/1 88/14 93/15
<b>entering [2]</b> 63/10 76/20	<b>everything [1]</b> 47/16	<b>excess [2]</b> 31/22 91/15	<b>explored [3]</b> 30/8 48/4 64/16	<b>far-reaching [2]</b> 40/17 93/15
<b>entire [2]</b> 83/4 126/3	<b>evidence [83]</b> 7/9 7/11 10/6 10/13 11/6 11/10 15/13 15/18 16/15 16/25 17/6 20/11 23/3 24/3 24/8 24/14 24/15 24/16 25/2 25/14 26/4 26/16 33/6 33/15 33/17 33/22 34/1 34/3 34/15 34/17 35/12 36/13 36/19 37/5 37/20 41/21 43/9 43/12 43/13 43/21 44/5 44/17 44/20 45/24 48/11 53/20 54/25 55/3 55/7 56/8 64/9 64/19 65/12 66/2 66/14 67/5 67/15 67/17 68/24 71/11 83/19 85/23 86/25 87/1 88/14 88/19 88/23 90/6 91/4 95/21 95/23 96/2 107/21 107/23 112/17 114/14 114/23 114/24 114/25 121/17 122/14 122/23 122/24	<b>exclusively [3]</b> 25/25 78/10 109/1	<b>express [1]</b> 70/23	<b>fatalities [1]</b> 70/11
<b>entirely [5]</b> 34/25 37/10 37/25 121/8 124/16	<b>evincing [1]</b> 110/9	<b>exercise [3]</b> 7/14 22/2 26/9	<b>expressly [2]</b> 11/20 33/3	<b>father [2]</b> 67/24 68/2
<b>environment [2]</b> 102/14 107/20	<b>evidently [1]</b> 101/17	<b>exhaustion [1]</b> 109/24	<b>extend [1]</b> 107/14	<b>fault [1]</b> 119/2
<b>environments [2]</b> 102/18 103/8	<b>evolving [1]</b> 114/2	<b>exhibits [2]</b> 22/22 72/23	<b>extended [2]</b> 39/14 82/1	<b>fawr [1]</b> 69/2
<b>envisaged [2]</b> 23/9 122/16	<b>exacerbated [2]</b> 82/3 101/19	<b>existed [1]</b> 119/14	<b>extra [1]</b> 61/5	<b>fear [3]</b> 42/14 105/24 122/2
<b>equal [1]</b> 59/15	<b>examination [1]</b> 31/20	<b>existing [1]</b> 80/7	<b>extraordinary [2]</b> 110/14 120/8	<b>fearful [1]</b> 103/19
<b>equality [5]</b> 65/8 88/20 88/20 94/18 99/13	<b>examine [16]</b> 7/21 8/9 8/15 9/9 10/19 13/22 14/21 15/2 15/7 53/12 64/20 65/25 77/4 83/16 107/2 124/16	<b>expand [1]</b> 61/14	<b>extremely [1]</b> 103/5	<b>fearless [1]</b> 121/18
<b>Equality Act [2]</b> 88/20 99/13	<b>examined [3]</b> 2/17 30/5 88/18	<b>expanded [1]</b> 67/3	<b>face [6]</b> 25/22 52/19 52/19 55/2 79/21 104/10	<b>feasibility [1]</b> 28/16
<b>equally [3]</b> 61/25 74/3 87/22	<b>examining [3]</b> 23/4 53/9 123/18	<b>expanding [1]</b> 85/3	<b>faced [8]</b> 39/23 54/24 85/12 87/19 93/7 96/22 105/12 119/1	<b>Featherstone [1]</b> 108/15
<b>equipment [6]</b> 9/15 41/9 41/18 41/23 116/15 116/19	<b>example [21]</b> 3/24 11/16 13/10 13/13 17/24 32/13 47/1 55/1 60/25 65/5 79/20 87/25 89/20 90/13 92/2 94/12 95/2 95/11	<b>expectation [1]</b> 105/6	<b>facilitate [1]</b> 96/24	<b>feature [3]</b> 5/3 8/17 101/21
<b>equipped [1]</b> 44/22		<b>expected [2]</b> 21/18 50/3	<b>facilities [4]</b> 40/25 87/21 88/2 91/11	<b>features [1]</b> 122/11
<b>equivalent [1]</b> 93/4		<b>experience [15]</b> 8/18 33/12 36/16 40/1 40/9 43/6 51/8 56/17 67/21 72/11 86/16 98/15 106/11 111/15 124/17	<b>fact [8]</b> 3/5 10/17 12/5 16/1 44/2 61/1 75/5 75/11	<b>feed [1]</b> 4/25
<b>erroneous [1]</b> 83/10		<b>experienced [6]</b> 42/14 42/16 64/12 67/21 105/23 123/25	<b>factories [1]</b> 96/24	<b>feedback [1]</b> 22/20
<b>especially [3]</b> 71/23 75/14 75/20		<b>experiences [14]</b> 26/11 26/14 27/8 31/12 49/19 52/13 67/11 83/4 84/24 84/24 85/17 118/17 118/18 118/23	<b>facings [3]</b> 104/21 104/21 119/13	<b>feelings [1]</b> 82/3
<b>essence [1]</b> 63/1		<b>expert [41]</b> 22/25 23/1 23/3 23/7 23/9 23/16 23/19 24/3 24/8 24/14 24/15 25/2 25/14 25/15 25/17 25/19 25/21 26/4 33/22 33/24 34/1 34/3 34/17 47/17 47/23 49/11 56/4 56/7 56/24 65/22 66/14 73/25 87/1 90/7 95/21 95/22 96/2 97/8 107/21 114/14 122/23	<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>felt [5]</b> 3/3 18/2 40/2 41/10 42/11
<b>essential [14]</b> 29/18 33/13 51/22 79/16 82/1 83/3 89/11 94/8 95/5 95/6 95/20 96/25 110/16 115/16		<b>expertise [9]</b> 34/16 47/21 48/1 66/1 66/6 80/21 85/23 86/15 97/10	<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>FENELLA [2]</b> 115/10 128/17
<b>essentially [1]</b> 12/21		<b>experts [24]</b> 23/10 25/24 26/3 35/10 35/14 35/17 35/21 37/1 47/12 47/20	<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>few [5]</b> 1/21 37/11 75/12 82/13 121/23
<b>establish [1]</b> 75/16			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>field [1]</b> 35/10
<b>established [2]</b> 21/2 26/10			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>fields [1]</b> 97/10
<b>estimate [2]</b> 38/7 38/22			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>fiercely [1]</b> 89/18
<b>estimated [1]</b> 3/19			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>fifth [4]</b> 41/25 63/20 91/9 114/7
<b>estimates [1]</b> 107/6			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>fifthly [1]</b> 62/21
<b>ethnic [6]</b> 3/23 99/11 100/18 105/11 107/17 109/21			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>fifths [2]</b> 18/4 19/9
<b>ethnically [1]</b> 109/1			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>figure [5]</b> 39/1 39/11 39/11 39/18 100/15
<b>ethnicity [1]</b> 99/17			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>figures [3]</b> 2/17 39/15 39/21
<b>evaluation [1]</b> 107/13			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>file [1]</b> 74/2
<b>even [9]</b> 52/11 64/4 68/15 82/2 89/16 96/23 101/4 101/7 104/22			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>Filipino [1]</b> 98/24
<b>event [3]</b> 10/22 14/25 103/18			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>filling [1]</b> 101/22
<b>events [1]</b> 27/9			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>films [1]</b> 64/9
<b>ever [3]</b> 68/6 110/7			<b>factories [4]</b> 40/25 87/21 88/2 91/11	<b>filtration [1]</b> 51/21



<b>F</b>	<b>follow</b> [1] 98/14 <b>followed</b> [1] 4/19 <b>following</b> [10] 1/14 2/4 4/12 5/5 17/20 21/22 38/16 40/8 59/1 60/5 <b>follows</b> [2] 14/19 76/11 <b>forced</b> [2] 99/22 104/8 <b>fore</b> [1] 42/24 <b>forefront</b> [1] 30/16 <b>foreseen</b> [1] 73/22 <b>foretold</b> [1] 70/13 <b>Forgive</b> [1] 70/17 <b>forgotten</b> [1] 85/21 <b>form</b> [4] 26/16 47/2 94/16 117/12 <b>fortunate</b> [1] 52/11 <b>Forum</b> [10] 6/9 61/20 65/9 72/5 74/23 77/17 77/22 77/24 88/3 128/2 <b>forward</b> [8] 33/5 53/25 54/17 57/11 71/7 78/14 85/7 93/18 <b>found</b> [2] 87/15 103/17 <b>Foundation</b> [1] 31/21 <b>founder</b> [1] 108/15 <b>four</b> [17] 6/22 23/12 23/17 29/21 30/4 30/11 30/18 31/1 55/10 59/9 59/17 60/13 67/25 69/20 71/24 75/23 84/19 <b>four days</b> [1] 67/25 <b>four nations</b> [8] 23/17 29/21 55/10 59/9 59/17 60/13 71/24 75/23 <b>fourth</b> [4] 63/6 75/20 90/9 114/3 <b>fourthly</b> [2] 41/12 62/20 <b>fragility</b> [1] 71/20 <b>fragmentation</b> [1] 71/20 <b>fragmented</b> [3] 31/4 112/21 120/10 <b>framework</b> [1] 11/2 <b>free</b> [2] 8/5 99/22 <b>frequent</b> [1] 104/13 <b>frequently</b> [3] 18/12 81/4 104/9 <b>Friedman</b> [7] 69/4 69/14 69/19 77/13 115/22 117/24 127/22 <b>friend</b> [1] 39/12 <b>friends</b> [2] 2/21 89/11 <b>front</b> [2] 7/17 69/6 <b>frontline</b> [7] 6/5 65/12 71/3 98/5 98/9	122/25 128/9 <b>fulfilled</b> [1] 113/19 <b>fulfilling</b> [2] 4/14 84/23 <b>full</b> [7] 48/11 87/2 100/13 109/3 117/17 121/18 123/16 <b>fullness</b> [1] 48/4 <b>fully</b> [3] 54/5 60/16 124/21 <b>function</b> [2] 120/6 121/13 <b>functional</b> [1] 94/20 <b>functions</b> [1] 90/12 <b>fundamental</b> [3] 51/16 81/17 106/17 <b>funded</b> [5] 7/22 13/1 23/11 27/4 112/10 <b>funding</b> [6] 44/24 45/18 82/6 93/5 112/7 112/11 <b>funds</b> [1] 103/17 <b>funeral</b> [1] 68/9 <b>funnel</b> [1] 121/25 <b>further</b> [22] 5/5 10/10 11/8 12/17 12/19 26/5 28/9 32/11 33/7 38/9 48/19 50/1 56/10 61/11 61/13 62/4 65/15 67/15 82/21 116/5 117/20 123/3 <b>furthermore</b> [2] 21/3 35/6 <b>future</b> [19] 14/16 14/25 25/14 28/9 29/24 35/8 45/1 48/16 69/1 76/17 77/9 85/9 86/3 90/4 111/22 114/12 117/6 118/2 124/24	85/17 98/13 <b>given</b> [27] 5/14 10/16 12/4 15/18 21/4 33/13 33/19 35/18 36/6 44/4 48/11 50/4 51/23 52/1 53/21 55/18 64/9 67/15 72/4 74/25 96/20 107/11 107/12 107/25 113/10 114/9 118/4 <b>gives</b> [1] 4/4 <b>giving</b> [4] 7/11 56/8 105/2 109/7 <b>gladly</b> [1] 20/6 <b>glaring</b> [1] 80/21 <b>global</b> [1] 95/11 <b>GMB</b> [1] 118/15 <b>go</b> [7] 1/19 27/12 45/14 74/2 76/12 103/2 103/2 <b>goes</b> [3] 32/12 38/1 76/10 <b>going</b> [6] 2/2 27/13 38/11 71/10 77/16 120/7 <b>gone</b> [2] 72/20 111/11 <b>good</b> [7] 1/4 31/14 58/6 75/13 86/12 118/10 123/11 <b>goodbye</b> [1] 2/21 <b>got</b> [4] 82/24 102/21 123/7 123/10 <b>governance</b> [1] 29/24 <b>government</b> [34] 6/13 6/14 6/21 7/25 9/4 16/20 17/13 18/2 19/8 46/2 54/25 56/18 62/2 62/7 70/7 79/21 80/4 82/6 87/25 90/18 99/21 117/10 123/6 123/12 123/13 123/16 123/20 123/24 124/2 124/11 124/19 124/21 124/25 128/23 <b>government's</b> [5] 53/24 62/15 99/23 102/7 102/14 <b>governmental</b> [1] 65/4 <b>Governments</b> [1] 49/21 <b>Gowman</b> [4] 58/2 58/4 69/3 127/19 <b>GPs</b> [1] 50/2 <b>granted</b> [4] 5/14 7/3 78/13 78/19 <b>granting</b> [1] 58/9 <b>grateful</b> [21] 10/13 17/1 20/2 28/2 29/3 33/25 48/21 49/14 77/14 78/24 97/14 103/5 109/7 114/7	114/16 115/1 115/2 115/7 119/6 123/13 123/14 <b>gratitude</b> [2] 70/23 124/12 <b>grave</b> [3] 68/12 68/14 85/1 <b>great</b> [9] 36/2 43/4 43/5 43/14 47/14 70/6 98/22 124/7 126/1 <b>Great Britain</b> [1] 98/22 <b>greater</b> [2] 20/19 101/7 <b>greatly</b> [2] 13/10 37/7 <b>green</b> [1] 123/7 <b>grief</b> [1] 105/23 <b>gross</b> [1] 84/13 <b>ground</b> [4] 63/7 63/17 65/14 73/1 <b>grounds</b> [1] 39/24 <b>group</b> [71] 5/23 6/5 6/10 6/11 7/7 33/14 38/23 41/21 42/24 43/4 46/4 58/8 58/10 58/11 58/13 58/17 58/19 59/12 60/1 60/2 60/23 60/25 61/8 61/9 61/13 62/3 62/7 62/12 62/23 63/8 64/13 64/20 64/24 65/14 65/18 65/24 66/8 66/15 66/23 67/2 67/6 67/16 68/19 68/22 74/12 74/15 80/22 87/10 88/9 90/1 90/9 91/9 93/1 93/24 95/9 95/9 95/18 95/22 97/4 97/13 97/18 98/6 98/10 98/16 98/20 99/9 99/14 102/15 103/25 109/8 128/10 <b>group's</b> [5] 63/22 67/21 98/13 105/23 106/11 <b>groups</b> [10] 3/23 16/24 27/25 57/14 65/4 77/6 78/5 86/24 93/18 98/25 <b>guardianship</b> [1] 89/9 <b>guidance</b> [25] 19/7 23/24 41/20 45/19 45/22 47/3 47/10 51/15 52/2 65/13 79/19 79/21 79/24 80/3 80/5 81/11 81/19 88/1 104/11 110/7 113/9 113/12 113/18 113/24 117/18 <b>guidelines</b> [1] 18/9
			<b>H</b>	
			<b>had</b> [27] 4/7 19/14	

H				
<p><b>had...</b> [25] 19/16 28/5 40/16 41/10 41/14 42/17 43/24 50/4 50/13 63/1 63/17 63/19 64/4 78/17 96/7 97/1 101/13 101/21 103/16 107/19 111/17 112/14 112/21 125/18 126/9</p>	<p>43/7 43/21 46/7 47/13 47/21 48/3 49/5 50/24 53/3 54/9 55/11 55/14 56/16 56/21 58/1 58/14 58/24 64/24 66/1 67/9 68/10 70/15 72/21 73/4 73/21 73/25 74/21 76/1 76/2 76/11 77/15 78/1 78/11 83/19 85/12 85/25 87/4 87/16 90/5 92/11 92/21 95/4 95/23 96/1 96/3 97/3 97/4 100/21 101/4 102/16 102/21 104/18 104/24 104/25 105/25 106/14 108/7 111/11 112/1 112/19 113/1 113/2 114/15 114/16 114/22 114/25 115/2 119/3 123/7 125/16 125/18 125/25 126/5 126/12</p>	<p>4/24 5/7 5/15 5/17 7/11 28/10 28/11 28/16 52/22 53/25 66/19 69/16 87/3 117/16 126/12 126/13 126/16</p>	<p><b>hitting</b> [1] 115/24 <b>hold</b> [2] 109/23 110/25 <b>home</b> [51] 3/8 4/2 8/3 10/1 13/9 13/11 13/17 13/24 14/1 27/2 27/6 32/2 39/10 39/17 39/19 39/20 40/23 41/3 41/6 41/6 41/13 41/17 50/5 50/10 56/19 60/20 67/25 68/2 72/7 72/9 73/7 78/10 79/23 80/14 83/18 83/22 84/4 85/4 96/17 96/25 98/18 99/4 100/14 101/12 104/3 104/23 105/4 106/3 107/4 109/4 112/12</p>	<p>105/25 <b>hospitals</b> [16] 8/6 9/6 18/19 27/20 31/17 49/25 50/7 50/14 50/16 53/15 62/5 89/22 96/20 99/22 113/12 116/16 <b>hostile</b> [2] 102/14 107/19 <b>hour</b> [1] 100/10 <b>hours</b> [6] 32/9 41/9 52/13 96/10 100/15 109/5 <b>House</b> [3] 4/20 5/9 28/11 <b>housing</b> [6] 8/4 14/3 60/22 84/4 87/16 105/21 <b>how</b> [30] 15/25 20/10 23/10 24/10 30/21 32/11 44/21 45/1 45/24 50/2 51/9 53/25 60/9 63/9 63/11 63/13 65/13 72/15 73/16 73/21 73/23 75/6 88/9 90/3 95/2 117/19 117/21 119/22 120/1 122/11</p>
<p><b>hammer</b> [1] 115/24 <b>hand</b> [2] 51/16 67/11 <b>Hannah</b> [1] 123/12 <b>Hannah Curtain</b> [1] 123/12 <b>happen</b> [2] 68/18 70/21 <b>happened</b> [2] 68/15 111/25 <b>happening</b> [1] 76/19 <b>happy</b> [1] 65/14 <b>hard</b> [2] 52/22 68/15 <b>harder</b> [1] 19/1 <b>hardships</b> [2] 52/6 86/1 <b>harm</b> [11] 80/20 89/12 91/10 91/13 91/14 91/15 92/2 92/6 92/7 92/9 94/11 <b>harms</b> [6] 24/12 70/11 92/1 92/4 94/6 96/2 <b>harrowing</b> [1] 67/19 <b>harsh</b> [2] 16/4 120/25 <b>has</b> [54] 1/11 3/22 4/6 5/8 10/8 10/24 12/15 16/17 17/3 21/7 22/6 22/10 22/12 22/13 23/2 24/2 24/23 26/10 26/21 28/5 28/20 43/25 46/1 48/8 52/7 54/16 54/21 55/6 56/5 57/8 57/13 58/16 58/24 59/6 59/8 61/17 64/10 66/23 68/12 68/13 69/11 69/15 71/25 73/6 73/24 74/7 74/15 86/15 87/7 106/19 108/17 109/1 114/15 118/21 <b>have</b> [122] 1/10 1/21 2/16 3/2 5/7 5/14 6/2 6/5 6/22 6/25 11/5 11/10 11/11 13/3 14/3 14/19 15/1 19/16 21/16 22/16 23/5 23/7 26/1 26/13 26/25 27/7 27/9 27/10 27/24 28/3 28/13 29/8 29/10 29/17 30/7 34/12 35/7 37/1 37/3 37/11 37/17 37/22 38/23 39/23 41/23 43/1 43/4 43/5</p>	<p><b>having</b> [8] 37/13 58/11 62/7 66/5 69/12 78/13 117/24 122/2 <b>he</b> [3] 68/8 68/8 68/9 <b>heading</b> [2] 62/14 62/24 <b>headlines</b> [2] 3/2 16/20 <b>heads</b> [1] 104/6 <b>health</b> [42] 6/5 6/17 6/18 6/19 6/22 6/23 6/23 6/24 20/8 24/19 27/16 31/21 34/7 34/10 35/11 40/12 42/9 43/22 44/1 45/6 45/20 46/13 46/18 52/16 53/10 59/4 64/2 65/6 65/9 65/10 71/9 80/17 81/6 84/7 91/21 92/9 94/24 98/5 98/10 100/24 112/22 128/10 <b>Health Foundation</b> [1] 31/21 <b>healthcare</b> [11] 9/16 11/17 18/11 27/20 44/3 44/16 45/19 51/11 79/25 100/5 116/12 <b>healthcare-focused</b> [1] 44/3 <b>hear</b> [15] 1/11 2/20 4/17 7/19 26/5 26/24 34/8 43/12 44/5 44/10 44/17 44/20 46/11 48/22 119/6 <b>heard</b> [11] 43/21 45/5 47/16 47/17 58/19 72/25 74/7 74/23 78/23 117/24 125/10 <b>hearing</b> [23] 1/5 1/11 1/15 2/3 4/19 4/20</p>	<p>12/14 <b>hearings</b> [8] 12/14 12/17 25/23 28/9 53/2 53/3 55/25 56/9 <b>heart</b> [1] 36/3 <b>heartbreaking</b> [3] 64/10 85/13 110/11 <b>heavily</b> [1] 94/7 <b>heavy</b> [2] 100/12 110/2 <b>heightened</b> [1] 81/3 <b>held</b> [3] 28/10 64/1 82/19 <b>help</b> [7] 10/12 19/18 41/3 48/20 57/19 76/23 97/22 <b>helpful</b> [3] 10/14 26/1 67/17 <b>helpfully</b> [1] 30/3 <b>helping</b> [2] 13/14 78/15 <b>Henry</b> [5] 48/22 48/23 48/24 57/19 127/16 <b>HEPA</b> [1] 51/20 <b>HEPA air</b> [1] 51/20 <b>her</b> [6] 57/8 67/24 68/2 68/13 69/10 69/12 <b>here</b> [10] 1/15 3/24 5/9 5/23 23/13 37/4 38/15 108/14 122/20 123/2 <b>hierarchy</b> [1] 8/16 <b>high</b> [7] 3/22 3/25 33/13 51/19 71/21 96/18 113/5 <b>high-traffic</b> [1] 51/19 <b>higher</b> [7] 31/24 50/11 84/19 94/4 102/17 103/7 105/10 <b>highest</b> [4] 4/2 31/8 100/23 109/15 <b>highlight</b> [8] 1/18 29/10 78/25 86/22 87/6 92/17 96/5 112/2 <b>highlighted</b> [3] 1/19 30/10 96/1 <b>highly</b> [4] 19/16 30/14 95/10 112/11 <b>him</b> [1] 68/7 <b>hindered</b> [1] 85/6 <b>his</b> [1] 117/25 <b>historic</b> [4] 16/8 106/19 121/3 121/20 <b>Historically</b> [1] 100/24 <b>history</b> [1] 106/20 <b>hit</b> [1] 44/11</p>	<p><b>Homecare</b> [8] 6/9 61/20 72/6 77/17 77/20 77/22 78/9 128/2 <b>Homecare Association</b> [2] 72/6 78/9 <b>homes</b> [78] 2/8 2/11 2/14 3/1 3/3 3/6 8/3 8/7 8/8 9/7 9/10 14/7 14/11 18/19 18/21 19/12 23/14 27/4 27/10 27/21 31/25 40/16 40/23 41/21 44/11 45/4 47/8 49/18 50/2 50/3 50/14 50/20 51/24 52/2 52/11 53/14 60/20 61/2 61/3 61/24 61/24 62/8 67/4 78/5 79/13 80/2 80/12 81/10 83/18 83/21 84/2 84/11 84/21 84/23 85/4 87/9 87/9 87/24 89/22 89/24 90/15 91/11 92/18 92/22 94/4 95/1 96/6 96/9 96/14 96/19 96/22 99/19 99/20 99/25 101/15 101/22 104/1 109/4 <b>homogeneous</b> [1] 97/17 <b>honour</b> [1] 86/1 <b>hope</b> [7] 15/7 22/15 50/21 54/4 69/5 73/18 122/15 <b>hoped</b> [5] 24/15 52/3 55/7 56/1 56/15 <b>horror</b> [1] 68/16 <b>hospices</b> [2] 13/7 61/5 <b>hospital</b> [12] 18/16 18/17 18/23 39/20 40/15 50/1 62/9 62/12 80/16 89/24 104/2</p>	<p>105/25 <b>hospitals</b> [16] 8/6 9/6 18/19 27/20 31/17 49/25 50/7 50/14 50/16 53/15 62/5 89/22 96/20 99/22 113/12 116/16 <b>hostile</b> [2] 102/14 107/19 <b>hour</b> [1] 100/10 <b>hours</b> [6] 32/9 41/9 52/13 96/10 100/15 109/5 <b>House</b> [3] 4/20 5/9 28/11 <b>housing</b> [6] 8/4 14/3 60/22 84/4 87/16 105/21 <b>how</b> [30] 15/25 20/10 23/10 24/10 30/21 32/11 44/21 45/1 45/24 50/2 51/9 53/25 60/9 63/9 63/11 63/13 65/13 72/15 73/16 73/21 73/23 75/6 88/9 90/3 95/2 117/19 117/21 119/22 120/1 122/11 <b>however</b> [12] 11/8 11/21 15/22 32/4 54/23 67/2 70/2 75/25 78/18 92/13 99/14 120/4 <b>hue</b> [1] 122/3 <b>huge</b> [2] 91/15 96/8 <b>hugely</b> [1] 97/11 <b>human</b> [6] 65/8 75/20 75/21 76/5 81/18 88/24 <b>humanitarian</b> [1] 70/9 <b>hygiene</b> [1] 51/17</p>
				<p><b>I</b> <b>I appear</b> [3] 29/7 48/25 86/13 <b>I appreciate</b> [1] 82/24 <b>I begin</b> [1] 69/5 <b>I can</b> [4] 38/8 48/19 75/21 123/3 <b>I cannot</b> [3] 102/22 103/2 103/2 <b>I congratulate</b> [1] 69/6 <b>I do</b> [1] 122/19 <b>I don't</b> [2] 58/17 106/6 <b>I finish</b> [1] 47/12 <b>I have</b> [9] 1/10 14/19 23/7 48/3 58/1 96/1 102/21 113/1 125/16 <b>I hear</b> [1] 34/8 <b>I hope</b> [4] 15/7 50/21</p>

<b>I</b>	22/12 23/2 23/6 24/2 47/1 59/23 66/11 87/4 94/19 95/23 114/15	60/9 73/17 112/8 119/22 120/2	<b>includes [17]</b> 8/2 8/5 13/15 33/9 51/15 65/1 71/19 73/23 91/15 96/10 97/6 112/7 112/9 112/20 113/17 113/23 124/8	<b>individualising [1]</b> 70/20
<b>I hope... [2]</b> 69/5 73/18	<b>identifies [1]</b> 60/6	<b>impacts [6]</b> 8/22 34/6 34/23 60/16 82/18 111/6	<b>including [40]</b> 8/3 9/5 9/20 9/24 10/2 14/17 23/21 27/1 27/5 27/15 34/11 41/2 41/4 49/1 63/12 72/15 77/8 78/5 83/5 83/24 84/6 86/21 89/4 91/19 93/8 93/24 98/17 99/3 99/6 103/19 109/3 109/18 111/5 112/9 112/10 113/2 113/20 113/25 114/23 122/9	<b>individuals [22]</b> 13/18 15/5 16/19 40/24 47/25 61/22 63/10 64/22 71/13 77/6 81/16 81/25 84/5 84/20 86/17 97/9 123/23 123/25 124/6 124/9 124/12 124/17
<b>I just [2]</b> 15/16 112/2	<b>identify [7]</b> 10/5 10/12 26/17 36/14 45/14 46/6 67/7	<b>impairment [1]</b> 25/9	<b>implemented [2]</b> 59/11 80/15 81/9	<b>induced [1]</b> 68/1
<b>I know [4]</b> 16/11 22/16 68/16 125/9	<b>identifying [3]</b> 16/17 35/6 73/20	<b>impairments [1]</b> 95/8	<b>implementing [2]</b> 65/14 113/16	<b>inequalities [1]</b> 32/25
<b>I make [4]</b> 8/16 48/18 64/7 115/12	<b>identity [3]</b> 25/14 56/11 66/10	<b>imperative [1]</b> 76/9	<b>implementing [2]</b> 14/10 110/10	<b>inequality [3]</b> 73/16 74/10 100/25
<b>I may [6]</b> 4/8 35/23 40/7 43/18 108/7 126/12	<b>ie [2]</b> 3/7 3/9	<b>implement [2]</b> 47/10 114/1	<b>implications [3]</b> 54/2 64/5 74/4	<b>inescapable [1]</b> 120/4
<b>I misunderstood [1]</b> 103/12	<b>if [28]</b> 4/8 5/1 5/5 7/10 7/11 15/13 20/11 22/17 26/22 32/14 35/23 40/7 43/18 44/19 47/22 48/12 59/18 63/18 65/15 69/6 72/6 76/1 79/3 82/24 103/3 103/9 103/12 109/15	<b>importance [10]</b> 14/13 36/4 38/19 41/20 42/5 42/12 70/6 97/15 111/21 124/22	<b>inclusion [6]</b> 6/2 31/19 35/24 69/22 92/12 98/18	<b>inevitable [1]</b> 68/4
<b>I need [1]</b> 106/7	<b>ignored [2]</b> 88/22 88/25	<b>important [28]</b> 7/18 15/5 33/9 47/20 61/7 69/9 71/18 72/4 74/25 75/6 78/15 83/2 87/12 88/10 89/14 89/16 91/25 92/20 92/23 93/15 95/15 96/7 105/16 110/22 119/25 122/10 122/24 125/11	<b>Inclusion Scotland [2]</b> 6/2 69/22	<b>inevitably [3]</b> 3/18 60/11 101/18
<b>I propose [2]</b> 29/9 98/12	<b>ill [5]</b> 40/12 44/22 45/2 104/11 104/22	<b>importantly [1]</b> 7/9	<b>income [1]</b> 100/25	<b>infected [3]</b> 41/15 79/24 105/7
<b>I reiterate [2]</b> 7/5 27/10	<b>ill-thought [1]</b> 40/12	<b>imposed [5]</b> 18/13 42/10 42/17 42/17 46/23	<b>incomplete [1]</b> 32/5	<b>infection [22]</b> 9/12 9/24 9/25 19/10 23/18 31/9 32/6 36/11 40/22 51/13 63/9 63/14 92/15 96/21 105/10 107/22 108/1 110/8 113/13 116/25 117/13 117/17
<b>I repeat [1]</b> 23/16	<b>illness [2]</b> 25/9 40/5	<b>imposes [1]</b> 117/9	<b>inconsistency [1]</b> 80/20	<b>inflexion [1]</b> 116/20
<b>I represent [3]</b> 58/6 98/9 108/13	<b>illnesses [1]</b> 91/18	<b>imposition [1]</b> 2/23	<b>inconsistent [1]</b> 81/1	<b>inform [4]</b> 29/22 60/17 82/14 105/10
<b>I said [1]</b> 108/8	<b>illustrates [1]</b> 50/21	<b>impossible [1]</b> 45/14	<b>increase [3]</b> 91/5 91/18 93/9	<b>informal [1]</b> 99/20
<b>I say [1]</b> 126/8	<b>illustrative [1]</b> 26/18	<b>impoverished [1]</b> 44/15	<b>increased [3]</b> 15/4 19/21 89/4	<b>informally [1]</b> 105/1
<b>I shall [4]</b> 1/22 97/23 126/1 126/8	<b>ILT [1]</b> 65/15	<b>improve [2]</b> 85/8 94/15	<b>indeed [22]</b> 1/8 5/8 5/16 7/17 10/20 15/12 15/21 18/25 21/17 25/13 26/3 29/2 46/7 47/16 59/22 73/21 77/13 79/11 109/19 111/10 124/22 125/23	<b>information [10]</b> 7/10 11/5 16/16 26/20 27/18 45/12 46/4 67/10 82/13 90/20 <b>informed [4]</b> 21/11 64/4 68/1 85/7
<b>I should [2]</b> 10/18 126/3	<b>imagine [1]</b> 68/6	<b>improvement [2]</b> 6/15 46/16	<b>indemnity [1]</b> 96/20	<b>informing [2]</b> 22/10 80/24
<b>I think [11]</b> 38/11 69/15 77/15 77/15 86/9 97/23 120/15 125/20 126/4 126/11 126/12	<b>immediate [2]</b> 70/9 74/5	<b>inadequacies [2]</b> 62/14 62/22	<b>independence [1]</b> 94/20	<b>informs [1]</b> 106/12
<b>I touch [1]</b> 32/16	<b>immediately [2]</b> 1/22 9/2	<b>inadequacy [1]</b> 104/20	<b>independent [6]</b> 72/8 75/16 78/4 90/7 98/21 108/20	<b>infrastructure [3]</b> 104/16 112/13 113/25
<b>I turn [1]</b> 64/19	<b>immense [2]</b> 81/17 100/5	<b>inadequate [4]</b> 18/15 62/10 62/11 110/7	<b>INDEX [1]</b> 126/17	<b>inherent [1]</b> 46/21
<b>I understand [1]</b> 103/9	<b>immigration [9]</b> 101/10 102/19 103/21 103/22 104/25 105/1 105/14 107/16 109/19	<b>inadvertently [2]</b> 83/9 121/12	<b>indicate [1]</b> 39/4	<b>inherently [1]</b> 14/8
<b>I want [1]</b> 125/24	<b>impact [67]</b> 1/25 3/2 3/12 3/16 3/16 7/21 8/11 8/12 8/18 10/21 11/16 12/25 13/5 14/16 14/24 16/7 16/25 19/17 24/3 24/8 24/17 25/2 27/14 29/22 32/9 32/20 33/1 33/12 33/19 33/22 34/2 34/4 34/19 36/6 40/17 53/2 53/3 56/22 58/15 58/22 62/14 62/16 62/20 62/22 62/24 64/9 78/17 84/14 89/21 90/3 94/18 96/8 96/17 106/17 107/11 107/24 109/12 111/4 112/14 112/21 114/9 115/19 116/5 120/5 120/18 121/2 123/18	<b>include [26]</b> 8/17 8/21 9/1 9/11 13/4 16/19 21/14 23/10 23/20 24/11 26/18 32/7 36/9 63/9 63/16 72/8 73/15 78/19 86/19 107/10 107/18 107/23 112/17 118/1 118/15 123/22	<b>indicating [1]</b> 117/5	<b>inhibited [1]</b> 2/24
<b>I was [1]</b> 105/14	<b>impaired [6]</b> 24/25	<b>included [6]</b> 11/12 28/1 32/13 33/3 49/15 61/3	<b>indicated [1]</b> 28/20	<b>initial [1]</b> 79/20
<b>I will [7]</b> 1/11 1/15 49/9 49/10 58/7 87/6 119/4			<b>indicates [3]</b> 11/4 88/15 88/19	<b>initially [1]</b> 80/25
<b>I wish [1]</b> 92/17			<b>indication [4]</b> 4/5 75/6 114/7 115/1	<b>injuries [1]</b> 84/8
<b>I won't [1]</b> 37/4			<b>indirect [10]</b> 24/12 91/10 91/13 91/15 92/1 92/2 92/4 92/7 94/6 96/2	<b>injury [1]</b> 117/3
<b>I would [2]</b> 11/22 103/4			<b>individual [11]</b> 7/12 12/14 13/9 24/10 31/12 40/23 74/12 81/15 84/11 86/16 97/16	<b>input [1]</b> 118/24
<b>I'd [4]</b> 17/16 17/18 29/11 96/5			<b>individual's [1]</b> 13/12	<b>inquiries [4]</b> 4/15 4/22 49/4 53/25
<b>I'll [5]</b> 4/8 17/8 68/17 103/13 103/14				<b>inquiry [160]</b>
<b>I'm [16]</b> 24/22 29/2 53/1 77/20 98/3 102/20 102/21 103/1 103/1 103/4 103/6 103/12 103/13 108/6 108/14 114/7				<b>Inquiry's [23]</b> 7/13 15/22 22/3 26/9 26/16 30/16 30/24 31/19 37/5 38/1 53/9 53/18 54/15 55/8 57/3 61/9 61/21 62/3 76/14 93/25 119/19 121/5 123/17
<b>I'm afraid [2]</b> 24/22 103/1				
<b>I've [7]</b> 7/16 26/4 102/20 104/13 105/18 105/19 126/9				
<b>identification [1]</b> 47/25				
<b>identified [12]</b> 12/10				

<b>I</b>	102/10 <b>insecure</b> [3] 100/14 102/1 120/14 <b>insecurity</b> [1] 113/3 <b>inserted</b> [1] 75/18 <b>insights</b> [2] 82/13 85/23 <b>insofar</b> [2] 65/18 66/14 <b>inspecting</b> [1] 46/17 <b>inspection</b> [2] 9/23 31/11 <b>inspections</b> [2] 46/22 90/14 <b>Inspectorate</b> [3] 2/9 6/16 65/6 <b>instead</b> [2] 14/14 85/7 <b>Institute</b> [1] 65/10 <b>institutional</b> [3] 33/2 34/18 56/23 <b>institutions</b> [2] 65/2 88/11 <b>instruct</b> [6] 23/18 34/1 47/20 56/6 90/7 114/17 <b>instructed</b> [5] 35/17 49/3 56/16 66/1 98/10 <b>instruction</b> [3] 23/1 36/25 65/22 <b>instructions</b> [1] 110/11 <b>instructive</b> [1] 125/25 <b>insufficient</b> [2] 55/23 62/10 <b>insurance</b> [2] 96/18 96/25 <b>integrated</b> [1] 112/23 <b>integration</b> [1] 29/23 <b>intellectual</b> [2] 33/12 34/4 <b>intend</b> [5] 10/19 15/18 54/1 87/8 122/6 <b>intended</b> [3] 11/18 61/21 115/13 <b>intends</b> [3] 23/18 53/12 56/6 <b>intensified</b> [1] 117/1 <b>intensive</b> [1] 13/15 <b>intention</b> [2] 53/18 62/4 <b>intentions</b> [1] 12/18 <b>interacted</b> [1] 26/25 <b>interaction</b> [1] 42/13 <b>interest</b> [4] 16/24 98/11 118/14 118/21 <b>interested</b> [1] 26/24 <b>interests</b> [1] 99/1 <b>intermittent</b> [1] 76/13 <b>international</b> [2] 35/1 35/11 <b>internationally</b> [1]	102/10 <b>interpret</b> [1] 71/2 <b>interpreter</b> [1] 28/15 <b>interrupt</b> [1] 102/20 <b>interrupting</b> [1] 108/7 <b>intersect</b> [1] 84/10 <b>intersectional</b> [1] 39/22 <b>intervention</b> [1] 70/21 <b>interviews</b> [1] 28/2 <b>into</b> [38] 1/5 8/6 9/6 11/3 15/12 18/19 20/19 24/8 28/18 32/4 32/6 38/1 40/15 40/16 42/12 44/23 44/24 49/25 62/5 72/20 73/6 73/24 74/2 75/19 89/12 89/22 89/24 92/4 92/24 93/20 99/23 99/25 104/2 110/15 113/12 113/19 113/24 120/7 <b>intransigence</b> [1] 104/10 <b>introduce</b> [1] 5/16 <b>introduces</b> [1] 10/4 <b>introducing</b> [1] 58/21 <b>introduction</b> [4] 2/2 2/3 4/4 62/20 <b>Introductory</b> [2] 1/3 127/3 <b>invaluable</b> [1] 93/1 <b>investigate</b> [4] 32/21 84/24 92/19 111/3 <b>investigated</b> [2] 91/8 116/18 <b>investigation</b> [12] 20/20 29/22 32/4 32/6 53/20 59/16 71/10 87/22 109/11 116/6 123/21 125/2 <b>investigations</b> [2] 46/20 121/25 <b>investment</b> [2] 112/13 112/18 <b>invisible</b> [1] 105/9 <b>invite</b> [9] 21/8 34/16 36/18 90/1 112/3 114/20 121/24 122/18 122/21 <b>invited</b> [3] 33/22 36/9 117/7 <b>invites</b> [4] 58/19 62/23 63/8 66/8 <b>involve</b> [4] 13/16 67/17 71/10 105/2 <b>involved</b> [1] 110/10 <b>involvement</b> [1] 77/11 <b>involves</b> [1] 95/13 <b>IPC</b> [9] 9/13 14/10 23/24 27/21 51/14	51/15 51/16 51/22 52/2 <b>Ireland</b> [40] 2/11 2/13 5/21 6/1 6/18 6/24 7/24 12/2 13/2 17/8 20/7 20/11 30/7 38/12 38/17 38/20 38/25 39/3 39/7 39/17 40/1 40/6 40/7 43/18 43/22 44/7 44/18 45/4 45/25 47/19 48/6 48/12 48/14 61/9 66/4 69/23 73/14 112/24 120/16 127/12 <b>Irish</b> [4] 46/3 47/13 48/1 54/11 <b>irregular</b> [1] 104/25 <b>is</b> [250] <b>isn't</b> [1] 68/11 <b>isolate</b> [3] 19/13 40/24 96/15 <b>isolated</b> [1] 42/1 <b>isolating</b> [1] 41/14 <b>isolation</b> [6] 42/4 42/21 82/1 89/7 94/13 99/25 <b>issue</b> [29] 22/25 29/12 29/14 30/9 30/13 32/16 36/3 36/10 37/2 43/5 54/14 58/14 62/1 62/3 63/6 63/20 76/2 88/17 89/14 92/15 93/21 96/7 102/8 115/12 115/14 116/21 120/22 125/17 126/9 <b>issue 3</b> [1] 62/3 <b>issued</b> [3] 20/14 20/17 117/19 <b>issues</b> [62] 1/9 1/18 4/7 10/6 10/10 10/12 10/12 11/2 11/8 14/5 14/20 14/21 14/23 15/3 15/6 15/14 16/4 16/11 20/16 20/18 23/25 25/15 32/24 32/25 36/14 42/24 43/14 44/12 46/24 48/3 51/2 53/4 53/14 56/12 59/16 59/24 61/12 64/21 65/25 67/1 67/16 83/2 85/18 87/1 94/25 95/7 96/13 99/15 101/15 103/4 104/16 104/17 105/12 106/13 111/4 112/25 114/14 118/21 120/25 121/7 122/1 125/13 <b>issuing</b> [1] 16/18 <b>it</b> [174] <b>it's</b> [37] 1/19 3/8 7/18 7/18 10/4 11/13 24/3 30/2 31/5 32/17 32/25 33/9 35/19 44/23 45/3	47/15 48/9 51/8 52/3 53/7 53/18 55/7 56/1 56/15 60/14 64/13 68/19 69/8 69/9 76/20 86/9 95/14 97/23 102/4 117/21 123/9 125/6 <b>item</b> [5] 5/9 7/15 16/14 21/20 26/8 <b>Item 2</b> [1] 7/15 <b>item 4</b> [1] 21/20 <b>item 5</b> [1] 26/8 <b>iterative</b> [1] 20/14 <b>its</b> [27] 17/14 36/3 37/8 51/21 55/12 60/4 61/14 63/4 66/15 75/4 75/12 76/22 77/9 78/1 78/15 79/9 90/14 108/22 110/22 113/25 117/15 117/23 118/13 122/14 123/16 124/2 124/11 <b>itself</b> [4] 72/3 72/13 73/10 93/5 <b>IWGB</b> [1] 99/5	74/23 82/23 82/25 91/24 100/8 103/3 103/6 112/2 121/23 125/15 <b>justice</b> [19] 5/20 5/21 5/22 11/24 29/1 29/5 29/8 33/16 38/13 38/18 58/4 58/7 68/20 73/13 92/12 112/15 127/9 127/13 127/19 <b>Justice Cymru</b> [2] 5/21 11/24 <b>Justice UK</b> [2] 5/20 92/12
			<b>J</b>		
			<b>Jac</b> [1] 1/8 <b>Jacobs</b> [5] 71/4 118/7 118/9 123/4 128/20 <b>Jane</b> [1] 77/20 <b>Jane Townson</b> [1] 77/20 <b>January</b> [2] 2/6 44/19 <b>Joanne</b> [1] 69/6 <b>Joanne Cecil</b> [1] 69/6 <b>job</b> [1] 101/12 <b>jobs</b> [2] 100/14 110/25 <b>John's</b> [5] 5/24 36/21 86/10 86/13 128/5 <b>John's Campaign</b> [3] 5/24 36/21 86/13 <b>joined</b> [2] 30/13 44/9 <b>joined-up</b> [1] 44/9 <b>joint</b> [2] 5/13 6/11 <b>journey</b> [1] 76/14 <b>judging</b> [1] 35/2 <b>July</b> [1] 31/24 <b>July 2020</b> [1] 31/24 <b>June</b> [5] 2/9 39/5 50/13 50/18 90/22 <b>June 2020</b> [1] 50/13 <b>June 2022</b> [3] 2/9 39/5 50/18 <b>jurisdictions</b> [3] 29/21 30/12 31/1 <b>just</b> [26] 1/14 2/18 3/3 3/8 15/16 16/19 17/8 17/17 19/23 21/24 29/14 45/3 47/7 47/16 71/24 74/15	<b>kanlungan</b> [2] 98/23 98/23 <b>Kanlungan's</b> [1] 104/24 <b>Katharine</b> [1] 98/9 <b>Katharine Newton</b> <b>KC</b> [1] 98/9 <b>KC</b> [12] 29/6 38/13 69/16 69/19 98/9 115/10 115/22 117/24 127/9 127/13 127/22 128/17 <b>keen</b> [1] 88/9 <b>keep</b> [1] 15/14 <b>kept</b> [1] 30/15 <b>Kevin</b> [1] 49/2 <b>Kevin McCaffery</b> [1] 49/2 <b>key</b> [37] 8/23 9/3 10/12 11/2 19/7 23/11 27/23 28/4 29/10 41/20 57/6 57/7 57/9 59/25 60/4 65/19 66/23 67/2 78/25 80/4 80/15 86/23 86/24 86/25 87/5 88/12 93/24 101/21 106/25 110/9 112/2 116/10 117/10 117/20 118/3 125/13 125/14 <b>key worker</b> [1] 110/9 <b>key workers</b> [1] 106/25 <b>kinds</b> [1] 24/25 <b>King's</b> [10] 1/8 28/25 30/4 39/12 49/2 59/21 66/4 69/7 69/10 69/12 <b>King's Counsel</b> [10] 1/8 28/25 30/4 39/12 49/2 59/21 66/4 69/7 69/10 69/12 <b>Kingdom</b> [3] 76/2 109/16 119/20 <b>kitchen</b> [1] 99/8 <b>knew</b> [2] 68/4 75/6 <b>know</b> [19] 16/11 22/16 38/15 42/5 42/5 43/3 43/23 48/8 49/19	

<b>K</b>	<b>Ladyship's</b> [4] 53/5 109/11 111/21 114/21	<b>level</b> [2] 47/25 72/19	32/1 67/25 72/17 84/4	16/13 17/1 18/25 19/2
<b>know...</b> [10] 49/20 49/23 58/6 58/11	<b>laminating</b> [1] 104/5	<b>levels</b> [2] 9/1 94/13	84/22 87/11 87/12	20/15 20/21 20/23
63/22 68/16 69/7	<b>Language</b> [1] 28/14	<b>liability</b> [2] 96/21	87/15 87/20 88/1	21/5 21/17 22/11
69/20 72/3 125/9	<b>large</b> [8] 17/21 31/25	96/23	91/11 91/11 93/23	22/17 25/21 28/3 28/6
<b>known</b> [7] 6/2 6/2	58/11 61/22 102/25	<b>liaison</b> [2] 49/10	94/5 94/7 95/1 95/14	29/18 35/9 36/20 37/1
6/20 7/23 9/13 54/21	104/23 104/25 112/11	52/25	96/14 100/11	37/3 37/10 37/15
94/15	<b>large-scale</b> [1]	<b>liberty</b> [3] 89/2 89/3	<b>local</b> [20] 6/13 6/13	37/17 43/25 54/19
<b>knows</b> [2] 1/14 70/15	112/11	90/17	6/20 17/6 17/10 17/13	54/21 56/2 56/3 60/23
<b>L</b>	<b>larger</b> [1] 79/18	<b>licensed</b> [1] 75/10	18/2 20/3 46/2 63/1	64/14 65/23 66/3
<b>lack</b> [18] 35/19 40/25	<b>last</b> [3] 52/12 71/5	<b>life</b> [7] 3/13 27/17	65/6 74/16 75/11	66/12 67/13 86/1
45/13 52/15 52/18	108/1	52/17 64/11 67/19	75/13 78/5 90/18	96/15 96/18 96/23
80/10 81/19 85/14	<b>Lastly</b> [1] 107/21	68/10 109/9	90/20 99/18 100/8	97/4 101/24 107/19
90/10 96/10 101/17	<b>late</b> [1] 82/7	<b>lifetime</b> [1] 68/17	120/11	112/1 112/14 116/4
103/25 105/5 113/4	<b>later</b> [3] 3/13 7/7	<b>light</b> [6] 16/4 90/6	<b>locations</b> [1] 4/11	120/15 121/8
116/8 116/14 116/18	10/22	90/21 115/20 120/25	<b>lockdown</b> [2] 94/13	<b>main</b> [3] 68/13 80/22
116/19	113/21	123/7	94/21	100/24
<b>lacked</b> [5] 45/16	<b>latter</b> [2] 18/10	<b>like</b> [13] 11/23 17/16	<b>lockdowns</b> [1] 27/15	<b>mainly</b> [1] 79/13
45/17 45/19 45/21	113/21	17/18 27/11 29/11	<b>London</b> [4] 3/24	<b>maintains</b> [1] 65/18
46/11	<b>law</b> [3] 75/3 75/9	40/2 71/9 82/15 96/5	28/12 100/19 104/4	<b>major</b> [3] 76/3 101/15
<b>lacking</b> [1] 71/1	98/11	97/19 98/16 114/19	<b>loneliness</b> [1] 82/3	102/1
<b>Lady</b> [119] 1/24 1/25	<b>laws</b> [1] 44/8	126/3	<b>long</b> [5] 16/11 44/12	<b>majority</b> [5] 11/9
2/15 3/9 5/7 6/4 7/3	<b>lawyers</b> [1] 75/9	<b>likelihood</b> [1] 70/12	44/13 82/7 121/7	17/22 45/7 99/11
10/3 12/22 14/13	<b>lay</b> [2] 73/21 75/9	<b>likely</b> [10] 11/3 23/3	<b>long-standing</b> [3]	109/22
15/10 17/15 19/15	<b>lead</b> [5] 1/23 21/12	23/19 30/19 35/12	16/11 44/12 121/7	<b>make</b> [40] 1/12 3/10
26/8 28/8 29/7 30/2	84/22 121/12 127/5	40/4 55/13 55/19	<b>long-term</b> [1] 82/7	8/16 10/18 11/16 14/4
34/25 36/12 36/22	<b>leaders</b> [1] 81/11	97/11 101/2	<b>longer</b> [2] 18/14	14/15 15/16 22/7
37/25 38/8 38/14	<b>leading</b> [5] 1/7 47/10	<b>Likewise</b> [1] 32/20	68/12	28/23 30/15 34/14
38/18 40/1 41/16 42/5	94/1 94/3 117/2	<b>limit</b> [1] 95/3	<b>look</b> [17] 4/8 9/3 9/13	35/23 44/20 48/15
42/23 43/17 45/3	<b>leads</b> [2] 101/18	<b>limitations</b> [2] 18/14	9/22 23/14 23/24 24/3	48/18 49/9 55/6 56/1
45/23 46/9 46/21	122/10	110/12	27/21 29/15 39/15	56/10 59/1 59/2 64/7
47/12 48/2 48/18	<b>league</b> [1] 35/3	<b>limited</b> [7] 18/12 35/4	53/25 54/17 57/11	68/14 71/8 74/2 76/9
48/25 49/5 49/14 50/5	<b>leaky</b> [1] 125/6	54/19 82/24 85/4 97/1	71/5 78/14 106/21	76/12 76/21 78/24
50/8 50/18 50/21	<b>learn</b> [3] 72/2 76/11	110/6	106/24	83/20 92/4 98/14
50/24 51/5 51/9 51/12	86/1	<b>line</b> [6] 20/21 41/19	<b>looked</b> [1] 8/25	103/9 104/23 109/17
52/3 52/24 53/1 53/17	<b>learned</b> [4] 39/12	81/7 82/21 107/25	<b>looking</b> [7] 12/1 17/9	115/12 118/13 122/22
54/7 54/12 54/14	68/25 72/14 124/24	108/1	24/17 25/7 27/17	123/15
54/24 55/12 55/19	<b>learning</b> [10] 24/18	<b>lines</b> [9] 27/23 28/4	28/17 54/10	<b>makers</b> [3] 55/9 79/7
55/20 56/4 56/14	34/23 36/9 47/5 72/12	57/6 57/7 57/10 66/23	<b>losing</b> [1] 101/12	81/4
56/21 57/1 57/2 57/16	81/20 84/6 84/16	67/2 67/7 119/2	<b>loss</b> [3] 2/19 64/11	<b>makes</b> [2] 12/24 86/5
57/20 58/5 58/9 58/19	87/17 95/12	<b>linked</b> [2] 102/9	123/25	<b>making</b> [21] 8/1
59/4 60/18 63/22 64/8	<b>learnt</b> [1] 60/17	107/4	<b>losses</b> [1] 85/13	17/23 22/15 45/13
64/18 65/17 66/20	<b>least</b> [5] 19/14 53/22	<b>list</b> [5] 6/25 10/11	<b>lost</b> [5] 40/18 40/20	59/11 59/17 62/1
67/8 67/20 69/2 69/5	69/8 110/21 121/16	61/12 106/13 126/5	58/12 68/11 124/3	65/20 75/1 77/10
69/20 70/15 72/4	<b>leave</b> [2] 55/22 72/14	<b>listen</b> [1] 26/7	<b>lot</b> [2] 43/6 73/1	77/21 79/11 82/14
73/18 73/24 74/7	<b>leaving</b> [2] 81/2	<b>listened</b> [1] 58/24	<b>loved</b> [28] 2/19 2/25	89/1 89/21 90/4 104/4
75/18 76/15 77/19	104/1	<b>listening</b> [5] 7/13	8/12 8/20 9/16 9/19	105/21 106/10 116/20
86/7 86/12 97/20 98/8	<b>led</b> [5] 49/22 80/19	26/9 27/9 69/2 125/8	27/3 32/1 35/24 36/8	120/19
103/6 103/13 105/16	104/20 112/12 112/19	<b>listening exercise</b> [1]	36/10 38/24 40/18	<b>manage</b> [1] 89/5
106/8 107/9 108/5	<b>left</b> [4] 68/10 72/13	26/9	42/18 49/17 49/20	<b>managed</b> [4] 63/10
108/13 110/16 111/8	81/24 85/21	<b>listens</b> [1] 83/3	51/6 52/8 52/12 52/16	63/11 63/14 126/5
114/13 114/19 115/11	<b>legal</b> [3] 17/3 25/5	<b>little</b> [13] 2/2 2/3 21/3	52/19 58/12 63/23	<b>management</b> [5] 9/9
118/10 118/19 119/10	89/8	44/3 79/25 80/6 82/11	91/2 91/23 92/12	63/7 72/21 91/12
119/15 120/20 121/8	<b>legalised</b> [1] 75/10	82/23 82/25 88/4 97/2	124/1 124/3	124/19
121/15 121/17 121/23	<b>leggings</b> [1] 104/6	110/1 120/12	<b>low</b> [8] 39/25 96/10	<b>managers</b> [1] 71/12
122/17 123/3 123/11	<b>legislation</b> [4] 44/7	<b>live</b> [7] 4/13 4/18 14/1	99/10 101/25 102/11	<b>managing</b> [1] 27/3
123/20 125/3 125/6	59/10 62/25 117/8	72/9 72/22 79/17 94/2	110/21 113/4 113/6	<b>mandatory</b> [1]
<b>Lady's</b> [1] 76/8	<b>legislative</b> [1] 88/13	<b>lived</b> [5] 36/15 39/19	<b>lower</b> [2] 104/10	114/10
<b>Ladyship</b> [12] 4/14	<b>lens</b> [1] 71/24	93/11 93/14 106/4	105/18	<b>many</b> [36] 10/14
7/17 12/15 21/6 28/5	<b>less</b> [5] 39/2 42/3	<b>lives</b> [5] 13/6 40/20	<b>lowest</b> [2] 31/9 101/3	22/22 39/23 40/2
28/20 52/5 53/1 57/8	88/15 88/17 113/21	61/5 84/23 88/16	<b>lying</b> [1] 71/3	40/10 40/18 40/20
57/14 109/7 111/13	<b>lessening</b> [1] 19/21	<b>livestreamed</b> [1]	<b>M</b>	40/23 41/2 41/21
	<b>lessons</b> [4] 60/17	4/11	<b>made</b> [50] 3/2 9/3	41/25 42/10 42/14
	68/25 72/14 124/23	<b>living</b> [25] 2/1 8/1	11/11 12/15 15/11	42/16 42/20 43/3
	<b>letters</b> [1] 36/25	13/6 13/7 13/16 27/1		45/11 47/8 64/1 64/5

<b>M</b>	<b>May 2020 [1]</b> 100/22	<b>might [5]</b> 47/3 75/13	10/11 10/23 11/24	45/5 48/4 48/19 48/25
<b>many... [16]</b> 72/2	<b>May 2022 [1]</b> 39/9	78/20 114/11 121/19	11/25 13/4 15/17	49/7 50/17 54/13
81/24 82/15 87/25	<b>Maybe [1]</b> 103/11	<b>migrant [10]</b> 3/25 6/5	15/19 16/6 16/17	54/16 54/20 106/14
91/13 94/10 99/20	<b>McCaffery [1]</b> 49/2	98/5 98/9 99/11 101/9	17/12 20/5 20/9 21/9	114/8 120/17 120/23
104/24 106/14 110/17	<b>me [7]</b> 5/16 11/13	101/13 102/16 107/3	21/11 21/22 21/24	<b>Morris [11]</b> 28/24
111/16 112/1 116/7	21/19 38/19 70/17	128/9	22/9 22/13 23/2 23/18	29/4 29/6 38/10 47/17
120/10 120/14 124/13	97/19 112/2	<b>migrants [1]</b> 99/1	24/2 26/12 26/24 28/7	59/21 115/8 115/10
<b>map [2]</b> 71/19 72/10	<b>mean [4]</b> 13/25 73/6	<b>million [5]</b> 3/20 79/18	28/10 28/12 29/17	118/6 127/9 128/17
<b>March [15]</b> 1/1 2/6	121/20 121/21	94/2 118/12 119/7	30/16 31/3 32/21 33/4	<b>mortality [5]</b> 31/9
2/9 2/12 2/12 39/5	<b>meaning [1]</b> 93/3	<b>millions [1]</b> 86/4	33/9 33/23 37/12 38/2	33/13 84/18 105/11
39/8 44/19 46/14	<b>meaningful [10]</b> 14/4	<b>mind [7]</b> 30/16 69/5	43/10 48/3 48/7 48/10	109/14
46/21 50/18 83/13	14/15 42/18 44/20	79/25 107/16 108/19	49/16 52/24 53/7 54/9	<b>most [29]</b> 1/18 3/5
89/23 90/13 90/22	48/15 76/21 82/13	114/5 121/18	55/18 58/19 64/21	32/19 36/15 40/3 40/4
<b>March 16 [1]</b> 90/13	83/20 85/19 120/19	<b>mindful [1]</b> 59/18	65/25 66/22 76/4	41/5 46/6 46/15 50/5
<b>March 2020 [8]</b> 2/6	<b>meaningfully [1]</b>	<b>mindful [2]</b> 41/16	78/12 83/8 85/3 92/13	52/7 55/1 63/22 70/9
2/9 39/5 39/8 44/19	47/22	54/23	109/8 111/9 117/12	70/11 81/8 83/24
46/14 46/21 50/18	<b>means [1]</b> 67/5	<b>minds [1]</b> 74/12	118/14 121/2 123/14	84/17 84/20 91/1
<b>margins [1]</b> 102/4	<b>meant [5]</b> 45/11 51/3	<b>minimise [2]</b> 53/19	123/21 124/16 125/7	95/15 95/16 95/17
<b>Marquis [8]</b> 98/3 98/3	52/18 80/22 116/25	68/25	125/15	99/18 100/1 107/12
98/4 98/4 98/6 102/20	<b>measure [2]</b> 92/1	<b>ministers [2]</b> 6/21	<b>Module 6's [2]</b> 16/9	110/20 122/10 123/23
108/6 128/10	92/5	16/21	121/6	<b>move [1]</b> 116/16
<b>masks [2]</b> 79/21	<b>measures [5]</b> 9/11	<b>minorities [1]</b> 32/18	<b>module's [3]</b> 24/9	<b>movement [4]</b> 32/7
104/4	9/12 10/1 27/22 51/14	<b>minority [6]</b> 3/23	54/5 98/19	52/1 63/15 91/13
<b>massive [1]</b> 75/15	<b>mechanisms [3]</b>	99/12 100/18 105/11	<b>modules [23]</b> 11/25	<b>moving [5]</b> 35/14
<b>match [1]</b> 31/10	17/23 90/24 91/1	107/17 109/21	15/22 21/22 22/14	52/25 54/14 65/22
<b>material [9]</b> 10/6 10/8	<b>medical [6]</b> 51/4	<b>minute [1]</b> 4/24	33/6 35/15 36/17	110/15
15/20 20/25 22/5	51/10 89/2 91/19	<b>mirrored [1]</b> 67/1	54/10 55/15 55/25	<b>Mr [27]</b> 48/22 48/23
22/12 22/14 22/25	103/19 103/20	<b>mismanagement [1]</b>	56/6 58/21 59/7 59/13	48/24 57/19 69/4
55/16	<b>medications [1]</b>	104/15	59/19 64/10 67/8	69/14 69/19 71/4
<b>materials [2]</b> 55/23	42/15	<b>mistake [1]</b> 121/15	70/16 72/22 74/1	77/13 98/3 98/4 98/6
74/3	<b>medicines [1]</b> 50/3	<b>mistaken [1]</b> 121/11	114/23 119/3 123/16	102/20 108/6 108/10
<b>matter [10]</b> 7/8 12/5	<b>meet [3]</b> 63/4 100/5	<b>mistakes [1]</b> 83/9	<b>Modules 1 [1]</b> 119/3	108/12 115/6 115/22
15/15 28/8 28/17 36/1	100/6	<b>misunderstanding</b>	<b>Modules 6A [2]</b>	117/24 118/7 118/9
36/2 54/1 72/20	<b>member [4]</b> 96/24	<b>[1]</b> 79/2	11/25 54/10	123/4 127/16 127/22
119/24	102/4 106/6 118/13	<b>misunderstandings</b>	<b>moment [2]</b> 1/9 17/9	128/10 128/14 128/20
<b>matters [39]</b> 1/20	<b>members [26]</b> 4/16	<b>[1]</b> 85/6	<b>moments [2]</b> 52/9	<b>Mr Friedman [5]</b> 69/4
4/23 7/14 8/17 11/3	17/14 17/14 42/2	<b>misunderstood [3]</b>	121/24	69/14 77/13 117/24
11/12 11/21 15/12	42/22 50/24 63/22	79/9 103/12 108/7	<b>monitor [1]</b> 41/24	127/22
23/4 23/20 25/25 26/9	64/1 64/14 65/2 67/17	<b>Mitchell [1]</b> 49/2	<b>monitoring [2]</b> 41/19	<b>Mr Friedman KC [1]</b>
26/10 26/13 26/20	67/21 67/24 68/8 78/1	<b>models [2]</b> 84/9	46/17	115/22
27/8 27/13 32/21	95/5 95/20 99/2 99/7	112/10	<b>month [1]</b> 94/21	<b>Mr Henry [3]</b> 48/22
36/22 37/17 49/12	99/9 99/18 102/16	<b>modification [1]</b> 31/3	<b>monthly [2]</b> 21/12	48/23 57/19
50/23 53/13 53/19	103/25 104/24 105/23	<b>module [177]</b>	22/9	<b>Mr Jacobs [5]</b> 71/4
54/5 56/17 57/2 57/16	108/22	<b>Module 1 [12]</b> 15/19	<b>months [4]</b> 18/7	118/7 118/9 123/4
66/21 66/24 72/20	<b>membership [6]</b>	15/21 20/21 29/15	22/22 68/7 99/21	128/20
90/8 91/7 120/17	16/22 77/24 78/9 99/6	43/8 43/21 44/17	<b>moral [1]</b> 117/2	<b>Mr Marquis [4]</b> 98/3
122/20 122/24 122/25	106/12 109/2	102/25 122/7 122/7	<b>more [33]</b> 3/4 3/20	98/4 102/20 108/6
125/11 126/10	<b>men [2]</b> 3/21 3/22	122/13 122/14	3/21 4/19 12/22 13/15	<b>Mr Payter [2]</b> 108/10
<b>may [47]</b> 2/16 3/2 4/8	<b>Mencap [1]</b> 87/15	<b>Module 2 [9]</b> 33/15	20/12 36/12 39/11	115/6
4/22 11/15 15/16 16/3	<b>menial [1]</b> 106/5	33/18 33/21 43/8 54/9	50/13 62/11 67/18	<b>Ms [43]</b> 1/8 1/11 1/22
20/15 25/9 26/18	<b>mental [12]</b> 19/20	58/21 74/11 78/14	72/15 75/8 76/15 77/1	28/24 29/2 29/4 29/6
30/13 30/14 31/15	24/18 25/8 27/16 34/9	79/6	77/7 82/20 84/8 86/2	30/3 34/8 38/10 38/11
32/24 33/5 35/6 35/7	42/8 42/9 81/22 84/7	<b>Module 2A [1]</b> 55/1	89/14 89/16 96/23	38/13 39/12 47/17
35/23 39/9 39/23 40/7	91/18 91/21 94/9	<b>Module 2B [3]</b> 62/7	100/25 101/1 101/2	48/21 58/2 58/4 59/21
43/18 47/19 57/15	<b>mention [2]</b> 5/3 86/25	88/15 90/6	101/9 103/11 105/22	66/3 69/3 69/10 69/12
61/10 76/19 79/3	<b>mentioned [4]</b> 4/23	<b>Module 2C [1]</b> 44/6	107/15 109/18 122/18	69/15 69/16 86/9
89/12 89/15 92/21	61/6 74/22 74/24	<b>Module 3 [6]</b> 1/8	125/21	86/11 97/21 115/8
95/12 100/22 108/7	<b>mere [1]</b> 77/3	30/24 31/18 37/13	<b>Moreover [3]</b> 3/9	115/10 118/6 120/16
110/4 111/5 112/2	<b>meritorious [1]</b> 61/25	46/8 117/16	10/23 12/15	123/5 123/6 125/4
112/19 113/1 114/13	<b>messy [1]</b> 120/5	<b>Module 4 [1]</b> 37/13	<b>Morgan [4]</b> 86/9	125/20 126/1 126/8
114/17 115/12 120/5	<b>met [3]</b> 25/4 58/11	<b>Module 5 [1]</b> 37/14	86/11 97/21 128/7	127/9 127/13 127/19
120/24 121/12 121/21	120/8	<b>Module 6 [74]</b> 1/5 1/7	<b>morning [22]</b> 1/4	128/7 128/17 128/23
122/3 126/12	<b>mid [1]</b> 50/10	2/17 3/12 4/6 5/12 7/1	4/13 5/10 5/18 13/14	<b>Ms Campbell [4]</b>
	<b>mid-2020 [1]</b> 50/10	7/6 7/10 7/16 7/21	17/18 30/3 39/13 43/2	38/11 48/21 66/3

<b>M</b>	56/21 57/1 57/2 57/16 57/20 58/9 58/19 59/4 60/18 63/22 64/8 64/18 65/17 66/20 67/8 67/20 69/2 69/5 69/20 70/15 72/4 73/18 73/24 74/7 75/18 76/15 77/19 86/7 86/12 97/20 98/8 103/6 105/16 106/8 107/9 108/5 108/13 110/16 114/13 114/19 115/11 118/10 118/19 119/10 119/15 120/20 121/8 121/15 121/17 121/23 122/17 123/3 123/11 123/20 125/3 125/6	92/19 95/3 95/3 95/16 106/6 106/7 107/11 110/25 116/25 119/12 121/9 122/14 125/13 <b>needed [7]</b> 21/8 46/15 82/19 91/1 101/6 121/22 124/8 <b>needing [3]</b> 15/5 88/24 90/24 <b>needs [21]</b> 24/20 25/7 30/1 30/17 38/5 61/23 63/2 63/3 63/5 65/19 73/10 79/20 80/8 80/23 81/20 84/6 87/19 88/7 97/16 100/5 121/19 <b>negative [3]</b> 19/16 42/6 60/15 <b>neglect [1]</b> 79/1 <b>neglected [1]</b> 85/15 <b>neglecting [1]</b> 61/22 <b>neither [3]</b> 10/5 21/1 63/24 <b>networks [1]</b> 72/17 <b>never [3]</b> 68/17 71/25 85/21 <b>nevertheless [1]</b> 75/8 <b>new [2]</b> 70/18 114/21 <b>news [1]</b> 75/14 <b>Newton [1]</b> 98/9 <b>next [5]</b> 16/14 38/11 77/16 86/9 126/11 <b>NHS [12]</b> 18/4 18/6 18/9 18/18 79/10 79/12 79/18 81/13 93/4 99/18 100/3 100/9 <b>nice [1]</b> 69/14 <b>nine [4]</b> 17/25 18/20 19/1 19/19 <b>ninefold [1]</b> 91/18 <b>no [24]</b> 7/6 12/9 20/19 26/4 26/6 41/10 42/2 68/6 68/11 75/11 75/15 79/25 101/13 103/16 104/21 105/20 105/21 110/1 110/6 119/24 123/4 125/16 125/20 125/22 <b>non [4]</b> 65/4 76/4 99/3 99/5 <b>non-clinical [1]</b> 99/3 <b>non-compliance [1]</b> 76/4 <b>non-governmental [1]</b> 65/4 <b>non-TUC-affiliated [1]</b> 99/5 <b>none [1]</b> 64/13 <b>nor [6]</b> 10/5 15/8 21/2 24/23 39/21 63/25 <b>normal [1]</b> 89/17 <b>north [5]</b> 40/17 41/22	43/7 44/11 104/4 <b>North London [1]</b> 104/4 <b>Northern [44]</b> 2/11 2/13 5/21 6/1 6/18 6/24 7/24 12/2 13/2 17/8 20/7 20/11 30/7 38/12 38/17 38/20 38/25 39/3 39/7 39/17 40/1 40/6 40/7 43/18 43/22 44/7 44/18 45/4 45/25 46/3 47/13 47/19 48/1 48/6 48/12 48/14 54/11 61/9 66/4 69/23 73/14 112/24 120/16 127/11 <b>Northern Ireland [33]</b> 2/11 5/21 6/1 6/18 6/24 7/24 12/2 13/2 17/8 20/11 30/7 38/17 38/20 38/25 39/3 39/7 39/17 40/1 40/6 40/7 43/18 43/22 44/7 45/4 45/25 47/19 48/6 48/12 48/14 66/4 73/14 112/24 120/16 <b>Northern Irish [4]</b> 46/3 47/13 48/1 54/11 <b>not [120]</b> 1/19 2/18 2/20 3/3 3/5 3/8 3/12 5/2 5/3 7/3 7/4 7/6 8/3 8/15 9/17 10/19 10/24 11/13 11/20 12/3 13/21 14/1 14/13 15/2 15/7 15/18 15/22 16/7 16/9 18/16 19/11 19/11 20/22 21/7 21/24 24/9 24/13 24/21 25/3 29/14 31/12 32/13 32/15 32/15 33/10 35/1 35/16 36/7 36/10 36/25 37/6 37/22 41/7 41/8 43/25 43/25 44/23 47/7 47/19 51/15 52/10 58/1 59/7 59/13 59/18 60/7 60/20 61/6 61/16 63/19 63/19 63/20 64/5 68/7 70/17 71/24 72/2 72/7 73/3 73/6 74/22 75/13 75/23 76/1 77/24 78/6 78/19 80/14 80/22 81/14 83/15 87/7 90/25 92/15 93/8 93/16 96/3 100/6 105/10 108/3 109/15 110/11 110/19 112/23 116/2 119/4 119/18 120/18 121/3 121/5 121/12 121/20 121/20 121/25 122/6 122/7 122/14 122/20 123/1 125/15	<b>note [20]</b> 25/1 25/6 35/14 36/23 51/12 52/9 54/7 54/12 54/15 54/15 56/20 57/6 57/8 66/25 76/8 78/18 83/12 114/24 119/7 119/17 <b>noted [2]</b> 18/7 53/7 <b>notes [2]</b> 51/10 64/24 <b>nothing [1]</b> 70/22 <b>noticeable [1]</b> 81/12 <b>notices [2]</b> 53/16 63/21 <b>notifications [3]</b> 2/10 50/19 90/16 <b>notified [1]</b> 75/12 <b>November [1]</b> 17/12 <b>November 2023 [1]</b> 17/12 <b>now [21]</b> 4/4 7/1 10/3 13/8 19/23 22/12 24/6 25/5 32/16 35/18 42/23 55/15 57/21 64/18 68/13 72/25 74/24 75/16 76/20 76/24 97/23 <b>NPIs [3]</b> 72/15 91/10 94/11 <b>nuanced [1]</b> 85/24 <b>number [35]</b> 2/19 4/11 11/11 13/3 13/17 13/20 14/18 23/2 24/22 26/1 27/9 32/1 36/18 37/2 37/18 43/5 44/6 46/24 49/17 53/4 56/6 57/14 83/14 90/2 90/23 91/15 91/17 91/21 97/1 109/17 111/14 114/14 114/24 116/13 118/16 <b>numbers [2]</b> 23/14 43/12 <b>nurses [1]</b> 99/3 <b>nursing [11]</b> 6/8 32/3 53/14 61/2 104/3 115/9 115/12 116/22 117/4 117/14 128/17
<b>Ms Campbell... [1]</b> 120/16 <b>Ms Carey [10]</b> 1/11 1/22 29/2 30/3 34/8 39/12 69/10 125/20 126/1 126/8 <b>Ms Cecil [2]</b> 69/12 69/15 <b>Ms Cecil KC [1]</b> 69/16 <b>Ms Curtain [2]</b> 123/5 125/4 <b>MS FENELLA [2]</b> 115/10 128/17 <b>Ms Gowman [2]</b> 58/2 69/3 <b>Ms Jac Carey [1]</b> 1/8 <b>Ms Morgan [2]</b> 86/9 97/21 <b>Ms Morris [7]</b> 28/24 29/4 38/10 47/17 59/21 115/8 118/6 <b>much [26]</b> 13/15 24/10 29/2 38/10 42/3 45/8 48/20 53/22 57/19 68/9 69/3 69/17 77/13 86/8 97/21 98/8 108/6 115/5 115/6 118/6 123/4 125/12 125/20 125/23 126/7 126/11 <b>multifaceted [1]</b> 101/25 <b>multiple [5]</b> 24/20 95/12 96/12 101/22 110/25 <b>multitude [1]</b> 15/2 <b>Mum's [1]</b> 68/10 <b>must [15]</b> 12/16 32/7 44/20 45/1 48/4 48/6 48/11 65/25 66/6 69/15 106/21 107/10 107/18 122/13 125/12 <b>my [137]</b> <b>my Lady [116]</b> 1/24 1/25 2/15 3/9 5/7 6/4 7/3 10/3 12/22 14/13 15/10 17/15 19/15 26/8 28/8 29/7 30/2 34/25 36/12 36/22 37/25 38/8 38/14 38/18 40/1 41/16 42/5 42/23 43/17 45/3 45/23 46/9 46/21 47/12 48/2 48/18 48/25 49/5 49/14 50/5 50/8 50/18 50/21 50/24 51/5 51/9 51/12 52/3 52/24 53/1 53/17 54/7 54/12 54/14 54/24 55/12 55/19 55/20 56/4 56/14	<b>my Lady's [1]</b> 76/8 <b>N</b> <b>NACAS [5]</b> 108/14 108/17 108/19 109/6 109/10 <b>NACAS's [2]</b> 108/15 111/15 <b>name [1]</b> 77/20 <b>names [1]</b> 35/17 <b>narrower [1]</b> 61/21 <b>narrowly [2]</b> 79/4 83/21 <b>nation [2]</b> 3/18 12/21 <b>national [20]</b> 6/6 6/9 19/8 19/10 30/11 30/13 61/20 72/5 74/23 77/17 77/22 77/24 78/6 88/3 100/17 105/9 108/11 108/13 128/1 128/12 <b>nationally [1]</b> 100/19 <b>nations [9]</b> 23/17 29/21 55/10 59/9 59/17 60/13 71/24 75/2 75/23 <b>nature [8]</b> 19/7 21/5 31/4 39/22 101/23 110/17 112/21 114/10 <b>Nazroo [1]</b> 33/23 <b>Nazroo's [1]</b> 33/21 <b>nearly [1]</b> 27/7 <b>necessarily [4]</b> 10/3 14/6 14/23 61/16 <b>necessary [14]</b> 12/9 13/22 15/25 18/15 28/6 30/9 60/8 60/11 85/24 90/7 96/1 96/16 119/21 120/1 <b>need [34]</b> 1/19 2/2 12/13 14/15 14/23 15/14 24/5 28/16 30/10 33/7 37/9 41/17 45/23 58/25 61/18 71/14 75/7 76/23 87/18 88/25 91/5	<b>nevertheless [1]</b> 75/8 <b>new [2]</b> 70/18 114/21 <b>news [1]</b> 75/14 <b>Newton [1]</b> 98/9 <b>next [5]</b> 16/14 38/11 77/16 86/9 126/11 <b>NHS [12]</b> 18/4 18/6 18/9 18/18 79/10 79/12 79/18 81/13 93/4 99/18 100/3 100/9 <b>nice [1]</b> 69/14 <b>nine [4]</b> 17/25 18/20 19/1 19/19 <b>ninefold [1]</b> 91/18 <b>no [24]</b> 7/6 12/9 20/19 26/4 26/6 41/10 42/2 68/6 68/11 75/11 75/15 79/25 101/13 103/16 104/21 105/20 105/21 110/1 110/6 119/24 123/4 125/16 125/20 125/22 <b>non [4]</b> 65/4 76/4 99/3 99/5 <b>non-clinical [1]</b> 99/3 <b>non-compliance [1]</b> 76/4 <b>non-governmental [1]</b> 65/4 <b>non-TUC-affiliated [1]</b> 99/5 <b>none [1]</b> 64/13 <b>nor [6]</b> 10/5 15/8 21/2 24/23 39/21 63/25 <b>normal [1]</b> 89/17 <b>north [5]</b> 40/17 41/22	<b>note [20]</b> 25/1 25/6 35/14 36/23 51/12 52/9 54/7 54/12 54/15 54/15 56/20 57/6 57/8 66/25 76/8 78/18 83/12 114/24 119/7 119/17 <b>noted [2]</b> 18/7 53/7 <b>notes [2]</b> 51/10 64/24 <b>nothing [1]</b> 70/22 <b>noticeable [1]</b> 81/12 <b>notices [2]</b> 53/16 63/21 <b>notifications [3]</b> 2/10 50/19 90/16 <b>notified [1]</b> 75/12 <b>November [1]</b> 17/12 <b>November 2023 [1]</b> 17/12 <b>now [21]</b> 4/4 7/1 10/3 13/8 19/23 22/12 24/6 25/5 32/16 35/18 42/23 55/15 57/21 64/18 68/13 72/25 74/24 75/16 76/20 76/24 97/23 <b>NPIs [3]</b> 72/15 91/10 94/11 <b>nuanced [1]</b> 85/24 <b>number [35]</b> 2/19 4/11 11/11 13/3 13/17 13/20 14/18 23/2 24/22 26/1 27/9 32/1 36/18 37/2 37/18 43/5 44/6 46/24 49/17 53/4 56/6 57/14 83/14 90/2 90/23 91/15 91/17 91/21 97/1 109/17 111/14 114/14 114/24 116/13 118/16 <b>numbers [2]</b> 23/14 43/12 <b>nurses [1]</b> 99/3 <b>nursing [11]</b> 6/8 32/3 53/14 61/2 104/3 115/9 115/12 116/22 117/4 117/14 128/17	
			<b>O</b> <b>o'clock [1]</b> 97/24 <b>object [1]</b> 102/18 <b>obligation [1]</b> 4/14 <b>observation [3]</b> 16/3 70/18 120/15 <b>observations [4]</b> 15/16 25/19 60/5 122/23 <b>observe [1]</b> 91/2 <b>observed [3]</b> 90/15 121/23 122/5 <b>obstacles [3]</b> 87/19 93/7 93/15 <b>obtain [9]</b> 10/9 17/6 20/10 24/14 26/20	

<p><b>O</b></p> <p><b>obtain...</b> [4] 34/17 65/12 92/2 96/2</p> <p><b>obtained</b> [4] 10/7 10/8 24/16 55/7</p> <p><b>obtaining</b> [3] 19/4 22/11 54/25</p> <p><b>obvious</b> [5] 24/13 36/6 46/23 95/2 114/5</p> <p><b>obviously</b> [4] 15/5 15/20 76/13 119/2</p> <p><b>occasions</b> [2] 37/2 37/18</p> <p><b>occupation</b> [1] 109/15</p> <p><b>occupations</b> [2] 4/2 100/23</p> <p><b>occurring</b> [1] 50/15</p> <p><b>off</b> [1] 42/1</p> <p><b>offer</b> [2] 20/4 20/5</p> <p><b>offered</b> [1] 64/15</p> <p><b>offering</b> [1] 82/13</p> <p><b>offers</b> [1] 123/16</p> <p><b>often</b> [23] 2/19 18/6 52/15 55/4 63/24 82/6 84/9 84/21 88/25 89/11 94/7 95/5 95/13 97/17 99/8 102/3 103/23 104/8 104/10 105/2 109/9 109/24 110/6</p> <p><b>old</b> [1] 3/8</p> <p><b>older</b> [5] 33/11 47/4 65/7 79/14 84/2</p> <p><b>Ombudsman</b> [1] 90/18</p> <p><b>on</b> [253]</p> <p><b>on site</b> [1] 13/19</p> <p><b>once</b> [12] 10/7 11/9 28/5 55/19 56/11 63/12 73/12 81/12 98/4 98/7 125/18 126/9</p> <p><b>one</b> [32] 2/19 10/25 13/25 17/5 19/25 25/6 30/9 30/23 31/2 39/16 45/5 47/18 49/1 52/7 55/11 67/23 67/23 68/7 68/12 71/11 76/8 77/11 86/3 96/5 102/4 106/6 113/11 116/1 117/7 118/20 119/11 122/1</p> <p><b>ones</b> [25] 8/12 8/20 9/16 9/19 27/3 32/1 35/24 36/8 36/10 38/24 40/18 42/18 49/17 49/20 51/6 52/8 52/12 52/19 58/12 63/23 91/2 91/23 92/12 124/1 124/3</p> <p><b>ones'</b> [1] 52/16</p> <p><b>ongoing</b> [2] 91/22</p>	<p>117/3</p> <p><b>online</b> [6] 1/14 2/4 4/12 7/1 17/13 27/12</p> <p><b>only</b> [23] 3/12 10/25 12/3 15/2 33/10 36/10 39/13 51/15 59/13 60/14 64/2 75/12 76/13 78/9 84/12 92/15 94/15 96/25 108/25 110/19 115/19 120/18 125/6</p> <p><b>ONS</b> [2] 2/5 100/22</p> <p><b>onset</b> [1] 17/20</p> <p><b>open</b> [1] 121/17</p> <p><b>opened</b> [1] 82/3</p> <p><b>opening</b> [5] 1/12 12/23 78/25 86/7 119/7</p> <p><b>operate</b> [1] 54/1</p> <p><b>operating</b> [1] 65/5</p> <p><b>operation</b> [4] 30/20 54/3 96/8 123/17</p> <p><b>operational</b> [1] 82/18</p> <p><b>opinion</b> [1] 25/21</p> <p><b>opportunities</b> [1] 57/4</p> <p><b>opportunity</b> [9] 4/25 43/9 43/10 67/15 78/24 85/25 97/14 123/13 123/15</p> <p><b>opposed</b> [1] 20/25</p> <p><b>option</b> [2] 97/2 104/21</p> <p><b>or</b> [103] 1/14 2/23 4/17 6/2 7/4 7/7 8/4 9/18 13/14 13/14 13/18 13/22 14/1 15/4 15/13 15/18 16/10 16/10 18/6 18/16 19/11 19/21 21/8 23/9 24/7 24/20 25/8 25/8 27/6 28/15 30/11 33/23 35/2 36/8 39/6 39/20 39/20 39/22 39/24 39/24 39/25 39/25 40/5 41/1 41/3 41/5 41/8 41/8 41/23 42/17 42/18 43/1 43/18 44/4 44/9 44/19 44/23 45/12 47/9 47/9 48/9 52/22 52/22 60/21 64/2 69/24 70/21 71/3 74/12 75/16 77/3 79/23 79/25 83/15 85/21 87/9 87/11 87/17 88/21 88/21 89/1 89/9 90/2 90/10 90/20 91/21 94/16 96/24 99/11 99/25 104/21 105/7 108/14 110/1 110/4 110/6 110/7 118/18 121/6 121/6 122/2 124/3 125/6</p>	<p><b>oral</b> [11] 1/17 1/20 25/23 26/7 28/23 36/19 37/1 56/8 67/15 114/23 123/15</p> <p><b>order</b> [16] 34/22 38/2 44/25 46/6 47/22 64/6 64/20 65/12 65/24 66/7 66/17 67/4 73/11 77/15 103/23 120/1</p> <p><b>ordered</b> [1] 8/16</p> <p><b>orders</b> [3] 9/18 18/5 81/15</p> <p><b>organisation</b> [2] 98/23 108/25</p> <p><b>organisations</b> [24] 6/3 11/5 16/18 16/23 16/24 20/18 28/13 36/21 45/7 57/14 64/23 65/1 65/5 69/18 69/21 69/24 69/25 77/25 78/7 78/20 86/15 93/21 114/1 127/22</p> <p><b>organisations'</b> [1] 25/2</p> <p><b>other</b> [46] 3/13 4/11 11/12 13/5 13/15 14/14 15/3 15/11 15/11 15/13 15/16 15/21 22/14 24/16 25/14 34/21 35/15 36/17 53/12 55/15 55/25 56/6 57/16 60/24 61/13 67/3 67/14 70/11 71/16 73/2 73/25 74/18 74/22 74/25 81/21 87/21 88/17 89/4 90/23 91/16 103/2 108/23 114/19 114/23 118/20 123/16</p> <p><b>others</b> [10] 73/13 74/9 75/14 77/11 88/16 106/14 112/1 114/16 119/4 124/19</p> <p><b>otherwise</b> [3] 82/25 88/22 124/3</p> <p><b>ought</b> [2] 59/20 91/7</p> <p><b>our</b> [76] 11/19 12/9 12/22 16/8 21/3 22/23 29/8 29/14 29/17 30/2 30/12 30/17 31/1 31/12 32/1 34/5 34/6 34/14 35/3 35/13 35/17 36/3 36/23 37/4 37/18 37/22 37/23 38/23 40/18 41/21 42/14 42/24 43/3 44/15 45/11 46/3 47/1 47/21 48/9 67/23 71/23 73/8 74/14 75/20 76/7 76/12 79/1 79/5 83/7 85/17 86/7 86/22 87/2 87/4 87/10</p>	<p>88/9 88/12 89/25 90/5 90/9 91/9 93/17 95/9 95/21 95/24 97/3 97/4 97/13 98/12 104/14 108/5 110/18 111/8 122/19 122/22 123/1 <b>out</b> [27] 1/20 4/14 7/24 8/14 10/14 17/25 19/1 19/19 23/4 30/3 34/20 36/13 40/12 50/17 52/5 57/7 60/1 63/2 72/13 72/14 73/3 80/25 91/2 93/12 93/17 122/12 122/18</p> <p><b>outbreak</b> [2] 68/1 90/21</p> <p><b>outbreaks</b> [3] 19/1 19/3 91/12</p> <p><b>outcome</b> [2] 32/18 44/10</p> <p><b>outcomes</b> [3] 90/16 112/19 116/12</p> <p><b>outdated</b> [1] 44/8</p> <p><b>outline</b> [18] 4/9 7/15 11/13 12/11 23/5 23/10 32/23 35/25 50/23 53/7 54/5 59/19 59/25 60/18 61/1 61/11 86/24 92/13</p> <p><b>outlined</b> [6] 33/14 42/25 43/14 66/24 74/15 78/25</p> <p><b>outset</b> [7] 8/17 10/16 60/14 82/20 90/12 99/14 104/1</p> <p><b>outside</b> [2] 84/21 99/18</p> <p><b>outsourced</b> [9] 99/8 99/15 100/12 101/5 102/2 104/7 104/18 105/13 105/17</p> <p><b>outsourcing</b> [1] 102/10</p> <p><b>over</b> [15] 2/15 5/12 19/19 31/21 39/5 39/6 39/7 45/16 63/25 64/2 68/16 68/17 107/7 118/12 126/6</p> <p><b>Overall</b> [1] 60/2</p> <p><b>overburdened</b> [1] 110/19</p> <p><b>overdue</b> [1] 44/13</p> <p><b>overestimating</b> [1] 70/20</p> <p><b>overexposed</b> [1] 105/5</p> <p><b>overlap</b> [3] 53/8 55/24 84/9</p> <p><b>overlooked</b> [4] 79/7 88/13 89/3 93/16</p> <p><b>overlooking</b> [2] 70/19 83/23</p> <p><b>overseas</b> [1] 102/9</p> <p><b>oversight</b> [7] 46/12</p>	<p>46/12 85/1 89/17 90/10 91/6 120/12</p> <p><b>oversights</b> [1] 85/6</p> <p><b>oversimplification</b> [1] 84/13</p> <p><b>overstate</b> [1] 38/19</p> <p><b>overstated</b> [2] 32/22 42/10</p> <p><b>overview</b> [1] 98/13</p> <p><b>overwhelmingly</b> [1] 99/9</p> <p><b>own</b> [12] 3/8 13/9 49/19 56/18 77/1 81/6 84/10 84/23 104/4 106/3 110/15 116/24</p> <p><b>owned</b> [1] 45/8</p> <hr/> <p><b>P</b></p> <p><b>packaged</b> [1] 44/1</p> <p><b>PAGE</b> [1] 127/2</p> <p><b>paid</b> [6] 27/6 62/18 93/9 99/10 101/3 110/20</p> <p><b>painful</b> [3] 16/4 33/19 120/25</p> <p><b>paint</b> [1] 85/24</p> <p><b>pandemic</b> [141]</p> <p><b>pandemics</b> [3] 14/25 45/1 72/17</p> <p><b>paragraph</b> [8] 29/17 32/23 34/5 34/14 35/25 47/2 60/2 66/25</p> <p><b>paragraph 1</b> [1] 32/23</p> <p><b>paragraph 13</b> [1] 29/17</p> <p><b>paragraph 22</b> [1] 47/2</p> <p><b>paragraph 4</b> [1] 35/25</p> <p><b>paragraph 41</b> [2] 34/5 66/25</p> <p><b>paragraph 42</b> [1] 34/14</p> <p><b>paragraph 9</b> [1] 60/2</p> <p><b>paragraphs</b> [1] 122/19</p> <p><b>paragraphs 9</b> [1] 122/19</p> <p><b>paralegals</b> [1] 22/4</p> <p><b>parlous</b> [1] 110/1</p> <p><b>part</b> [19] 4/6 7/13 12/21 15/22 24/8 25/6 26/16 49/13 71/7 72/10 73/14 73/18 76/24 92/19 95/6 104/15 104/16 117/12 119/18</p> <p><b>participant</b> [24] 5/13 5/23 6/10 6/11 7/4 7/5 7/6 10/25 49/15 58/10 78/13 78/19 87/10 88/9 90/1 90/9 91/9 95/9 95/21 97/3 97/13</p>
---	---	--	--	--



<b>P</b>	<b>Paul [1]</b> 108/15 <b>Paul Featherstone [1]</b> 108/15 <b>Pause [1]</b> 123/8 <b>paused [1]</b> 5/1 <b>pave [1]</b> 85/19 <b>pay [13]</b> 96/11 100/10 100/11 102/1 104/19 104/19 104/20 105/21 106/7 106/18 106/21 110/10 113/3 <b>Payter [4]</b> 108/10 108/12 115/6 128/14 <b>people [75]</b> 3/9 3/20 4/19 9/6 10/21 11/4 13/21 18/19 24/18 24/21 24/23 24/25 26/25 27/4 27/7 31/22 33/11 34/4 39/16 41/17 50/13 58/1 62/5 69/25 70/2 70/6 70/10 70/17 71/3 72/9 72/12 72/16 75/7 75/21 76/5 76/25 77/2 77/6 79/15 79/22 80/19 81/1 81/20 84/2 84/16 86/4 86/20 87/13 87/14 87/15 87/16 87/23 87/24 88/10 88/17 89/9 91/5 91/10 91/18 91/21 92/8 94/2 94/5 94/7 94/14 94/22 95/1 95/7 95/10 95/13 95/16 96/14 97/16 105/3 118/13 <b>people's [13]</b> 6/3 8/18 25/1 26/14 28/13 36/20 65/7 69/18 69/21 69/24 80/2 84/10 127/21 <b>perceived [1]</b> 18/10 <b>percentage [3]</b> 50/11 106/22 107/3 <b>performance [2]</b> 34/21 35/5 <b>performed [1]</b> 35/7 <b>perhaps [10]</b> 39/2 43/25 45/7 47/1 50/5 55/1 67/18 115/23 119/15 122/10 <b>period [6]</b> 31/25 39/8 74/6 106/15 107/8 117/18 <b>perpetuating [2]</b> 83/9 85/5 <b>persistent [2]</b> 32/19 85/14 <b>person [6]</b> 7/7 90/17 93/11 93/13 94/14 95/4 <b>Person-centred [1]</b> 94/14 <b>personal [4]</b> 9/14 13/13 41/9 124/13	<b>persons [3]</b> 39/5 39/6 47/4 <b>persons' [1]</b> 75/10 <b>perspective [3]</b> 36/15 53/23 111/12 <b>pertinently [1]</b> 50/5 <b>phase [1]</b> 48/10 <b>phases [1]</b> 19/25 <b>physical [12]</b> 19/21 24/19 25/8 27/16 34/7 34/9 42/8 81/22 84/6 91/17 91/21 94/8 <b>picture [1]</b> 85/24 <b>pieces [1]</b> 104/5 <b>pigeonhole [1]</b> 24/23 <b>pillars [1]</b> 59/10 <b>pitfalls [1]</b> 66/11 <b>place [9]</b> 19/5 22/5 27/10 28/12 64/3 91/7 121/11 121/14 125/2 <b>placed [3]</b> 63/23 79/10 100/4 <b>places [3]</b> 77/12 110/15 111/1 <b>placing [1]</b> 106/25 <b>plain [1]</b> 12/15 <b>plainly [1]</b> 102/1 <b>planning [5]</b> 62/17 76/6 112/8 117/10 118/2 <b>plastic [1]</b> 104/5 <b>platform [1]</b> 122/13 <b>play [2]</b> 23/13 122/12 <b>please [3]</b> 29/12 32/16 103/3 <b>pleased [1]</b> 78/11 <b>pm [4]</b> 57/25 97/25 98/2 126/15 <b>point [22]</b> 46/24 64/7 65/17 68/5 68/6 70/16 70/19 73/8 74/14 75/20 76/7 82/17 106/21 107/9 107/9 109/24 112/25 113/8 114/3 114/7 119/11 122/5 <b>point 2 [1]</b> 106/21 <b>point 3 [2]</b> 107/9 107/9 <b>points [9]</b> 35/23 40/9 59/2 71/8 74/25 79/8 107/21 112/1 112/2 <b>points 4 [1]</b> 107/21 <b>policies [13]</b> 19/11 40/12 40/22 65/13 80/16 97/18 99/24 102/14 105/14 107/20 113/9 113/11 113/18 <b>policy [9]</b> 10/18 40/14 40/19 80/24 81/12 85/8 89/23 90/3 113/24 <b>Policymakers [1]</b> 85/15	<b>political [2]</b> 59/10 122/3 <b>politicians [1]</b> 71/11 <b>politics [1]</b> 103/3 <b>poor [6]</b> 31/14 40/21 44/14 80/4 89/20 116/10 <b>poorer [1]</b> 100/25 <b>poorly [2]</b> 110/20 117/13 <b>populated [1]</b> 99/25 <b>population [4]</b> 73/5 84/19 107/13 109/20 <b>populations [2]</b> 83/24 93/19 <b>portfolio [1]</b> 53/9 <b>portion [1]</b> 83/23 <b>pose [1]</b> 35/4 <b>posed [2]</b> 14/8 51/23 <b>position [15]</b> 12/4 21/7 21/9 23/17 37/3 37/7 37/18 59/14 59/22 66/8 111/23 113/8 113/10 113/14 113/20 <b>positions [3]</b> 99/9 105/21 107/1 <b>positive [3]</b> 40/14 50/6 63/24 <b>positively [1]</b> 57/11 <b>possibility [1]</b> 52/20 <b>possible [14]</b> 15/7 20/11 24/12 37/16 37/16 55/6 56/2 83/15 86/6 103/15 107/6 114/20 115/3 115/4 <b>post [1]</b> 102/8 <b>post-pandemic [1]</b> 102/8 <b>posts [1]</b> 116/22 <b>potential [9]</b> 14/11 14/21 15/3 24/2 27/25 66/11 68/25 93/18 97/5 <b>potentially [3]</b> 4/23 19/14 22/13 <b>power [1]</b> 64/1 <b>powerful [1]</b> 67/10 <b>powers [1]</b> 89/9 <b>PPE [26]</b> 2/22 9/15 18/1 18/5 23/25 51/16 52/18 62/10 62/22 63/13 67/17 80/5 80/7 101/16 103/25 103/25 104/7 104/9 105/5 106/7 108/1 108/2 108/3 110/6 113/22 116/15 <b>practicable [1]</b> 66/17 <b>practical [7]</b> 10/5 11/13 21/4 36/22 54/2 59/14 80/1 <b>practically [1]</b> 25/10 <b>practice [5]</b> 21/2	31/14 45/16 51/22 85/8 <b>practices [1]</b> 41/4 <b>pre [12]</b> 16/5 73/10 74/6 80/7 100/7 101/17 102/3 106/15 106/16 111/13 119/14 120/25 <b>pre-Covid [1]</b> 102/3 <b>pre-existed [1]</b> 119/14 <b>pre-existing [1]</b> 80/7 <b>pre-pandemic [9]</b> 16/5 73/10 74/6 100/7 101/17 106/15 106/16 111/13 120/25 <b>precarious [5]</b> 99/10 101/1 106/22 107/1 107/15 <b>preceding [1]</b> 21/21 <b>precious [1]</b> 82/9 <b>precisely [1]</b> 102/15 <b>precludes [1]</b> 7/7 <b>preliminary [6]</b> 1/5 5/15 28/10 108/5 117/15 126/13 <b>premises [1]</b> 96/21 <b>premiums [1]</b> 96/18 <b>preparation [6]</b> 38/1 48/3 55/24 55/25 66/18 76/17 <b>preparations [2]</b> 11/7 56/3 <b>prepare [2]</b> 37/13 114/21 <b>prepared [4]</b> 45/2 52/3 76/18 118/3 <b>preparedness [8]</b> 15/17 29/13 29/15 44/25 85/9 102/24 122/8 122/12 <b>preparing [1]</b> 69/11 <b>prescribed [1]</b> 42/15 <b>presence [2]</b> 2/24 70/18 <b>present [3]</b> 4/20 28/23 61/1 <b>press [2]</b> 34/5 34/10 <b>pressing [1]</b> 37/9 <b>pressure [1]</b> 100/5 <b>pressured [1]</b> 103/23 <b>pressures [1]</b> 117/1 <b>prevent [3]</b> 8/8 91/7 92/6 <b>prevented [1]</b> 2/23 <b>preventing [2]</b> 9/11 93/12 <b>prevention [12]</b> 9/12 9/25 19/10 23/19 32/6 36/11 40/22 51/14 92/16 110/8 113/13 117/17 <b>previous [3]</b> 67/8 72/22 74/1
----------	--	---	--	---

<b>P</b>	<b>promotion [1]</b> 46/18	30/25 31/16 45/17	46/16 46/19 82/15	102/21
<b>previously [1]</b> 105/19	<b>proper [8]</b> 11/2 41/18	45/19 71/12 78/4 78/6	89/6	<b>reason [2]</b> 44/16
<b>primarily [2]</b> 10/18	41/18 80/18 91/6 96/8	78/8 78/10 82/5 82/12	<b>quarter [1]</b> 100/17	47/15
44/2	102/5 106/7	82/17 90/16 90/21	<b>queried [1]</b> 22/17	<b>reasonable [2]</b> 4/16
<b>primary [1]</b> 87/17	<b>properly [12]</b> 21/11	97/1 100/8 112/12	<b>question [6]</b> 2/18	88/21
<b>principle [2]</b> 89/14	30/1 30/8 39/21 44/25	120/11	75/18 115/18 118/1	<b>reasonably [1]</b> 66/17
119/24	48/13 55/23 64/20	<b>provides [4]</b> 4/25	118/3 119/25	<b>reasons [5]</b> 5/5 24/13
<b>prior [7]</b> 9/2 15/24	65/24 72/3 96/14	11/2 21/12 108/22	<b>questionnaires [2]</b>	68/22 87/13 102/6
60/8 63/10 89/25	121/9	<b>providing [18]</b> 3/17	76/16 118/1	<b>reassuring [1]</b> 42/23
119/21 120/3	<b>proportion [6]</b> 3/11	4/1 7/9 10/1 18/1 20/4	<b>questions [6]</b> 25/15	<b>recall [1]</b> 62/6
<b>prioritisation [1]</b>	3/22 3/25 58/11	22/20 27/5 35/3 35/16	37/19 37/22 56/12	<b>receive [6]</b> 17/2
80/10	104/25 107/17	56/7 66/9 78/22 81/7	122/11 123/22	21/23 27/16 48/6 72/9
<b>private [13]</b> 13/12	<b>proportional [1]</b>	85/23 86/20 87/20	<b>quickly [2]</b> 56/2	84/20
45/10 45/18 78/7	31/24	124/25	81/13	<b>received [14]</b> 2/10
99/20 100/8 100/10	<b>proportionality [2]</b>	<b>provision [8]</b> 35/21	<b>quintiles [1]</b> 107/13	5/12 11/10 11/22
100/13 102/2 106/24	59/1 61/18	45/10 53/10 53/13	<b>quite [1]</b> 1/21	21/14 22/6 25/12 26/1
112/11 112/17 120/11	<b>proportionate [7]</b>	56/19 67/3 93/3 117/4	<b>quoted [1]</b> 39/12	28/21 29/8 58/16
<b>privately [4]</b> 7/22	13/22 15/9 31/2 35/9	<b>provisional [23]</b> 4/9		64/22 65/19 93/5
12/25 27/3 45/8	35/12 36/18 83/16	7/15 10/3 10/23 11/1	<b>R</b>	<b>receiving [15]</b> 1/15
<b>privatised [1]</b> 99/19	<b>proportionately [2]</b>	11/13 12/10 23/4	<b>race [2]</b> 39/25 109/19	3/15 18/23 18/24
<b>proactively [1]</b> 68/23	73/1 73/23	29/12 32/23 35/25	<b>racialised [1]</b> 32/18	18/25 24/10 31/22
<b>problem [5]</b> 70/20	<b>proposal [1]</b> 11/16	42/25 43/15 59/19	<b>racism [3]</b> 33/2 56/23	32/2 36/7 39/19 41/3
100/4 102/10 102/13	<b>proposals [2]</b> 17/4	59/25 60/18 61/11	56/24	79/23 87/20 87/24
121/20	86/24	63/6 63/20 64/7 64/18	<b>raft [1]</b> 67/5	88/7
<b>problems [3]</b> 16/8	<b>propose [3]</b> 29/9	92/13 106/9	<b>raise [3]</b> 48/5 82/17	<b>recipients [5]</b> 20/15
106/19 121/4	58/17 98/12	<b>provisionally [2]</b>	125/11	22/19 46/6 64/25 77/3
<b>procedure [2]</b> 54/18	<b>proposed [8]</b> 27/23	23/2 23/6	<b>raised [6]</b> 11/21	<b>recklessly [1]</b> 62/8
55/9	28/1 57/13 83/7 93/19	<b>provisions [2]</b> 74/15	38/23 48/3 48/8 53/3	<b>recognise [4]</b> 31/11
<b>procedures [1]</b> 65/13	95/22 97/9 111/9	74/21	126/10	34/25 37/10 83/25
<b>proceed [1]</b> 121/17	<b>proposes [2]</b> 32/21	<b>prynhawn [1]</b> 123/11	<b>raising [1]</b> 104/14	<b>recognised [4]</b> 32/17
<b>proceedings [5]</b> 4/10	114/17	<b>prynhawn da [1]</b>	<b>range [14]</b> 10/4 17/16	46/1 93/8 110/17
4/13 4/18 5/6 38/17	<b>protect [3]</b> 75/3	123/11	17/24 61/15 61/17	<b>recognises [3]</b>
<b>process [14]</b> 10/7	96/14 107/12	<b>psychological [1]</b>	63/10 63/12 78/20	123/20 123/24 124/22
16/17 20/10 24/17	<b>protected [2]</b> 89/19	117/2	84/5 92/24 95/13	<b>recognising [2]</b>
37/5 37/24 38/5 46/7	99/13	<b>public [21]</b> 4/16 4/22	109/3 113/19 124/18	43/13 70/4
54/21 55/3 63/24	<b>protecting [3]</b> 79/12	6/22 6/23 6/23 6/24	<b>ranging [1]</b> 35/1	<b>recognition [4]</b> 47/4
69/13 72/1 116/20	92/8 92/9	7/11 10/16 27/3 28/11	<b>rapidly [1]</b> 17/21	85/14 108/21 121/9
<b>processes [1]</b> 37/8	<b>protection [4]</b> 71/22	28/16 36/1 45/10 65/9	<b>rate [1]</b> 109/16	<b>recommend [3]</b>
<b>produced [3]</b> 62/16	101/6 101/14 104/9	88/18 98/10 100/9	<b>rates [6]</b> 31/9 33/13	76/17 95/10 118/2
74/8 88/1	<b>protective [2]</b> 9/14	103/17 106/24 109/9	84/18 105/11 109/14	<b>recommendation [2]</b>
<b>production [1]</b> 77/9	41/9	112/17	113/5	117/11 121/22
<b>profession [1]</b> 113/5	<b>protocol [1]</b> 22/3	<b>publications [1]</b>	<b>rather [10]</b> 43/18	<b>recommendations</b>
<b>professional [2]</b> 83/6	<b>proud [1]</b> 109/6	73/25	59/8 70/2 79/12 79/14	<b>[19]</b> 14/4 14/15
108/20	<b>prove [2]</b> 111/5 122/3	<b>publicly [3]</b> 7/22	82/7 88/10 95/6 102/4	14/25 29/23 30/14
<b>professionals [4]</b>	<b>proved [1]</b> 52/21	12/25 112/10	126/6	34/24 35/8 43/24
9/16 18/12 32/3 81/5	<b>provide [19]</b> 3/21	<b>publish [2]</b> 19/25	<b>ratings [1]</b> 31/11	44/20 48/16 76/7
<b>Professor [2]</b> 33/21	13/8 13/13 16/25	28/21	<b>rationale [1]</b> 106/25	76/10 76/22 77/5
33/23	19/18 25/19 27/17	<b>published [3]</b> 1/16	<b>re [2]</b> 12/20 82/3	83/20 85/8 111/21
<b>Professor Nazroo [1]</b>	31/10 34/1 66/2 67/9	7/1 50/9	<b>re-opened [1]</b> 82/3	120/19 125/14
33/23	67/17 67/23 74/11	<b>punitive [1]</b> 42/11	<b>re-worded [1]</b> 12/20	<b>record [1]</b> 26/17
<b>Professor Nazroo's</b>	82/18 89/11 92/25	<b>purchasing [1]</b> 18/1	<b>reaching [4]</b> 16/7	<b>recorded [2]</b> 4/10
<b>[1]</b> 33/21	124/7 125/11	<b>purpose [5]</b> 21/4	40/17 93/15 121/3	51/10
<b>Professors [1]</b> 33/14	<b>provided [33]</b> 3/6 3/7	35/19 68/12 85/2	<b>reading [1]</b> 71/17	<b>recording [1]</b> 92/18
<b>profile [1]</b> 73/5	8/3 8/4 13/10 13/21	118/4	<b>ready [2]</b> 46/5 47/24	<b>records [1]</b> 64/3
<b>profit [4]</b> 77/25 78/6	13/24 13/25 15/21	<b>put [10]</b> 7/16 81/6	<b>real [7]</b> 14/14 42/12	<b>recourse [1]</b> 103/16
102/3 102/4	20/22 22/8 22/13	85/7 93/18 102/3	44/14 58/14 82/14	<b>recover [2]</b> 55/3
<b>profound [2]</b> 95/12	27/19 29/21 31/5 41/7	102/4 104/13 110/21	125/10 125/13	82/22
124/11	49/5 60/20 60/21 63/8	111/23 117/21	<b>real-time [1]</b> 82/14	<b>redacting [1]</b> 22/21
<b>profoundly [1]</b> 71/1	71/14 72/7 74/10 82/6	<b>putting [1]</b> 18/10	<b>realising [1]</b> 42/16	<b>redactions [2]</b> 22/2
<b>progress [2]</b> 21/13	82/11 83/15 83/18		<b>realistic [1]</b> 22/23	22/3
22/10	87/9 91/3 97/1 104/7	<b>Q</b>	<b>realities [1]</b> 80/1	<b>reduced [1]</b> 89/18
<b>prolonged [1]</b> 80/10	104/9 104/11	<b>qualified [1]</b> 33/24	<b>reality [5]</b> 22/18 34/8	<b>reducing [1]</b> 46/21
<b>promotes [1]</b> 108/21	<b>providers [22]</b> 16/23	<b>qualitative [1]</b> 28/2	39/15 47/8 120/4	<b>refer [4]</b> 17/18 58/7
	17/25 23/15 24/9	<b>quality [6]</b> 6/14 6/15	<b>really [2]</b> 46/25	72/25 93/17

<b>R</b>	49/10 50/22 53/18 54/1 56/4 56/17 57/5 57/9 75/4 95/21 113/9 113/13 116/11 124/19	97/17 98/9 108/13 118/15	<b>resilient [3]</b> 77/8 86/3 102/7	<b>resuscitate [1]</b> 110/11
<b>reference [8]</b> 15/23 40/13 102/22 102/23 110/22 119/13 119/19 121/10	<b>relations [1]</b> 42/13 <b>relatives [2]</b> 51/2 52/15	<b>representations [1]</b> 66/12	<b>resource [1]</b> 46/4 <b>resources [5]</b> 41/1 48/10 59/15 82/9 108/23	<b>Resuscitation [3]</b> 9/18 63/21 81/14
<b>referred [4]</b> 11/20 69/16 105/18 105/19	<b>relevance [4]</b> 14/24 22/1 22/5 122/15	<b>representative [2]</b> 78/3 86/17	<b>resourcing [1]</b> 30/20	<b>retention [1]</b> 113/4
<b>referring [2]</b> 103/6 105/15	<b>relevant [29]</b> 7/10 11/5 15/20 16/18 16/20 16/23 21/25 22/11 22/13 23/24 24/14 30/14 53/5 55/7 64/22 65/20 75/19 87/5 89/21 95/7 96/13 96/17 97/10 111/4 117/17 120/17 121/21 122/4 122/10	<b>representatives [1]</b> 55/22	<b>respect [16]</b> 9/5 28/3 32/12 34/6 37/3 37/9 37/17 59/9 59/16 64/8 65/23 94/19 106/15 107/4 107/22 122/23	<b>return [3]</b> 4/8 97/23 103/23
<b>refining [1]</b> 61/11	<b>reliance [1]</b> 100/12	<b>representing [1]</b> 5/19	<b>respectfully [2]</b> 74/24 121/11	<b>review [4]</b> 15/15 22/1 22/5 44/2
<b>reflect [5]</b> 12/3 12/5 39/18 39/22 59/13	<b>reliant [1]</b> 48/17	<b>represents [1]</b> 2/19	<b>respectively [1]</b> 12/2	<b>reviewed [1]</b> 22/14
<b>reflected [2]</b> 30/1 43/1	<b>reliving [1]</b> 68/15	<b>reputations [1]</b> 97/10	<b>respite [3]</b> 13/7 19/22 81/24	<b>reviewing [1]</b> 22/20
<b>reflects [1]</b> 14/14	<b>rely [2]</b> 87/2 118/18	<b>request [4]</b> 17/3 21/17 66/15 117/15	<b>respond [3]</b> 8/10 22/20 110/3	<b>reviews [1]</b> 43/24
<b>reform [1]</b> 44/13	<b>remained [2]</b> 82/16 94/3	<b>requested [4]</b> 21/16 64/4 64/22 65/19	<b>responded [3]</b> 17/15 17/21 70/8	<b>revised [1]</b> 59/20
<b>reforms [1]</b> 74/5	<b>remains [1]</b> 21/9	<b>requests [20]</b> 11/9 16/15 16/18 20/12 20/14 20/17 20/23 20/24 21/1 21/5 21/15 21/15 22/19 46/7 64/24 67/13 75/19 93/22 106/10 106/10	<b>respondees [2]</b> 18/2 18/11	<b>revisited [1]</b> 28/4
<b>refugees [1]</b> 99/1	<b>remarks [4]</b> 1/3 67/20 103/11 127/3	<b>require [7]</b> 3/14 11/14 37/15 115/15 115/16 116/5 123/21	<b>respondents [7]</b> 18/7 18/21 19/6 19/9 19/12 19/16 19/19	<b>riddled [1]</b> 44/7
<b>refuse [1]</b> 101/11	<b>reminder [1]</b> 55/3	<b>required [12]</b> 21/1 21/8 41/23 47/6 50/1 50/4 60/25 67/7 74/18 76/24 110/2 124/14	<b>response [23]</b> 11/9 21/17 26/12 29/25 48/14 62/17 70/10 83/11 85/7 85/19 86/19 92/21 94/25 102/8 102/24 102/25 111/2 111/18 111/22 112/6 113/2 121/21 125/5	<b>right [6]</b> 6/4 57/21 77/1 108/10 108/16 124/16
<b>refusing [1]</b> 104/19	<b>reminds [2]</b> 76/8 117/15	<b>requirements [3]</b> 82/9 114/2 114/11	<b>responses [2]</b> 18/4 54/11	<b>rights [15]</b> 5/24 5/25 45/21 45/21 65/8 69/22 75/20 75/21 75/25 76/5 81/18 86/11 86/14 88/24 128/6
<b>regard [16]</b> 10/13 12/18 14/5 17/12 19/9 25/1 25/12 46/3 54/6 56/11 57/15 62/18 63/17 63/18 66/3 116/17	<b>reminders [1]</b> 64/11	<b>requires [4]</b> 30/5 31/3 55/17 116/18	<b>responsibilities [5]</b> 45/17 59/5 89/8 93/10 93/13	<b>ripped [2]</b> 101/19 117/21
<b>regarding [2]</b> 34/6 67/10	<b>remits [2]</b> 16/10 121/6	<b>requiring [2]</b> 3/11 10/24	<b>responsible [4]</b> 16/21 17/10 20/9 46/17	<b>rising [1]</b> 100/18
<b>regardless [1]</b> 99/16	<b>removal [1]</b> 51/21	<b>residence [2]</b> 13/12 40/5	<b>responsibility [5]</b> 53/21	<b>risk [9]</b> 4/2 63/17 81/3 82/21 100/23 101/8 102/18 103/7 103/20
<b>regimes [2]</b> 9/23 51/17	<b>removing [1]</b> 94/16	<b>resident's [1]</b> 9/20	<b>responsible [4]</b> 16/21 17/10 20/9 46/17	<b>risks [7]</b> 14/7 41/16 46/21 61/22 79/3 83/8 114/5
<b>region [1]</b> 3/20	<b>rendered [1]</b> 75/7	<b>residential [21]</b> 3/3 8/2 8/7 8/8 9/7 9/10 13/24 14/7 14/11 30/25 31/6 31/8 31/15 60/20 61/3 83/17 84/2 84/21 85/4 87/8 118/18	<b>responses [2]</b> 18/4 54/11	<b>robust [2]</b> 59/16 116/1
<b>registered [1]</b> 45/4	<b>renewed [1]</b> 73/15	<b>residents [24]</b> 2/7 8/12 8/19 9/19 9/25 13/17 14/8 14/17 19/13 27/1 27/21 36/6 39/10 39/17 42/6 42/9 46/14 47/5 47/11 50/10 51/23 52/1 62/21 105/25	<b>responsibilities [5]</b> 45/17 59/5 89/8 93/10 93/13	<b>robustly [1]</b> 68/23
<b>regularly [2]</b> 31/6 80/15	<b>repeat [11]</b> 15/18 23/16 30/17 37/4 37/6 58/17 119/5 122/6 122/20 123/1 125/24	<b>residing [1]</b> 61/24	<b>responsibility [1]</b> 53/21	<b>robustness [1]</b> 112/8
<b>regulated [2]</b> 29/20 107/6	<b>repeated [1]</b> 122/14	<b>resilience [4]</b> 71/1 85/11 122/8 122/11	<b>responsibility [1]</b> 53/21	<b>role [4]</b> 14/11 32/8 110/17 122/24
<b>regulation [6]</b> 6/15 32/8 46/16 89/18 90/10 113/6	<b>Repeatedly [1]</b> 79/19		<b>responsible [4]</b> 16/21 17/10 20/9 46/17	<b>roles [3]</b> 105/2 109/3 113/19
<b>regulators [3]</b> 16/22 90/23 90/25	<b>repeating [3]</b> 12/21 70/18 73/9		<b>restate [2]</b> 124/2 124/11	<b>roll [1]</b> 80/25
<b>regulatory [4]</b> 9/22 46/12 46/12 90/11	<b>replicate [1]</b> 30/23		<b>restraint [1]</b> 89/7	<b>roll-out [1]</b> 80/25
<b>rehearse [1]</b> 15/18	<b>report [11]</b> 23/16 25/19 26/13 26/14 26/17 33/21 56/24 75/14 87/15 94/12 103/25		<b>restraints [1]</b> 15/4	<b>rolling [2]</b> 20/17 22/7
<b>reiterate [2]</b> 7/5 27/10	<b>reported [10]</b> 17/24 18/5 18/14 18/18 19/2 19/9 19/16 19/19 92/20 102/16		<b>restriction [1]</b> 92/3	<b>roof [3]</b> 121/13 121/19 125/6
<b>reiterates [1]</b> 66/15	<b>reporting [4]</b> 17/22 53/20 100/22 104/19		<b>restrictions [14]</b> 2/23 9/15 18/13 27/15 42/7 42/10 46/23 80/18 89/10 91/12 93/12 94/6 95/19 96/19	<b>room [5]</b> 1/15 2/4 4/20 5/17 7/18
<b>relate [2]</b> 33/7 102/23	<b>reports [13]</b> 25/17 25/22 31/21 33/7 37/21 43/23 49/11 56/4 56/7 56/8 71/17 73/25 74/10		<b>result [6]</b> 1/10 19/2 40/19 58/13 104/15 104/17	<b>root [1]</b> 60/15
<b>related [12]</b> 2/7 2/10 9/24 25/8 39/7 39/9 50/11 50/19 80/16 89/4 103/10 122/5	<b>represent [9]</b> 38/4 38/17 58/6 70/2 70/3		<b>resultant [1]</b> 113/18	<b>routes [1]</b> 23/21
<b>relates [4]</b> 33/11 34/18 35/3 55/12			<b>resulted [2]</b> 18/14 59/8	<b>routine [4]</b> 4/22 27/20 46/20 90/14
<b>relating [7]</b> 9/6 23/25 49/24 53/14 87/1 90/24 96/19			<b>results [2]</b> 18/25 54/20	<b>routinely [1]</b> 18/20
<b>relation [27]</b> 15/16 15/17 20/2 20/11 23/22 25/13 26/23 28/9 29/13 36/12 44/15 45/25 47/17				<b>Royal [5]</b> 6/7 115/9 115/11 117/14 128/16

<b>R</b>	74/20 <b>schedule 12 [1]</b> 74/20 <b>schemes [1]</b> 13/7 <b>science [1]</b> 70/7 <b>scientific [2]</b> 23/21 80/24 <b>scope [62]</b> 4/9 7/16 10/3 10/23 11/1 11/13 11/19 11/20 11/22 12/11 12/19 12/22 12/24 13/4 15/12 15/17 16/10 21/4 23/5 28/7 29/12 31/20 32/12 32/24 33/4 33/9 33/20 35/23 35/25 42/25 43/15 50/23 53/7 54/6 55/18 59/19 59/24 59/25 60/3 60/6 60/18 61/1 61/11 62/3 63/6 63/20 64/7 64/19 79/3 79/9 83/7 84/14 85/3 92/13 98/14 98/19 103/15 106/8 106/9 111/9 115/13 121/6 <b>scope's [1]</b> 107/9 <b>Scotland [17]</b> 2/8 6/2 6/23 7/23 12/2 13/2 17/7 17/9 20/2 30/6 50/11 50/20 54/6 56/18 69/22 74/20 112/24 <b>Scotland's [1]</b> 56/18 <b>Scottish [56]</b> 5/22 6/11 6/18 6/19 6/21 20/3 20/4 48/24 49/1 49/5 49/11 49/14 49/21 50/8 50/9 50/14 50/22 50/24 51/8 51/12 51/25 52/9 52/14 52/23 52/25 53/2 53/4 53/9 53/11 53/12 53/17 53/18 53/21 53/23 53/23 53/24 54/4 54/7 54/10 54/11 54/16 54/23 54/25 55/5 55/11 56/4 56/10 56/14 56/18 56/20 56/25 57/3 57/8 57/11 57/17 127/15 <b>Scottish Care [1]</b> 6/11 <b>Scottish Inquiry [6]</b> 49/11 50/9 52/25 53/2 53/12 53/21 <b>Scottish Inquiry's [1]</b> 53/9 <b>Scottish Ministers [1]</b> 6/21 <b>screens [2]</b> 5/9 7/17 <b>scrutinise [2]</b> 66/7 85/18 <b>scrutinised [1]</b> 59/24	<b>scrutiny [2]</b> 124/22 124/23 <b>search [1]</b> 66/6 <b>second [4]</b> 73/8 79/8 88/12 112/25 <b>secondly [8]</b> 40/20 60/18 62/16 63/11 76/3 108/2 116/10 116/15 <b>section [2]</b> 87/13 88/21 <b>section 149 [1]</b> 88/21 <b>sections [1]</b> 74/21 <b>sector [128]</b> 1/6 2/2 3/4 3/21 3/22 4/6 7/23 7/23 8/2 8/10 8/13 8/19 8/21 8/23 9/5 9/23 13/1 14/22 16/6 18/10 23/8 23/10 23/13 23/25 24/1 26/25 27/2 27/8 29/16 29/20 31/5 32/8 32/13 33/11 34/19 34/21 34/22 35/5 38/25 39/20 40/6 40/15 43/7 44/4 44/18 44/21 46/1 49/19 49/25 58/15 60/13 62/5 62/15 62/20 64/15 65/3 70/8 70/13 73/4 73/11 73/17 74/4 74/13 78/16 78/22 79/2 80/5 80/8 80/9 80/19 80/23 83/5 85/10 85/20 97/6 98/13 99/3 99/7 99/19 99/20 99/23 100/7 100/10 100/11 100/13 100/17 101/3 101/20 102/3 102/6 103/10 103/16 106/17 106/23 107/5 107/7 108/4 111/2 111/17 111/18 111/22 111/23 112/6 112/9 113/25 115/15 115/19 115/20 115/25 116/4 116/11 116/22 117/5 117/22 118/16 118/17 118/24 119/1 119/7 119/14 120/10 121/2 122/9 123/19 123/22 124/5 124/9 124/20 <b>sector's [2]</b> 71/20 117/5 <b>sectors [4]</b> 30/4 99/6 106/24 112/23 <b>sedation [2]</b> 15/4 89/5 <b>see [5]</b> 4/17 7/24 35/19 42/23 68/7 <b>seek [12]</b> 16/10 33/22 34/23 45/15 52/4 53/19 64/25 68/20 71/18 88/25	117/16 121/6 <b>seeking [1]</b> 103/19 <b>seeks [1]</b> 62/13 <b>seems [4]</b> 22/23 40/23 55/19 68/11 <b>seen [2]</b> 72/21 97/3 <b>segregation [2]</b> 63/13 67/18 <b>self [2]</b> 109/5 113/21 <b>self-employed [2]</b> 109/5 113/21 <b>senior [1]</b> 81/11 <b>sense [5]</b> 44/8 68/12 71/23 118/20 122/13 <b>sensible [1]</b> 24/24 <b>sensitive [2]</b> 4/23 5/1 <b>sent [2]</b> 64/24 67/13 <b>separated [1]</b> 94/10 <b>separating [1]</b> 110/14 <b>separation [1]</b> 95/19 <b>September [1]</b> 37/12 <b>September 2024 [1]</b> 37/12 <b>series [1]</b> 82/22 <b>serious [4]</b> 50/24 88/18 91/19 94/11 <b>serve [2]</b> 21/3 35/20 <b>served [2]</b> 64/10 120/13 <b>service [6]</b> 30/11 30/13 45/10 71/12 123/22 124/13 <b>services [19]</b> 3/7 6/12 30/11 46/18 46/19 53/10 74/17 75/15 78/1 79/15 79/16 81/23 82/2 83/5 84/4 84/13 88/6 109/25 112/21 <b>set [18]</b> 1/20 4/14 7/24 8/14 10/14 12/13 23/4 30/3 30/17 34/20 50/17 56/19 57/7 60/1 72/16 93/17 103/13 122/18 <b>set-up [1]</b> 56/19 <b>setting [4]</b> 41/17 73/7 73/19 93/14 <b>settings [49]</b> 4/7 13/5 13/8 13/16 13/20 13/22 14/14 15/3 15/11 15/13 23/23 27/5 30/25 31/6 31/8 31/10 31/16 32/4 32/7 40/23 41/13 58/13 61/2 61/4 61/16 61/16 63/11 63/12 63/14 79/25 80/11 80/14 81/2 83/14 83/16 86/20 87/8 87/11 87/12 87/14 87/21 87/23 88/6 92/25 96/12 112/16 112/17	113/12 117/14 <b>seven [3]</b> 17/17 40/8 87/6 <b>Seventh [1]</b> 42/20 <b>several [4]</b> 87/5 93/18 98/24 99/6 <b>severe [2]</b> 91/20 95/11 <b>severely [1]</b> 83/24 <b>sex [1]</b> 39/25 <b>sexism [2]</b> 33/3 56/25 <b>Shakespeare [1]</b> 33/15 <b>shall [5]</b> 1/22 48/22 97/23 126/1 126/8 <b>shambolic [1]</b> 80/6 <b>share [3]</b> 27/12 36/25 49/18 <b>shared [5]</b> 13/6 27/7 27/24 40/9 61/5 <b>sharp [2]</b> 76/20 90/15 <b>she [7]</b> 1/9 67/24 67/25 68/3 68/11 68/12 69/11 <b>sheltered [4]</b> 13/6 13/18 32/14 61/4 <b>shield [1]</b> 116/25 <b>shocking [1]</b> 94/13 <b>short [7]</b> 13/12 29/9 57/24 71/8 82/7 98/1 108/14 <b>short-term [1]</b> 82/7 <b>shortages [4]</b> 44/12 96/11 103/24 117/3 <b>shortly [1]</b> 75/22 <b>should [42]</b> 5/2 10/18 11/12 11/24 12/19 13/4 15/12 17/2 24/7 25/3 26/2 29/15 30/15 33/3 43/10 48/16 56/22 56/24 63/16 64/16 64/21 67/2 73/15 73/21 74/2 74/11 75/18 88/18 89/18 92/14 93/16 93/24 105/25 106/24 107/2 107/14 114/24 117/12 122/7 122/15 124/16 126/3 <b>shouldn't [1]</b> 44/18 <b>show [1]</b> 40/2 <b>showed [2]</b> 81/19 85/10 <b>shown [1]</b> 79/2 <b>shunt [1]</b> 100/3 <b>shut [1]</b> 91/2 <b>shy [1]</b> 45/4 <b>sic [1]</b> 44/17 <b>sick [6]</b> 96/11 103/22 104/19 104/20 104/20 110/10 <b>sickness [3]</b> 32/10 101/23 103/18
----------	---	---	---	--

<b>S</b>	106/8 108/5 109/9 110/6 110/17 114/17 115/3 115/21 116/4 117/13 121/4 125/16 126/7 126/7	119/15 <b>sometimes [5]</b> 3/6 18/3 18/22 42/7 117/2 <b>somewhat [2]</b> 20/7 54/19 <b>soon [5]</b> 37/16 63/23 66/17 115/3 115/3 <b>sorely [1]</b> 76/1 <b>sorry [5]</b> 98/3 102/20 103/12 105/19 108/7 <b>sought [2]</b> 107/22 108/17 <b>sounded [1]</b> 103/11 <b>source [2]</b> 71/2 94/10 <b>sourced [1]</b> 104/6 <b>South [1]</b> 99/2 <b>Southeast [1]</b> 98/24 <b>spanning [1]</b> 45/10 <b>speaking [1]</b> 25/10 <b>Special [1]</b> 6/19 <b>specialist [1]</b> 87/16 <b>specialists [2]</b> 57/4 57/12 <b>specific [12]</b> 11/21 12/20 24/4 24/7 34/11 34/14 48/9 65/15 67/7 93/7 97/7 107/14 <b>specifically [7]</b> 26/23 33/7 58/22 66/2 73/17 74/13 76/15 <b>spectrum [2]</b> 33/10 84/3 <b>speed [1]</b> 115/3 <b>sphere [1]</b> 45/11 <b>spoken [2]</b> 1/11 43/3 <b>sporadic [1]</b> 112/7 <b>spotlight [3]</b> 30/24 31/8 31/17 <b>spotlighting [3]</b> 31/15 73/1 112/16 <b>spread [4]</b> 8/8 9/11 80/12 95/3 <b>staff [37]</b> 8/12 9/25 18/8 32/7 32/8 32/10 40/25 41/19 41/24 50/2 62/11 62/21 63/15 65/12 68/1 71/21 96/11 96/15 99/4 99/8 101/17 103/24 104/7 104/8 104/14 105/17 105/19 107/3 107/11 107/14 107/17 107/19 107/25 108/4 112/13 113/4 122/25 <b>staffed [1]</b> 100/1 <b>staffing [8]</b> 9/1 41/4 74/18 96/6 96/7 116/9 116/19 116/21 <b>stage [6]</b> 10/6 48/2 48/5 56/14 66/12 115/17 <b>stages [1]</b> 9/7 <b>staggering [1]</b> 84/18	<b>stakeholders [1]</b> 80/4 <b>stand [1]</b> 123/1 <b>standard [1]</b> 104/11 <b>standing [4]</b> 16/11 44/12 58/14 121/7 <b>stark [4]</b> 14/16 39/15 55/1 89/20 <b>start [11]</b> 8/25 22/15 22/24 23/15 23/23 35/18 38/6 77/12 116/23 121/25 122/8 <b>started [2]</b> 16/17 17/4 <b>starting [3]</b> 37/16 70/16 70/19 <b>state [19]</b> 15/23 43/22 44/11 46/25 60/7 60/12 70/13 72/16 73/18 74/8 75/3 75/6 106/16 110/1 111/13 111/16 119/20 120/2 120/6 <b>stated [1]</b> 79/21 <b>statement [6]</b> 1/23 22/22 77/21 78/25 79/5 127/5 <b>statements [7]</b> 20/13 21/7 22/21 37/4 37/7 64/21 72/23 <b>states [3]</b> 42/21 67/25 71/22 <b>statistics [7]</b> 2/5 2/13 2/18 3/1 39/2 39/3 105/9 <b>status [19]</b> 5/14 7/4 14/9 18/22 39/25 58/10 78/13 78/19 94/24 101/10 102/19 104/25 105/1 109/18 109/19 110/9 111/7 113/6 116/11 <b>statutes [3]</b> 103/23 107/16 114/4 <b>statutory [3]</b> 74/14 96/11 104/20 <b>stay [2]</b> 103/14 105/22 <b>Staying [1]</b> 116/21 <b>stenographer [1]</b> 83/1 <b>step [1]</b> 110/14 <b>stepping [1]</b> 19/17 <b>steps [4]</b> 4/15 8/7 51/6 56/1 <b>still [1]</b> 37/22 <b>stop [1]</b> 77/2 <b>story [14]</b> 7/14 26/9 26/10 26/13 26/20 27/8 27/12 27/13 37/17 49/12 57/2 66/20 66/24 122/23 <b>straightforward [1]</b> 55/4	<b>strain [2]</b> 105/23 124/15 <b>strategic [2]</b> 112/8 120/12 <b>streaming [2]</b> 4/13 4/18 <b>strengthen [2]</b> 29/24 111/22 <b>stress [3]</b> 19/20 48/5 88/9 <b>stressed [1]</b> 59/20 <b>striking [1]</b> 110/18 <b>stroke [1]</b> 34/13 <b>strong [1]</b> 97/9 <b>stronger [1]</b> 86/2 <b>strongly [1]</b> 59/12 <b>struck [1]</b> 111/24 <b>structural [12]</b> 12/12 17/23 33/1 34/17 56/22 73/16 74/10 107/2 119/13 120/21 122/1 122/17 <b>structurally [1]</b> 125/7 <b>structure [8]</b> 8/23 23/8 45/9 58/18 61/10 112/5 112/5 115/24 <b>structured [2]</b> 12/6 23/11 <b>structures [3]</b> 30/19 34/20 59/11 <b>struggled [3]</b> 40/24 40/24 40/25 <b>struggling [2]</b> 81/25 83/1 <b>studies [3]</b> 26/18 71/18 72/24 <b>study [2]</b> 35/2 76/4 <b>sub [2]</b> 48/8 58/21 <b>sub-modules [1]</b> 58/21 <b>subclass [1]</b> 102/15 <b>subdivide [1]</b> 59/18 <b>subdivided [1]</b> 11/24 <b>subdivision [1]</b> 59/12 <b>subject [4]</b> 4/24 22/1 54/1 60/4 <b>submission [28]</b> 12/9 12/22 16/9 21/3 22/23 25/2 25/6 29/14 30/2 30/12 31/1 34/14 35/3 35/9 35/13 35/17 37/5 37/22 60/2 60/10 61/19 66/3 79/1 112/14 117/25 121/5 121/8 122/19 <b>submissions [106]</b> 1/13 1/16 1/17 1/21 7/19 10/15 11/22 15/11 16/12 17/2 25/11 26/5 26/7 28/3 28/6 28/21 28/22 28/24 29/5 29/9 29/17 34/6 34/15 36/19 37/2 37/18 38/8 38/12 43/1
----------	--	--	---	--

<b>S</b>	34/13 52/6 70/10 94/5 109/12 124/3 <b>suffering [6]</b> 51/24 52/22 67/22 69/1 110/4 123/24 <b>sufficient [13]</b> 22/19 43/11 43/12 47/21 48/10 56/16 59/21 62/18 63/16 66/1 66/5 66/18 101/17 <b>sufficiently [5]</b> 11/4 14/3 30/18 60/3 83/19 <b>suggest [6]</b> 2/6 31/7 31/13 76/14 112/16 112/18 <b>suggested [8]</b> 10/25 12/19 57/13 74/9 83/13 87/7 95/24 114/16 <b>suggestion [2]</b> 28/17 54/7 <b>suggestions [9]</b> 10/14 11/11 17/1 26/1 46/5 65/15 74/2 76/12 97/4 <b>suggests [5]</b> 15/13 60/19 109/13 110/24 111/16 <b>suitably [1]</b> 33/23 <b>suite [1]</b> 117/17 <b>summarise [2]</b> 26/11 98/12 <b>summary [2]</b> 21/14 119/10 <b>summer [4]</b> 22/16 22/23 28/12 54/18 <b>summing [1]</b> 85/10 <b>supply [4]</b> 36/16 80/5 108/2 117/10 <b>support [34]</b> 3/7 6/7 13/10 13/15 17/25 19/18 32/2 39/19 47/7 63/5 64/8 64/15 72/4 77/25 78/22 79/15 80/17 80/19 81/7 82/1 82/2 84/10 84/20 85/14 87/18 88/5 108/12 108/14 108/21 108/22 113/22 114/3 123/17 128/13 <b>supported [17]</b> 8/4 13/6 13/16 14/3 60/21 72/8 72/16 80/9 84/4 84/22 87/11 87/12 87/16 87/20 88/1 91/11 124/5 <b>supports [4]</b> 61/13 84/25 85/20 86/4 <b>sure [5]</b> 53/1 55/5 56/1 68/14 103/9 <b>surface [1]</b> 107/23 <b>surprise [2]</b> 58/1 100/21 <b>surprising [1]</b> 39/2	<b>surrounded [1]</b> 2/22 <b>surrounding [2]</b> 60/24 61/6 <b>survey [9]</b> 17/13 17/15 17/17 18/4 18/24 19/6 19/24 20/5 46/2 <b>surveyed [2]</b> 94/22 94/23 <b>suspend [2]</b> 46/20 74/17 <b>suspended [2]</b> 90/12 90/19 <b>sustainability [1]</b> 82/8 <b>sustained [1]</b> 95/4 <b>sympathy [1]</b> 124/2 <b>symptom [1]</b> 41/19 <b>symptoms [2]</b> 41/24 94/21 <b>Syndrome [1]</b> 47/6 <b>system [30]</b> 12/13 40/13 43/17 43/23 44/2 44/16 44/24 46/3 46/10 47/21 48/6 48/15 70/17 71/1 71/10 71/19 72/2 73/12 73/20 75/7 76/3 76/20 77/5 77/7 77/7 79/14 86/3 100/6 115/22 120/7 <b>systemic [5]</b> 26/19 36/14 85/18 99/15 112/25 <b>systems [11]</b> 12/1 13/1 15/24 23/13 30/18 35/6 60/7 82/10 111/16 119/20 120/3	47/24 49/4 51/11 69/10 70/24 73/9 85/23 95/7 114/22 115/2 126/3 <b>teams [1]</b> 70/18 <b>technicians [1]</b> 71/12 <b>telescope [1]</b> 71/6 <b>tell [1]</b> 1/9 <b>ten [5]</b> 18/1 18/18 18/21 19/2 19/19 <b>term [2]</b> 82/7 82/7 <b>terms [16]</b> 8/16 15/22 31/24 35/8 44/14 75/10 76/5 77/8 90/3 92/5 102/22 102/23 106/8 119/12 119/19 121/10 <b>Territorial [1]</b> 6/18 <b>test [2]</b> 19/2 80/15 <b>tested [2]</b> 25/23 63/23 <b>testing [19]</b> 9/13 18/9 18/20 41/18 52/18 53/15 62/9 62/11 62/21 63/13 67/18 80/10 89/25 99/25 103/19 110/7 113/13 113/22 116/15 <b>tests [2]</b> 18/25 19/5 <b>than [26]</b> 3/21 3/22 4/19 39/11 50/12 50/14 67/3 70/2 74/22 79/12 79/14 79/18 82/7 84/19 88/11 88/16 88/17 89/16 91/14 91/16 94/4 95/6 102/5 105/18 105/19 126/6 <b>thank [37]</b> 1/24 29/2 38/10 38/14 48/20 57/19 57/20 58/5 58/9 69/2 69/3 69/10 69/14 69/16 70/4 77/10 77/13 77/19 83/1 86/8 97/21 98/8 98/16 108/6 108/9 115/5 115/6 118/6 123/4 123/9 125/3 125/4 125/20 125/23 126/7 126/11 126/14 <b>thank you [16]</b> 1/24 38/14 57/20 58/9 69/2 69/14 70/4 77/19 83/1 108/9 123/9 125/3 125/4 125/23 126/7 126/14 <b>thanks [1]</b> 125/24 <b>that [484]</b> <b>that's [4]</b> 2/15 15/20 24/21 125/18 <b>their [101]</b> 1/20 3/8 3/16 8/12 8/20 9/19 11/7 13/9 14/8 14/11 18/5 18/21 19/13	19/20 20/4 27/3 27/7 27/12 33/15 36/8 36/15 37/24 38/24 40/5 40/9 40/18 40/20 42/1 42/3 42/3 42/17 43/6 43/8 43/13 46/15 49/18 49/20 52/8 52/12 52/12 52/13 52/15 52/19 55/22 67/10 74/12 74/17 75/25 77/1 77/11 79/20 81/6 82/21 84/11 84/23 84/24 87/17 88/16 90/17 90/18 93/12 94/8 95/5 95/17 95/19 96/21 97/10 98/15 99/2 99/7 101/7 101/23 102/18 103/17 104/3 104/4 104/6 104/6 105/2 105/7 105/12 105/24 106/3 107/4 107/16 108/22 109/18 110/2 110/9 110/14 110/15 110/17 110/19 113/9 114/25 116/24 116/24 119/17 124/1 124/12 126/4 <b>them [38]</b> 2/24 2/25 5/16 8/22 13/14 18/20 18/23 19/18 21/25 24/11 37/4 42/22 48/5 58/8 58/12 70/3 70/4 70/6 74/8 74/23 75/4 77/8 81/2 84/22 85/1 93/12 96/14 96/24 98/17 101/24 104/1 104/5 106/1 107/12 122/2 122/21 123/2 126/1 <b>theme [3]</b> 29/16 44/9 119/15 <b>themes [3]</b> 12/10 26/18 95/25 <b>themselves [6]</b> 20/25 70/3 71/21 103/18 106/2 110/14 <b>then [11]</b> 1/11 10/10 22/21 22/21 23/23 49/10 72/9 75/16 89/16 98/14 126/13 <b>there [81]</b> 2/7 2/14 3/16 4/11 4/22 5/6 5/16 5/19 7/25 8/15 11/21 11/25 12/20 13/17 13/18 13/20 14/6 14/22 17/7 20/8 22/3 23/5 23/12 24/23 25/20 27/9 27/23 28/9 28/22 30/19 31/13 31/15 31/21 33/6 35/10 38/5 39/9 41/12 41/20 45/3 45/13 45/16 45/17 45/19
----------	--	--	---	---

<b>T</b>	107/23	tirelessly [1] 124/6	91/22	47/9
<b>there... [37]</b> 45/21	<b>think [20]</b> 38/11	<b>today [24]</b> 1/10 1/22	<b>traumatic [1]</b> 42/7	<b>unchecked [1]</b> 80/12
45/22 46/11 46/24	68/15 69/15 74/24	2/4 4/21 5/4 11/14	<b>treated [4]</b> 18/3	<b>unclear [1]</b> 61/2
47/12 49/23 49/25	77/15 77/15 82/25	11/23 26/5 28/23	87/23 95/6 97/17	<b>uncovered [1]</b> 33/18
50/18 51/5 51/9 52/14	86/9 97/23 111/5	38/16 38/19 70/25	<b>treatment [9]</b> 9/20	<b>under [13]</b> 10/7 14/2
52/16 52/20 53/8 55/7	111/20 114/13 120/15	76/8 87/6 92/17 96/1	18/15 18/15 38/24	15/15 53/2 62/13
55/19 55/20 57/16	123/5 125/12 125/18	108/15 115/1 117/21	50/1 91/19 94/15	62/24 62/25 64/6
68/8 74/3 75/15 83/13	125/20 126/4 126/11	119/4 119/16 119/18	94/17 103/19	92/20 100/4 116/4
88/4 88/23 91/4 91/25	126/12	125/19 125/24	<b>tremendous [1]</b>	124/14 126/5
93/7 94/25 97/19	<b>thinks [1]</b> 71/16	<b>today's [2]</b> 5/7 125/8	64/11	<b>under way [1]</b> 53/2
100/12 103/8 104/13	<b>third [7]</b> 53/9 62/1	<b>together [3]</b> 38/15	<b>trends [1]</b> 26/17	<b>under-reported [1]</b>
112/17 112/18 116/14	74/14 79/9 89/20	85/25 118/12	<b>trespassing [1]</b>	92/20
117/3 117/8	100/13 113/8	<b>toilets [1]</b> 51/19	103/1	<b>underfunded [4]</b>
<b>there's [2]</b> 17/17 37/9	<b>thirdly [3]</b> 41/2 62/17	<b>told [2]</b> 100/3 114/17	<b>tried [1]</b> 99/21	43/19 43/21 100/3
<b>therefore [6]</b> 14/2	117/13	<b>too [13]</b> 40/10 40/20	<b>true [2]</b> 84/14 90/23	120/9
16/9 41/14 71/8 77/10	<b>this [176]</b>	41/2 41/25 42/14	<b>truly [5]</b> 68/17 68/25	<b>underfunding [3]</b>
121/5	<b>thorough [1]</b> 32/5	42/16 42/20 76/12	75/16 83/3 86/4	16/5 106/18 121/1
<b>thereof [1]</b> 90/10	<b>thoroughly [1]</b> 59/24	79/4 82/6 95/5 97/17	<b>trust [1]</b> 85/16	<b>underlines [1]</b> 36/3
<b>these [38]</b> 4/10 4/13	<b>those [149]</b>	122/2	<b>trusts [3]</b> 20/9 45/6	<b>undermined [1]</b>
11/8 25/10 25/21 28/4	<b>though [6]</b> 10/16	<b>took [5]</b> 104/4 109/23	45/20	83/10
32/24 36/19 37/21	21/10 25/25 52/20	110/13 113/19 113/24	<b>truth [1]</b> 68/20	<b>undermines [1]</b>
38/16 51/1 72/19	84/21 85/12	<b>topic [9]</b> 16/13 29/11	<b>try [2]</b> 17/6 24/24	37/23
74/15 74/19 74/21	<b>thought [2]</b> 40/12	47/23 58/18 63/16	<b>trying [1]</b> 103/13	<b>undermining [1]</b> 85/1
79/16 83/2 84/9 84/20	69/14	65/20 66/20 96/5	<b>TUC [5]</b> 71/5 99/5	<b>underpaid [1]</b> 120/13
86/15 86/22 87/6	<b>thoughtful [2]</b> 10/14	114/8	118/12 118/21 120/4	<b>underpin [1]</b> 24/5
87/14 87/23 89/15	125/10	<b>topics [8]</b> 10/4 12/10	<b>TUC's [1]</b> 118/24	<b>underpinning [1]</b>
90/7 91/7 93/18 95/7	<b>thousands [1]</b>	17/16 21/15 29/10	<b>Tuesday [1]</b> 1/1	111/17
96/13 103/6 105/9	120/11	57/6 95/22 95/24	<b>turn [2]</b> 64/19 111/1	<b>underrepresented [1]</b>
106/25 107/1 118/10	<b>three [12]</b> 4/24 12/22	<b>total [2]</b> 8/15 103/25	<b>turning [8]</b> 16/14	109/9
119/10 120/17 123/15	19/9 22/1 23/5 25/13	<b>touch [1]</b> 32/16	49/13 57/2 58/18	<b>underscore [1]</b> 47/18
<b>they [93]</b> 1/16 1/18	39/16 43/18 75/2 79/6	<b>touched [1]</b> 113/1	59/25 66/20 67/20	<b>understaffed [2]</b>
1/19 2/20 2/22 6/3	84/18 87/13	<b>touching [1]</b> 47/12	83/7	102/6 120/13
7/13 8/15 11/14 15/5	<b>three-fifths [1]</b> 19/9	<b>towards [2]</b> 52/17	<b>turnover [2]</b> 71/21	<b>understaffing [9]</b>
16/19 17/21 18/4	<b>threw [2]</b> 16/4 120/24	79/2	113/5	101/16 101/16 101/23
18/12 19/18 25/8	<b>through [12]</b> 1/19	<b>Townson [5]</b> 77/16	<b>two [10]</b> 15/16 18/4	101/25 102/3 102/8
25/15 26/16 26/23	1/21 24/16 71/6 71/24	77/18 77/20 86/8	25/10 34/21 53/25	106/15 106/18 110/24
27/6 40/18 41/10 43/7	84/21 88/4 101/19	128/3	68/13 98/20 101/15	<b>understand [23]</b> 5/5
44/2 45/12 45/12	102/11 105/5 105/5	<b>track [1]</b> 95/25	107/23 118/19	15/25 24/24 29/19
49/18 49/19 49/20	117/22	<b>trade [3]</b> 16/22 98/20	<b>type [1]</b> 34/12	37/25 45/1 48/13 51/7
49/23 52/4 52/18 54/6	<b>throughout [6]</b> 7/20	99/5	<b>type 2 [1]</b> 34/12	53/17 56/5 58/25 60/9
55/15 56/12 58/12	23/23 30/16 52/6	<b>Trades [5]</b> 6/8 60/10	<b>types [1]</b> 23/14	61/17 64/5 65/13
58/14 63/23 66/6	85/12 94/4	118/8 118/11 128/19		68/24 73/11 75/11
66/25 67/11 69/21	<b>Thus [1]</b> 116/17	<b>Trades Union [3]</b> 6/8	<b>U</b>	78/16 92/3 103/9
70/1 70/6 70/25 74/20	<b>tied [1]</b> 101/10	60/10 118/11	<b>UK [35]</b> 3/5 3/24 5/20	119/22 120/1
74/24 75/13 75/24	<b>time [30]</b> 13/12 22/19	<b>tradition [1]</b> 69/8	5/24 5/25 8/24 9/4	<b>understandably [1]</b>
75/24 76/1 77/4 77/7	29/9 30/7 30/18 35/18	<b>traffic [1]</b> 51/19	15/24 23/9 23/12	15/1
77/9 79/8 79/9 79/13	38/6 43/8 43/11 46/14	<b>tragic [1]</b> 3/1	26/22 29/1 29/6 29/8	<b>understanding [5]</b>
80/19 80/22 82/19	46/22 48/4 48/10	<b>trained [2]</b> 41/18	35/2 35/6 49/21 56/21	23/21 80/7 81/19
86/17 86/19 89/16	54/20 55/23 59/21	41/24	59/17 60/8 62/2 69/21	106/17 120/18
89/18 92/25 93/2	66/18 69/15 72/20	<b>training [2]</b> 110/1	69/22 73/14 78/2	<b>understood [4]</b> 51/3
93/11 93/13 94/9	82/9 82/14 82/24	113/4	86/11 86/14 87/25	51/20 60/16 64/13
97/15 97/16 98/25	89/16 90/25 96/4	<b>tranches [1]</b> 22/7	92/12 94/1 94/3 99/2	<b>undertake [1]</b> 41/19
99/12 101/4 104/22	97/23 107/24 115/21	<b>transfer [1]</b> 53/14	102/11 127/9 128/6	<b>undertaken [3]</b> 17/5
105/7 105/12 105/16	126/6 126/6	<b>transfers [2]</b> 18/15	<b>UK Government [3]</b>	18/16 18/17
105/24 105/25 106/1	<b>timekeeping [1]</b>	18/17	9/4 62/2 87/25	<b>undertaking [2]</b>
106/1 106/3 106/4	126/4	<b>transient [1]</b> 105/21	<b>UK's [2]</b> 26/12 78/9	17/24 35/1
107/12 107/25 110/4	<b>timely [1]</b> 113/10	<b>transmission [7]</b>	<b>UKHSA [1]</b> 6/23	<b>undervalued [2]</b> 81/5
110/6 110/13 112/23	<b>timeous [1]</b> 55/8	4/17 14/12 23/22	<b>ultimately [4]</b> 51/4	120/14
113/15 114/6 122/3	<b>times [5]</b> 12/8 12/22	63/18 63/18 107/24	67/11 117/1 121/19	<b>undervaluing [2]</b>
<b>they've [2]</b> 1/20	68/13 84/19 89/17	114/6	<b>umbrella [1]</b> 14/2	16/5 121/1
11/20	<b>timetable [1]</b> 30/2	<b>transmitted [1]</b> 96/21	<b>unable [6]</b> 14/21 47/9	<b>undocumented [4]</b>
<b>thing [2]</b> 75/2 75/5	<b>timetabling [1]</b> 30/6	<b>transpose [1]</b> 46/2	52/8 52/19 91/2	101/13 105/18 105/20
<b>things [3]</b> 22/1 72/2	<b>timing [2]</b> 55/12	<b>trauma [5]</b> 42/16	102/18	107/7
	55/21	64/12 67/22 68/16	<b>unaware [2]</b> 18/22	<b>unenviable [1]</b> 125/8

<b>U</b>	<b>us</b> [8] 1/9 37/6 38/23 76/8 110/17 111/11 114/20 114/22	80/12 101/19 101/24 105/8 105/22 106/3 107/24 110/5	<b>warden</b> [1] 13/19	<b>welcomes</b> [3] 57/13 62/3 124/23
<b>unequal</b> [3] 8/22 34/3 34/6	<b>usage</b> [1] 80/7	<b>vis</b> [2] 45/18 45/18	<b>wards</b> [1] 51/17	<b>welfare</b> [2] 64/2 98/25
<b>uneven</b> [1] 111/6	<b>use</b> [10] 9/17 15/4 29/9 50/25 51/21 53/16 75/12 89/4 89/7 104/12	<b>vis-à-vis</b> [1] 45/18	<b>warning</b> [1] 62/18	<b>well</b> [12] 11/6 14/11 19/11 19/11 32/9 34/22 46/4 70/2 71/17 76/21 78/7 85/7
<b>unexpected</b> [1] 5/2	<b>used</b> [4] 26/16 28/15 71/4 96/12	<b>visas</b> [3] 102/9 103/17 107/3	<b>was</b> [104] 3/3 18/3 18/13 19/15 21/17 27/18 33/18 33/20 36/1 42/17 44/1 44/14 44/21 44/21 45/1 45/13 45/14 45/22 46/12 46/19 47/8 49/25 50/1 52/1 52/2 52/14 52/16 52/20 53/23 54/13 55/1 62/6 62/18 63/9 63/11 63/14 63/17 63/19 64/3 68/4 69/7 70/12 70/16 70/17 75/4 75/5 75/7 75/8 75/15 79/22 79/24 80/4 80/6 80/25 81/10 81/12 81/13 83/13 88/4 88/25 90/22 90/23 90/25 91/6 91/13 91/24 91/25 92/20 94/17 95/18 98/4 98/7 100/3 100/10 100/11 100/15 101/16 101/18 102/8 104/9 104/9 105/14 108/3 109/16 109/25 110/12 113/10 113/14 114/3 114/4 114/9 115/18 115/25 116/8 116/10 116/14 116/24 117/13 117/19 117/19 121/8 122/5 123/25 124/5	<b>wash</b> [1] 13/14
<b>unfamiliar</b> [1] 108/19	<b>users</b> [2] 86/19 123/22	<b>visit</b> [2] 52/12 52/19	<b>watching</b> [1] 69/8	<b>watch</b> [1] 13/14
<b>unfilled</b> [1] 116/22	<b>using</b> [1] 41/8	<b>visiting</b> [10] 2/23 13/11 27/15 42/7 42/11 46/22 52/10 80/17 81/19 95/19	<b>water</b> [1] 121/15	<b>watching</b> [1] 69/8
<b>uniformly</b> [1] 52/10	<b>utmost</b> [1] 36/1	<b>visitors</b> [1] 95/6	<b>Watson</b> [1] 33/14	<b>Watson</b> [1] 33/14
<b>Union</b> [6] 6/8 60/10 98/22 118/8 118/11 128/19	<b>UVW</b> [2] 99/5 104/4	<b>visits</b> [10] 9/16 18/11 35/24 36/7 36/10 68/12 91/13 92/12 96/25 110/12	<b>wave</b> [3] 31/23 80/6 91/16	<b>wave</b> [3] 31/23 80/6 91/16
<b>unions</b> [5] 16/22 98/20 99/5 118/13 118/14	<b>V</b>	<b>vital</b> [3] 81/23 109/25 118/4	<b>ways</b> [2] 72/8 91/13	<b>ways</b> [2] 72/8 91/13
<b>unique</b> [2] 51/23 80/23	<b>vaccination</b> [5] 11/17 18/8 81/9 103/20 114/10	<b>voice</b> [2] 85/17 109/8	<b>we</b> [182]	<b>we</b> [182]
<b>Unison</b> [1] 118/15	<b>vaccines</b> [2] 71/9 80/25	<b>voices</b> [3] 78/21 83/4 98/21	<b>we'll</b> [2] 36/18 57/21	<b>we'll</b> [2] 36/18 57/21
<b>Unite</b> [1] 118/15	<b>vacuum</b> [1] 120/21	<b>voluntary</b> [3] 45/7 45/11 78/6	<b>we're</b> [2] 33/25 46/5	<b>we're</b> [2] 33/25 46/5
<b>United</b> [4] 76/2 98/21 109/16 119/20	<b>valuable</b> [1] 67/10	<b>volunteers</b> [1] 124/10	<b>we've</b> [3] 47/1 72/25 102/24	<b>we've</b> [3] 47/1 72/25 102/24
<b>United Kingdom</b> [2] 109/16 119/20	<b>value</b> [3] 93/3 108/21 110/21	<b>vulnerabilities</b> [3] 62/19 73/20 73/21	<b>weak</b> [3] 115/24 116/4 125/7	<b>weak</b> [3] 115/24 116/4 125/7
<b>units</b> [1] 51/17	<b>valued</b> [2] 77/1 88/15	<b>vulnerability</b> [2] 71/2 117/6	<b>website</b> [1] 7/2	<b>website</b> [1] 7/2
<b>unless</b> [6] 15/25 38/8 48/19 57/16 97/19 123/3	<b>values</b> [3] 76/9 83/3 86/4	<b>vulnerable</b> [22] 14/8 36/7 40/3 40/11 40/21 41/4 41/17 70/17 71/21 75/4 75/6 75/8 87/14 91/5 95/16 100/1 101/9 105/3 107/15 107/19 109/18 123/23	<b>week</b> [2] 2/6 71/5	<b>week</b> [2] 2/6 71/5
<b>unlikely</b> [1] 79/22	<b>variable</b> [1] 112/12	<b>W</b>	<b>weekly</b> [1] 68/13	<b>weekly</b> [1] 68/13
<b>unnecessary</b> [3] 12/23 18/17 79/22	<b>variations</b> [2] 29/19 59/9	<b>wage</b> [2] 100/12 106/4	<b>weeks</b> [2] 39/14 44/6	<b>weeks</b> [2] 39/14 44/6
<b>unpaid</b> [13] 3/22 10/2 19/17 19/19 27/6 32/2 71/15 86/21 92/24 93/1 93/3 93/7 124/9	<b>varied</b> [1] 52/13	<b>wages</b> [3] 96/10 102/12 105/17	<b>welcome</b> [8] 31/19 35/24 51/13 52/23 54/12 56/25 92/11 95/22	<b>welcome</b> [8] 31/19 35/24 51/13 52/23 54/12 56/25 92/11 95/22
<b>unprepared</b> [1] 44/22	<b>varies</b> [1] 3/18	<b>waiting</b> [1] 91/19		
<b>unprotected</b> [2] 104/2 106/2	<b>variety</b> [1] 86/20	<b>waits</b> [1] 18/14		
<b>unreasonable</b> [1] 101/11	<b>various</b> [6] 45/17 64/25 72/8 73/25 84/9 97/4	<b>Wales</b> [37] 2/8 6/1 6/23 7/24 12/2 13/2 17/7 17/9 17/15 30/6 48/9 50/12 58/15 59/22 64/21 64/23 65/3 65/5 65/7 65/7 65/8 65/9 65/9 65/9 65/12 65/21 65/25 66/2 66/8 67/13 68/21 69/23 74/19 75/12 93/2 112/22 123/19		
<b>unregulated</b> [2] 43/20 46/9	<b>varying</b> [1] 13/10	<b>wall</b> [2] 115/24 125/7		
<b>unsafe</b> [1] 101/18	<b>vast</b> [3] 45/7 55/16 109/22	<b>want</b> [8] 16/12 73/3 75/24 76/21 77/4 77/7 125/9 125/24		
<b>untested</b> [1] 113/11	<b>vectors</b> [2] 14/12 101/24	<b>wanted</b> [2] 45/12 45/12		
<b>until</b> [4] 31/24 39/8 54/20 80/15	<b>vein</b> [1] 65/23	<b>wants</b> [1] 25/5		
<b>untold</b> [1] 81/21	<b>ventilation</b> [1] 51/20			
<b>unwilling</b> [1] 47/9	<b>version</b> [1] 20/5			
<b>unwittingly</b> [1] 41/6	<b>very</b> [43] 14/14 16/12 18/6 19/11 24/10 29/2 29/3 37/11 38/10 48/20 48/21 57/19 69/3 69/14 69/17 75/2 75/5 75/21 76/21 77/13 77/13 79/22 85/1 86/8 94/7 94/11 97/2 97/21 98/8 101/23 108/6 115/5 115/6 115/6 118/6 121/16 123/4 125/13 125/20 125/23 125/25 126/7 126/11			
<b>up</b> [18] 3/10 7/16 8/5 12/13 13/13 19/17 30/13 31/23 44/9 56/19 59/17 72/16 85/10 99/22 104/23 115/3 118/13 122/8	<b>view</b> [2] 25/21 85/4			
<b>update</b> [1] 22/9	<b>views</b> [1] 76/25			
<b>updates</b> [4] 21/12 21/14 22/8 74/12	<b>virtue</b> [1] 40/5			
<b>upon</b> [7] 14/4 34/5 34/10 78/17 83/19 113/1 118/24	<b>virus</b> [10] 41/6 68/2			
<b>urge</b> [5] 30/20 43/11 84/15 87/10 121/16				
<b>urged</b> [1] 15/2				
<b>urgent</b> [1] 30/10				



<b>W</b>	109/23 111/1 113/1 113/1 115/13 115/24 117/7 118/15 118/24 119/4 119/11 119/14 121/12 122/17 124/23	28/23 30/14 49/19 49/20 49/23 58/9 59/1 68/18 88/6 92/17 97/15	<b>work-dependent [1]</b> 103/22 <b>worked [4]</b> 19/11 82/16 109/24 124/6 <b>worker [2]</b> 102/15 110/9 <b>workers [69]</b> 3/23 3/25 4/1 6/5 6/6 6/7 11/18 32/9 41/5 41/7 71/12 81/1 96/11 98/5 98/10 98/21 99/8 99/12 100/2 100/4 100/7 100/12 100/15 100/20 100/22 101/3 101/4 101/5 101/9 101/13 101/21 102/2 102/9 102/17 103/6 103/16 103/22 104/4 104/18 104/20 104/23 105/4 105/9 105/20 106/22 106/25 107/7 108/12 108/14 108/21 109/1 109/8 109/9 109/12 109/17 109/20 109/24 110/2 110/19 111/5 112/3 113/1 113/8 113/14 113/20 114/4 114/10 128/10 128/13 <b>workers' [1]</b> 111/12 <b>workforce [12]</b> 3/18 3/19 23/15 44/12 71/4 79/17 84/25 86/5 100/18 117/10 119/9 120/14 <b>working [23]</b> 2/1 3/9 3/21 8/1 8/13 8/20 27/4 69/12 80/8 81/5 81/10 85/22 99/10 99/16 105/6 105/20 107/13 109/2 113/3 116/23 117/1 118/12 119/1 <b>workloads [2]</b> 110/3 113/3 <b>workplaces [1]</b> 101/18 <b>works [1]</b> 99/7 <b>World [1]</b> 98/21 <b>worse [2]</b> 70/21 91/14 <b>worsening [1]</b> 94/20 <b>worth [2]</b> 88/16 110/22 <b>worthy [1]</b> 87/22 <b>would [48]</b> 11/22 12/3 12/17 15/8 21/3 21/8 27/11 31/2 35/12 37/7 37/14 38/18 46/19 49/6 54/11 56/25 59/13 59/14 61/3 65/11 65/16 68/5 70/12 72/13 72/14 73/4 76/16 77/5 79/23	83/22 84/13 85/1 90/14 92/2 92/6 92/7 97/19 98/16 103/4 111/12 112/3 114/16 115/2 118/1 121/15 124/2 124/11 124/21 <b>wouldn't [3]</b> 68/7 68/9 68/18 <b>write [1]</b> 65/15 <b>writing [1]</b> 37/21 <b>written [31]</b> 1/16 10/15 17/2 26/17 28/21 28/22 29/9 34/15 37/1 47/2 49/6 56/8 58/16 61/8 72/23 79/1 87/3 87/4 90/5 93/17 95/24 97/4 98/12 104/14 111/8 117/23 119/17 122/19 122/22 123/1 125/19 <b>wrong [4]</b> 68/24 71/2 71/6 72/13 <b>wrongly [1]</b> 106/5	
<b>what... [23]</b> 74/2 75/9 75/16 75/24 76/16 92/2 102/21 106/14 109/25 110/10 111/5 111/25 114/11 114/15 114/22 115/14 115/18 116/3 116/18 118/1 119/25 122/10 122/16	<b>while [5]</b> 49/7 49/18 82/5 82/13 89/15 <b>whilst [9]</b> 3/1 3/17 21/6 32/1 47/15 67/24 82/16 104/22 106/2	<b>wishes [3]</b> 7/12 26/21 99/14 <b>withdrawal [2]</b> 80/17 81/23 <b>withdrawn [2]</b> 46/13 81/13 <b>within [39]</b> 8/1 8/4 8/13 8/20 9/23 11/19 14/22 16/9 23/25 27/1 31/19 32/14 40/6 40/12 40/22 41/13 41/17 41/22 42/24 48/7 48/12 51/24 52/2 53/23 59/24 60/14 60/21 62/19 64/18 65/2 67/25 77/6 82/19 98/18 99/12 104/13 109/4 121/5 125/15 <b>without [26]</b> 12/13 18/20 32/5 42/18 42/21 62/9 63/24 68/15 70/21 73/9 80/18 81/15 81/16 81/25 89/6 89/7 89/12 89/25 99/24 101/5 101/12 104/8 104/11 105/1 110/9 116/17 <b>witness [3]</b> 20/13 47/18 48/11 <b>witnessed [1]</b> 67/11 <b>witnesses [14]</b> 20/18 23/1 25/15 36/12 36/17 47/18 65/22 71/17 72/22 74/7 76/15 76/18 93/21 118/3 <b>wittingly [1]</b> 41/5 <b>WLGA [1]</b> 65/5 <b>women [5]</b> 3/20 3/21 99/11 100/20 109/22 <b>won't [1]</b> 37/4 <b>wonder [1]</b> 51/25 <b>word [1]</b> 43/17 <b>worded [1]</b> 12/20 <b>words [3]</b> 43/18 90/19 106/6 <b>work [43]</b> 14/1 17/5 21/13 24/9 38/1 38/2 38/3 41/11 46/5 47/19 65/2 67/6 68/22 70/6 70/23 78/15 98/13 98/25 99/2 99/18 99/20 101/22 103/22 103/23 104/8 104/22 105/20 106/4 106/5 108/22 110/10 110/15 110/21 113/7 114/11 116/24 118/16 118/17 118/24 119/7 120/14 123/17 124/14	<b>who [84]</b> 1/12 1/14 2/25 4/12 5/4 7/3 7/4 11/5 14/1 17/2 17/10 19/13 26/2 26/21 26/25 27/2 27/11 27/16 28/23 36/6 37/20 37/21 38/16 39/16 39/18 39/19 39/20 39/23 40/3 40/10 40/20 41/2 41/5 41/7 41/8 41/10 41/14 41/25 42/20 48/17 50/4 52/11 52/21 55/14 56/16 56/21 57/14 65/20 66/1 69/7 71/13 71/21 74/10 78/20 79/16 81/6 86/4 86/17 87/16 89/11 91/21 95/16 97/17 101/13 103/16 105/25 107/14 107/19 108/15 110/4 114/17 116/23 118/13 118/16 118/17 118/18 118/23 119/7 124/3 124/3 124/6 124/8 124/9 126/5 <b>who's [1]</b> 21/14 <b>whole [8]</b> 33/10 67/5 71/10 71/19 73/5 102/22 106/23 125/16 <b>whom [7]</b> 45/15 64/1 110/4 110/13 113/21 114/6 117/19 <b>whose [3]</b> 49/17 61/22 65/2 <b>why [13]</b> 4/6 22/17 32/15 44/21 49/20 49/20 50/6 63/19 68/24 73/11 76/17 90/5 108/3 <b>wide [9]</b> 10/4 14/24 16/7 17/15 17/24 21/4 35/1 84/5 121/3 <b>wide-reaching [2]</b> 16/7 121/3 <b>widely [1]</b> 3/4 <b>widened [1]</b> 13/4 <b>wider [4]</b> 51/10 78/19 80/14 92/9 <b>widespread [1]</b> 92/1 <b>will [145]</b> <b>window [1]</b> 39/13 <b>wish [16]</b> 1/12 1/18 15/10 26/7 26/23	<b>What's [1]</b> 67/8 <b>whatever [2]</b> 39/15 102/6 <b>when [42]</b> 4/8 21/16 21/17 36/7 36/24 39/2 44/10 45/12 45/12 46/14 47/19 50/1 52/2 55/2 68/8 69/9 70/7 70/13 71/16 71/23 74/18 75/14 82/2 89/17 90/25 93/20 101/4 101/10 101/19 104/2 104/7 104/9 105/7 106/1 106/3 106/10 107/21 111/25 113/11 113/15 115/22 117/18 <b>where [28]</b> 2/20 4/22 13/17 13/18 23/3 24/11 25/20 32/5 34/21 35/2 45/14 52/16 60/8 64/4 70/8 70/10 70/12 73/20 93/10 93/13 96/15 100/13 103/2 107/6 112/18 112/22 119/21 121/14 <b>whether [30]</b> 25/3 25/7 27/6 28/14 30/10 48/7 48/9 49/22 49/23 49/25 50/2 61/2 62/17 63/16 88/13 88/20 89/1 92/20 112/5 112/7 112/9 112/13 112/20 113/9 113/14 113/17 113/23 114/4 114/8 125/6 <b>which [74]</b> 1/6 2/23 5/2 5/8 5/13 5/14 7/19 10/9 13/21 13/24 14/2 14/4 16/14 17/18 20/5 24/4 24/6 26/18 30/13 31/24 32/12 32/13 33/18 35/4 35/6 36/13 36/17 37/23 42/24 48/8 53/4 53/9 55/11 55/16 55/17 62/25 72/19 73/4 76/9 76/13 82/22 83/14 83/19 88/18 91/6 92/25 93/5 93/21 95/1 95/25 96/20 96/23 97/18 100/11 102/24 104/13 107/5 108/17 109/2	<b>Y</b> <b>year [2]</b> 41/22 93/3 <b>yesterday [1]</b> 69/7 <b>yet [3]</b> 72/2 74/22 82/22 <b>yn [1]</b> 69/2 <b>you [120]</b> 1/24 4/15 6/25 7/19 7/24 11/14 15/10 16/11 17/16 21/8 26/5 28/20 28/21 28/24 29/2 29/8 29/11 30/14 34/5 35/13 36/18 36/19 38/3 38/9 38/10 38/14 38/15 39/12 42/5 43/3 43/11 43/13 43/21 43/23 44/5 44/10 44/17 44/19 44/20 46/10 47/13 47/20 47/22 47/24 48/19 48/20 57/19 57/20 58/2 58/5 58/6 58/9 58/11 59/2 62/5 63/21 69/2 69/3 69/5 69/6 69/14 69/16 69/20 70/4 71/23 71/25 72/9 72/21 73/3 76/4 76/16 77/13 77/16 77/19 82/23 82/24 83/1 86/8 97/19 97/21 98/8 100/25 101/1 101/2 101/10 103/1 103/3 103/9 108/6 108/7 108/8 108/9 115/1 115/5 115/6 118/1 118/6 119/4 119/16 121/17 121/23 121/23 123/4 123/5 123/7 123/9 123/10 125/3 125/4 125/9 125/10 125/11

**Y**

**you... [8]** 125/16  
125/18 125/20 125/23  
126/4 126/7 126/11  
126/14

**you'll [1]** 26/7

**you're [1]** 38/11

**you've [7]** 43/3 45/5  
47/15 47/16 58/19  
82/24 126/10

**young [1]** 10/21

**younger [1]** 72/11

**your [50]** 4/14 6/3

7/17 12/15 12/17  
20/21 21/6 28/5 28/18  
28/20 40/8 42/25 43/1  
43/14 43/15 46/5  
47/24 48/20 52/5 53/1  
53/5 57/8 57/14 57/19  
59/2 59/2 70/16 72/6  
73/8 76/7 97/21 101/1  
101/12 101/12 103/11  
108/18 109/7 109/11  
111/13 111/21 114/8  
114/21 114/22 115/1  
119/12 120/22 121/10  
121/25 122/18 123/17

**your Ladyship [12]**

4/14 7/17 12/15 21/6  
28/5 28/20 52/5 53/1  
57/8 57/14 109/7  
111/13

**your Ladyship's [4]**

53/5 109/11 111/21  
114/21

**yourself [1]** 72/10

**Z**

**zero [5]** 32/9 41/9  
96/10 100/15 109/5

**zero-hours [5]** 32/9

41/9 96/10 100/15  
109/5

**zone [1]** 13/25