IN THE UK COVID-19 INQUIRY

MODULE 10

SUBMISSIONS ON BEHALF OF

CLINICALLY VULNERABLE FAMILIES ('CVF')

FOR THE 1st PRELIMINARY HEARING, 18th FEBRUARY 2025

A. INTRODUCTION

1. CVF was founded in August 2020 and currently represents those who are Clinically Vulnerable ('**CV**'), Clinically Extremely Vulnerable ('**CEV**') and the Severely Immunosuppressed[1], as well as their households, across all four nations (collectively referred to as '**Clinically Vulnerable**'). This group of vulnerable individuals were, and remain, at higher risk of severe outcomes from the disease, such as greater mortality[2] and long Covid,[3] than the greater population.

2. CVF continue to seek to ensure that the Inquiry considers the full impact of the pandemic on those who were designated CV, CEV, and those who are Severely Immunosuppressed, their families and households, particularly within Module 10. Such individuals not only faced but continue to face greater risks to their lives than any other category of person. As such, any planning for future pandemics and/or consideration of the effectiveness of public health services needs to do so with the impact on clinically vulnerable people as a key group at the forefront of such planning. Moreover, mitigations are required now for new Covid-19 variants.

3. As the Inquiry will be aware, CVF were designated as a Core Participant ('**CP**') for Module 10 of the Inquiry on 12th November 2024. CVF looks forward to assisting the Inquiry by providing, by way of evidence, lived experience of how inequalities affected and continue to affect Clinically Vulnerable people and their households.

---

[1] These terms are used as they were during the acute stage of the pandemic according to the contemporaneous Government definitions

[2] Pre-existing conditions of people who died due to coronavirus (COVID-19), England and Wales - Office for National Statistics

[3] Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK - Office for National Statistics

4. CVF are grateful to Counsel to the Inquiry ('**CTI**') and Solicitors to the Inquiry ('**STI**') for the helpful notes dated 22nd January 2025, together with other information circulated ahead of this hearing.

B. SUBMISSIONS

'Impact on society'

6. Module 10 provides an important opportunity – the final opportunity given it is the final module – for the Inquiry to take account of the severe and lasting impact that the pandemic has had on Clinically Vulnerable people and their families.

7. Clinically Vulnerable people had a unique experience of the pandemic, being most at risk of severe injury or death from Covid-19. For the general non-Clinically Vulnerable population, the acute stage of the pandemic was hugely impactful and stressful, filtering into all areas of their, and their families', lives. The measures imposed by the Government, in addition to the fact of the virus itself, will undoubtedly have impacted on the mental health of some and caused serious inconvenience for others. However, Clinically Vulnerable people were in a materially different position, because of the additional risk to life that the virus posed to them. When society reopened for many, it did not reopen for many who were Clinically Vulnerable. Many remained in their homes, with no choice but to shield themselves (even after formal shielding ended) from the virus which, if they became infected, would potentially lead to their deaths.

8. There were aspects of the Government response to the pandemic which made things worse for Clinically Vulnerable people. For example, the framing of protective measures (such as social distancing rules and compulsory mask wearing) as 'restrictions', and of the lifting of those measures as 'freedom' (including initially referring to the expected final lifting of the measures as 'Freedom Day'). Certain measures undoubtedly felt restrictive for some, just as a seatbelt might feel 'restrictive'. However, like seatbelts, most people accepted at that time they were needed as basic safety measures, particularly for the millions of people at serious risk of injury or death from Covid-19.

9. The framing of safety measures as restrictions had profound and long-term consequences. It arguably prevented simple measures which improved safety, such as mask wearing, from being continued in a proportionate way in the longer term, for example within

healthcare settings. Mask wearing became seen as part of a 'culture war' rather than an important and protective public health measure. This has had serious consequences for Clinically Vulnerable people, because as the Chair heard from Dr Finnis in her evidence in Module 3, people who continue to wear masks for health reasons are frequently subjected to public abuse and discrimination.

10. The other consequence of health protection measures being framed as 'restrictions' is that no serious consideration appears to have been given to what measures can be put in place now, and in the medium and long term, to protect the public, including for the future pandemic which has been a focus of many Inquiry witnesses' evidence. This was probably the greatest missed opportunity of the pandemic: to educate the public, businesses and public authorities on the importance of high-quality masks, ventilation and clean air, and make steps towards lasting change in those areas. Appropriate investments should already have been made to improve air quality in (for example) healthcare facilities, schools and other busy environments. This would not only mitigate the current risks to Clinically Vulnerable people, but also to protect the broader population from infections, now and in the inevitable next pandemic.

11. Investment in those measures would also reduce the need, in a future pandemic, for '*restrictive*' social distancing measures and to make those spaces safer not just for high-risk people but for everyone. Covid-19 may no longer kill as many people as it did in 2020, but it as the Professor Wei Shen Lim, chairman of the Covid-19 subcommittee of the Joint Committee on Vaccination and Immunisation, agreed in his evidence to Module 4, Covid-19 has not transitioned to a seasonal virus. Covid-19 is also still rife, as are 'flu, Norovirus and other airborne pathogens such as RSV. A more enlightened approach to ventilation and other protective measures would reduce the spread of all airborne infections – not just in a future pandemic but <u>now</u>.

12. The opportunity to protect the public from these pathogens is still available, but it is receding. Whilst the whole of society was thinking and talking of nothing else but Covid-19 there was the chance to educate the public, including Clinically Vulnerable people, on the importance of ventilation, how to reduce the spread of airborne pathogens in crowded spaces and how to ensure that Clinically Vulnerable people could return safely to society without feeling marginalised and as if their basic safety was an unwanted 'restriction'. The 'Living with Covid-19' policy was another missed opportunity, as it was not accompanied

by a long-term impact analysis and plan for public education and changes to infrastructure.

13. Many Clinically Vulnerable people have ended up feeling excluded from a society which left them behind in the rush to 'escape' from restrictions, and towards the false promise of 'Freedom Day'. Immunocompromised Clinically Vulnerable people have no prophylactic (preventative) medicines such as Evusheld to rely upon and many cannot depend on vaccination (and many millions, including the majority of CV and former CEV people, face being removed from the Covid vaccination programme later this year). The anti-virals programme is in disarray, providing little reassurance to people at higher risk of Covid-19, should they become infected. The result is that some have already withdrawn from parts of society – from the workplace, from crowded, poorly ventilated spaces and certainly from the public consciousness. This is a great loss not just for Clinically Vulnerable people but for society at large. Indeed, it is mistake to see Clinically Vulnerable people as somehow detached from the 'general public'. They represent millions of people. Everyone either has, has had, or will have a loved one who is clinically vulnerable.. They are our partners, friends, family - and they are 'us'.

14. Clinically Vulnerable people have been consistently left behind and sidelined. This is one of the major reasons why CVF was set up, and has provided a much needed support service to so many families. However, as a small organisation it can only do so much. This is why CVF has proposed a more permanent change to the legal protection of Clinically Vulnerable people, to include Clinically Vulnerable as a protected characteristic in the Equality Act 2010. This would, amongst other things, require that employers, service providers and other institutions do not discriminate against Clinically Vulnerable people, and make reasonable adjustments to accommodate them in spaces to improve their safety. It would go some way towards ensuring that all CV people are protected and no longer left behind.

15. It is hugely important that Module 10 foregrounds the experience of Clinically Vulnerable people. CVF are concerned that the current Provisional Scope fails to do this, instead making what unfortunately appears to be a tokenistic reference to them without properly integrating them into the three provisional scope 'topics', or into the 13 questions which the Inquiry team has posed itself. There is no Clinically Vulnerable roundtable, nor is there any reference to 'clinical vulnerability' in the potential instructions of experts. It is important that this changes before the evidence gathering process properly begins.

Provisional outline of scope for Module 10 and accompanying questions

16. The experience of Clinically Vulnerable people should be considered in relation to every subtopic in this module. This is because for every impact of the pandemic, whether (for example) in prisons, places of worship or the justice system, the impact was <u>different</u> and often <u>more severe</u> for those who are or were Clinically Vulnerable. Clinically Vulnerable people did not always benefit from the reopening of parts of society. Shielding (which CEV people were strongly advised to do and some Clinically Vulnerable people who could, chose to do) was more severe and isolating than the restrictions which applied to the healthier population. The mental health of these higher risk individuals suffered as a consequence, and to a significant degree, and this must be taken account of in this important module.

17. The Chair has heard powerful evidence in Module 3 from Dr Catherine Finnis on behalf of CVF regarding the mental health impact of shielding and the lack of access to safe healthcare, and in Module 4 from Lara Wong on vaccines and therapeutics. There is much more to be said by CVF which could assist the Chair and CVF would be happy to provide further Rule 9 evidence in this module.

18. CVF requests that the following points are taken into account / amendments made to the provisional outline of scope and key questions:

    <u>Provisional Scope Topic No. 1</u>

19. It is important that the impact on the Clinically Vulnerable is explicitly included as an issue relating to the impact of the "*closing and reopening restrictions*" (para. 1). Clinically Vulnerable people faced and continue to face greater risks to their lives than any other category of person. Government strategies relating to community testing, surveillance and the movement from 'contain' to 'delay' had a huge impact on the mental health of Clinically Vulnerable individuals who were advised to shield, often with frightening messages. Others chose to shield to protect themselves. Many are still shielding, or living limited lives on the periphery of society, to this day. The regulations and their enforcement had a huge impact on the lives of Clinically Vulnerable individuals in both positive and negative ways.

20. Moreover, because they were often formally (in the case of the CEV), and informally (as in the case of some CV, or some CEV once formal shielding ended) ,they were not always beneficiaries of reopening of parts of society. An important element of this, which CVF will provide further evidence on if called to do so, is the timeliness and clarity of communication regarding support from both the UK Government and Devolved Administrations, including the delays and issues that impacted CV/CEV persons and their households.

21. Accordingly, it is important that the Inquiry recognises that there was not a generic story about closing and opening; and as CVF has submitted in Modules 3 and 4, for many Clinically Vulnerable people, 'Freedom Day' never came. This disparity should be recognised in Module 10. CVF therefore proposes the following amendment to (1):

The general population of the UK including the impact on mental health and wellbeing of the population. This will include the community level impact on sport and leisure and cultural institutions and the societal impact of the closure and reopening restrictions imposed on the hospitality, retail, travel and tourism industries, including the impact on those who could not benefit from reopening such as many clinically vulnerable people. It will also cover the impact of restrictions on worship resulting from the closure and reopening of places of worship.

Provisional Scope Topic 2

22. It is important that the experiences of clinically vulnerable key workers are covered by Module 10. Clinically Vulnerable people , including some who had even been advised to shield, were often not supported and kept safe in their jobs, meaning some lost their jobs (particularly frontline workers such as teachers), experienced financial hardship, and general difficulties in accessing support mechanisms like Universal Credit. This resulted in substantial disparities as compared to non- Clinically Vulnerable members of the public. The impact of the pandemic on Clinically Vulnerable teachers is an issue which CVF is particularly concerned by, and it is clear from the scope of Module 8 that this issue must be covered in Module 10 or it will not be covered at all.

23. CVF hopes to share observations through Rule 9 evidence (if it is invited to provide such evidence) on the steps taken to reduce disparities in support delivery, noting any successful initiatives or areas needing improvement to help inform credible and impactive

recommendations for the future.

24. A significant issue which CVF has noted is that the Office of National Statistics did not gather any data to monitor the experiences of those who were Clinically Vulnerable, seemingly focusing all of their attention on a small subset the group the government identified and labelled as CEV. This led to a serious gap in the understanding of the impacts on the Clinically Vulnerable and their need for targeted support. CVF is able to plug this gap by providing the Inquiry with much needed information and lived experiences from this group to further inform and strengthen the Inquiry's understanding of the experience, issues faced and what recommendations to make for the future for those Clinically Vulnerable people working in high-risk frontline environments as key workers.

25. CVF does not propose any amendment to Provisional Scope Topic 3, as it assumes that "*any inequality in the impact of…*" will include consideration of inequality for Clinically Vulnerable keyworkers, given the overall focus of this Module.

Provisional Scope Topic 3

26. It is important that Provisional Scope Topic 3 makes clear reference to *"the most vulnerable… as well as the clinically vulnerable*", however CVF is concerned that there is insufficient focus on how Clinically Vulnerable people will be considered within this topic.

27. CVF raises as an additional issue, either for this topic or Topic 1, the variation of support across the UK. There were important differences as to how England, Scotland, Wales, and Northern Ireland implemented and managed support measures for Clinically Vulnerable people and their families. For example, the approach to shielding, economic support schemes, and local restrictions varied significantly across the devolved administrations. Scotland and Wales had different timings and durations for lockdowns and stay-at-home orders compared to England and Northern Ireland, affecting the support received by vulnerable populations Many CVF members found that the differing approaches in each devolved administration sometimes led to inconsistencies in support, which could either increase or reduce the efficacy of the measures. The localised responses and varying levels of support impacted on financial stability, health outcomes, and access to services.

The questions in §19 of CTI's note

28. CVF notes that there is no mention of the clinically vulnerable in the 13 questions posed at §19. CVF therefore requests that (k) is amended as follows:

What was the impact of the pandemic and measures put in place on the most vulnerable in society, including clinically vulnerable people, such as the impact on access to support services?

29. CVF proposes an additional questions after (g) as follows:

h. Were there disparities of impact for clinically vulnerable people who could not access sports, leisure, cultural institutions, retail, travel and places of worship at times when they reopened for the rest of the population?

i. Would it have been possible to mitigate any disparity of impact for clinically vulnerable in accessing [reopened[parts of society?

j. How did the framing of measures taken by the Government to protect public safety as 'restrictions' impact on the way in which the public responded to them?

k. Did equalities law protect clinically vulnerable people sufficiently in light of issues arising from the emergence of Covid-19 ?

30. In order to address the issue of disparities across different parts of the UK, CVF proposes including this additional question:

To what extent, if any, did different policies in England, Wales, Scotland and Northern Ireland impact on the issues covered by Module 10?

Expert reports

31. The expert evidence should cover the impact on Clinically Vulnerable people, both on their mental health and generally.

Roundtables

32. It is very important to CVF that a roundtable is added to assess the impact of the pandemic on Clinically Vulnerable people.

33. Further and in any event, Clinically Vulnerable representative groups should be invited to each of the nine roundtables so that the serious disparities of impact on Clinically Vulnerable people in relation to each issue is considered, and the voices of Clinically Vulnerable people are not left out of account altogether.

C. CONCLUSION

34. Module 10 is the final chance for the Inquiry to listen to the voices of Clinically Vulnerable people, and understand the profound and lasting impact which the Covid-19 pandemic has had on them. Despite the regular talk of 'protecting the vulnerable', the pandemic has been a major missed opportunity to make the permanent changes to attitudes, infrastructure, and equalities law needed to protect vulnerable lives and to make our society more inclusive and safer for everyone. The Inquiry now has an opportunity to begin to reverse that.

KIM HARRISON
SHANE SMITH
Solicitors for CVF

Slater & Gordon

ADAM WAGNER
Counsel for CVF

Doughty Street Chambers
5th February 2025