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Witness Name: FMHWG

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**UK COVID-19 INQUIRY**

**MODULE 6**

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**WITNESS STATEMENT OF THE  
FRONTLINE MIGRANT HEALTH WORKERS GROUP**

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The Frontline Migrant Health Workers Group (“**the Group**”), says as follows:

1. The Group is a collective grouping of two trade unions, United Voices of the World (“**UVW**”) and Independent Workers’ Union of Great Britain (“**IWGB**”), and a consortium of community organisations, Kanlungan, for the purpose of their participation in Module 6 of the Covid-19 Inquiry (‘the Inquiry’). This statement is prepared jointly by representatives of those organisations: Alex Marshall (IWGB – President); Petros Elia (UVW - General Secretary); and Francesca Humi (Kanlungan – affiliate). They make this statement on behalf of their respective organisations and are duly authorised to do so.
2. This statement is prepared in response to the Request for Evidence by the Chair of the UK Covid-19 Inquiry under Rule 9 of the Inquiry Rules 2006 (Reference: M6/FMHWG/01).
3. In accordance with the request, the statement will speak to the impact of the pandemic on workers in the adult care system who are predominantly low-paid and precariously employed, the majority of whom are from migrant communities.
4. The statement will, for the most part, address the impact over the “*relevant period*” as set by the Inquiry, i.e. 1 March 2020 to 28 June 2022. On occasions it has been necessary to refer to dates outside of that period, in order to contextualise that impact. Where the accounts of interviewees have been referred to, pseudonyms have been used to preserve their anonymity.

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**Brief overview of the history, legal status and aims of the organisations**

5. As the IWGB's president, Alex Marshall, stated in evidence to the Inquiry in Module 3 on behalf of the Group, "*the work that Kanlungan, the IWGB and UVW do is we represent precarious workers, many of whom struggle to pay the bills, let alone pay for union membership or anything like that. ...The work we do is a microcosm of ...what needs to happen across the whole of the UK.*" Hence, despite the relatively small size of the Group, their evidence speaks to a broad experience across the country. [See MHW/01 INQ000474330 Witness Statement of the IWGB's president to Module 3 of the Inquiry.]

Kanlungan

6. Kanlungan is a registered charitable incorporated organisation consisting of several Filipino and Southeast and East Asian grassroots community organisations. It works for the welfare and interests of migrants, refugees, and diaspora communities from the Philippines and East and Southeast Asia living in the UK. It acts across the UK to empower Filipino, East, and Southeast Asian migrant workers providing immigration, welfare, and employment advice. In addition, it organises cultural and spiritual activities, it assists its members with mental health and wellbeing support, and campaigns for workers' and migrants' rights through lobbying local and national government.
7. Between 2021 and 2022 Kanlungan supported approximately 2,081 individuals. The majority of their service's users are in the UK on visas which are attached either to their work (such as domestic workers and health and social care workers) or attached to their spouse/partner, however, many are undocumented. In most instances, service users who became undocumented were lawfully admitted to the UK and had previously held valid visas.
8. Some service users are victims of trafficking or modern slavery and are going through the National Referral Mechanism process. As well as providing extensive support to such people during the pandemic, Kanlungan have also engaged with external researchers to produce reports on the experiences of migrant and undocumented workers during the pandemic. As a result , they have accumulated and developed special expertise on the informal care sector that deals with care needs unmet by the NHS/formal social care sector. This expertise is reflected in a number of key reports that Kanlungan have contributed to which overlap with the evidence [see, for instance, MHW/02

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INQ000509511, concerning the extent of exploitation and modern slavery in the care sector and the prioritisation of immigration enforcement over labour standards, e.g. from page 22].

9. The Philippine government says that about one-third of its 10 million citizens overseas are women working as domestic workers and carers [see MHW/03 INQ000506972, Guardian reporting on the international context of domestic workers and which also shows there is an overlap between “domestic workers” and “domiciliary carers”]. This equates to roughly one quarter of the estimated number of migrant domestic workers worldwide [see MHW/04 INQ000509512, page xi, for ILO statistical reporting on this issue]. In 2019, the UK government issued just under 23,000 Overseas Domestic Worker visas to workers temporarily accompanying their foreign national employers to the UK. About half of these six-month visas were issued to workers from the Philippines [MHW/05 INQ000509513, reporting in Al Jazeera referencing members of the Filipino Domestic Workers’ Association, which was at the time a constituent member of Kanlungan, and implicitly highlighting the overlap between domestic work and adult care, e.g. at page 17]. Similarly, since February 2021, the Health and Care Worker visa has brought a significant number of Filipino care workers to the UK [see pages 12 and 13 of MHW/06 INQ000551236 for the evolution of the Health and Care Worker visa, including through the relevant period, and noting that Filipino is in the “top five nationalities” issued the visa]. Given that Kanlungan’s primary focus is advocating for the rights of Filipino persons in the UK, it is well-placed to comment on the situation of migrant care workers here.

UVW

10. UVW is a national trade union founded in XXXX. It organises predominantly low paid, migrant & precarious workers. UVW is an anti-racist, member-led, campaigning trade union that has been established to organise, support and empower the most vulnerable groups of precarious, low-paid and predominantly ethnic minority and migrant workers in the UK. UVW brings together hundreds of workers across several sectors including the care sector, many of whom worked on the frontline in care homes during the pandemic as carers, cleaners, porters and kitchen staff. At present, it represents approximately 77 care workers across 6 sites. All but a few of these members are migrants with temporary immigration status. Despite the relatively small number, these workers are the foundation of the organisation and helped establish the union and the branch’s campaigning which

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has had national reach through illuminating the conditions in the sector. [See exhibit MHW/07 INQ000551237 for a collection of articles from 2020 through to 2022 from various outlets in the national press indicating the impact of their organising in the care sector]. UWW combines industrial and legal action to demand that all members receive at least the London Living Wage, full pay, sick pay, dignity, equality and respect at work. It is an unincorporated association with quasi-corporate status by reason of its being a trade union under s.10 of the Trade Union and Labour Relations Consolidation Act 1992.

### IWGB

11. The IWGB is a national trade union founded in 2012. It was established by Latin American cleaners organising for better pay, pensions and working conditions in London. Its members in the adult social care sector include at least 81 individuals across a number of charities providing supported living services and advising disabled people of their rights. Its service sector branch comprises couriers and cleaners in outsourced positions whose vital services to the adult care sector are often overlooked, and during the pandemic included delivering necessities such as food, medicines and hygiene supplies. It organises industrial action to challenge the exploitative practices which deny its members basic rights such as health and safety protections and sick pay. In particular, it has been at the forefront of organising workers who have previously been unorganised. It is an unincorporated association with quasi corporate status by reason of its being a trade union under s.10 of the Trade Union and Labour Relations Consolidation Act 1992.

### Definitions

12. "The Care Sector" - The Scope of this module concerns the publicly and privately funded adult social care sector. We welcome the fact that this is stated to include care provided in the home (i.e. domiciliary care). The Group suggests that in order to ensure that the Inquiry captures the way that informal structures have developed to fill the deficiencies in care provision on the ground, it adopt a broad conception of care work when examining Module 6. Arrangements regarding domestic care were often informal and were made when our members were engaged via domiciliary care agencies as well as directly by private individuals. These informal structures represent an important element of the adult care sector provision during the pandemic.

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13. As such, as well as the formal private and public sector care homes and services, we urge the Inquiry to scrutinise the effect of the pandemic on that portion of the market which encompasses domestic workers employed in private households who also provided domiciliary care. This work is arranged outside the formal social care sector and therefore is part of the “*informal care sector*”, which is the term we shall adopt. As the National Audit Office noted in 2021, there is little visibility or understanding of the self-funded sector of the care market. As reported therein, “*LaingBuisson estimates that, as at 31 March 2020, there were 11,000 self-funders aged 18 to 64 in England and 137,000 self-funders aged 65 and over in England living in independent sector care homes*” [MHW/08, INQ000506973, National Audit Office report into the social care sector, paragraph 1.16]. The definitions and assumptions used to arrive at this figure are unknown – for example, to what extent are domestic services included – because the study cited is private, hence its validity is questionable.
14. In what follows, we use the terms “*Domestic Carer*” and “*Domiciliary Carer*” interchangeably. We note that all “*Domestic workers*” interviewed and discussed in this statement were or are in fact carers. [This treatment is supported by the International Labour Organisation: see exhibit MHW/09 INQ000506974, from page 4 and 5 regarding the domestic work which includes “*a range of indirect and direct care services in or for a private household*”.] For example, much of the domestic/domiciliary work done by Filipino individuals who are represented by Kanlungan was casualised and changeable, meaning that while on some days they provided direct care to elderly, disabled or unwell family members, on others they spent their time cleaning, cooking and looking after children. The reality was that undocumented and other migrant workers were required to undertake whatever role was asked of them by their employers. As these domestic care workers formed an important part of the UK’s capacity to respond effectively to the pandemic, and reliance upon their contribution was an important consequence of the fragmented state of the care sector, it is suggested that their work should form part of the Inquiry’s focus.
15. We use the term “*Privatised care sector*” to refer to privately owned entities which provide adult care services (but excluding the voluntary and not for profit providers). These privately owned entities now make up the vast majority of the care sector: the proportion of care provided “*by council employed staff in the community or in council owned care*

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*homes or in council owned day centres*” reduced by around 90 per cent between 1993 and 2014 [MHW/10 INQ000509680, introductory chapter to legal text on social care law, explaining the evolution of social care provision in the UK, paragraph 1.32]. Care providers in the privatised care sector seek to make profits as a result of providing their care services.

16. We use the term “*unregulated care sector*” to refer to those homes and other care providers which - despite the stipulation in section 10(1) of the Health and Social Care Act 2008 that it is a criminal offence to engage in activities involving, or connected with, the provision of health or social care unless registered with the Care Quality Commission (“**CQC**”) – we assume to be providing regulated services without registering with the CQC. Strikingly, one Kanlungan interviewee reported that she had worked in care homes that were not registered with the CQC, stating that such employers would knowingly employ undocumented staff members and would not pay tax. We ask the Inquiry to seek further evidence from the CQC and independent researchers on how common such institutions are in the sector, and the impact that the pandemic had on the CQC ability to fulfil its functions then and since. We will of course seek to assist with this and further detail is provided below when we address the structure of the sector, under the subheading, “Regulatory failure” at page 20. This is particularly pertinent given the growing extent of exploitation within the sector [see, for example, MHW/11 INQ000509514, a report into modern slavery within the care sector;].

17. We use the terms “employer” and “employee” to describe those who engage the services of carers and those who are so engaged, even where that relationship is an informal one that may not meet the statutory definition in s.230 Employment Rights Act 1996.

**Structure of the Sector and Unequal Impact: Systemic issues existing pre-pandemic and the effect of these issues on care sector workers during the pandemic**

18. The view of the Group is that the UK was profoundly ill-equipped to deal with the exigencies of the Covid-19 pandemic in the care sector due to the combined effects of underfunding, austerity, marketisation, casualisation, accommodation issues, understaffing, structural racism and the Hostile Environment, all of which contributed to instability, fragmentation and increased risks to both service users and workers. These problems are endemic and arise from the structure of the market, ineffective regulation by

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an under-resourced regulator (the CQC, discussed further below) and statutory duties falling on Local Authorities without enough resources to fulfil them, who in turn engage private providers whose purpose (profit) combines with the foregoing to prioritise/privilege cheap instead of safe care.

19. The Group wishes to draw particular attention to the situation of undocumented migrant workers, who performed vital and largely invisible care work for millions of people during the pandemic, yet faced myriad overlapping issues that made them especially vulnerable to exploitation and abuse. That they were overrepresented in the care sector is the result of a sector dependent on cheap and precarious labour. The key themes the Group wishes to draw attention to are as follows:

- a) Profiteering, underfunding and low-pay. The for-profit privatised care sector was uniquely poorly placed to cope with the demands of the pandemic. The implementation of austerity measures in the years immediately preceding the pandemic had resulted in chronic underfunding of the care sector. This squeezed the profit margins of care providers, who sought to save costs, particularly staffing costs. One way of achieving this was to engage migrant carers on poor pay and conditions. The pandemic exacerbated this picture. In particular, many of the Group's interviewees noted that understaffed care homes frequently opted to turn a blind eye to their staff members' obvious symptoms of Covid-19 to avoid paying higher rates of pay to agency cover workers. There is also evidence that providers also deliberately failed to follow the government's Covid-19 rules and guidance in order to save money and thereby put the health of both service users and migrant carers at risk. Crucially, the widespread non-availability of sick pay for migrant workers in the care sector meant that poorly paid care workers were regularly faced with a deadly choice between going to work while symptomatic and being reduced to destitution while off sick. [See, generally, MHW/12 INQ000506975, report from the Nuffield Trust arguing that extending the availability of sick pay is key to building a more resilient care system.]
- b) The Hostile Environment and the "no recourse to public funds" condition ("NRPF"). Many care workers are migrants on visas which are contingent on their continued employment because they have been sponsored by social care providers. Many other migrant care workers are undocumented, often as a result of the expiry of

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their Overseas Domestic Worker visas which, since 2012, automatically expire after 6 months without the possibility of renewal [see exhibit MHW/13, INQ000509515 for overview and implications for modern slavery]. These workers are especially vulnerable to exploitation, being fearful of upsetting their employers in the knowledge that not only their income but also their ability to remain in the UK depends on their continued employment. The evidence gathered shows that in many cases, those employers were well aware of the precarious and vulnerable situations of their employees which they exploited in order to maximise labour and minimise employee safeguards and entitlements. These workers also reported systemic discrimination at all levels, including in being required to undertake dangerous work with Covid-infected residents that workers with secure immigration status (British citizenship, settlement) would refuse to do. In addition, some workers supported by the Group are tied to their employers through the Health and Care Worker visa, which provides little time to find new employers in the event of termination, leaving workers further vulnerable to exploitation. [See MHW/06 INQ000551236 for the need for reforming the Health and Care Worker visa given the impact it has on migrant care workers' bargaining position, e.g. pages 39 – 41 for overview.]

Most migrant care workers are on visas that have a “*No Recourse to Public Funds*” (“**NRPF**”) condition attached. An NRPF condition prevents the person from claiming mainstream benefits, tax credits and housing assistance. In practice, almost all public funds that a non-migrant care worker would normally be entitled to claim are not available to a migrant care worker doing the same work. This includes, for example, free childcare or disability support in the event of a long-term condition, such as Long Covid. Consequently, migrant care workers are in an even lower socio-economic category than their non-migrant colleagues. Inevitably this has implications in respect of health inequality and vulnerability to exploitation.

- c) The unique importance of care workers. Care work depends on close physical contact with others. Many care workers put themselves in harm's way in order to safeguard those they were working with whilst living on poverty wages. Others did this invisibly: undocumented workers performed incredible work for highly vulnerable patients in dangerous conditions while being paid significantly below the national minimum wage (“**NMW**”). While the UK was celebrating care workers

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and clapping for them each Thursday, the system that engaged them routinely failed to treat them with dignity, fairness and respect. The societal undervaluation of care work existed before the pandemic but it became deadly during it, leading to many unnecessary deaths because care workers were forced to choose between working while either symptomatic or being vulnerable to contracting Covid-19 on the one hand, and falling into destitution on the other.

### Underfunding and Austerity

20. The care sector was ill-equipped to cope with the Covid-19 pandemic due to austerity and underfunding in both the NHS and in the care sector itself.
21. In relation to the NHS, there are over 7.5 million patients (and rising) on the biggest ever waiting list in England [see NHS statistics presented to House of Commons, MHW/14 INQ000327656, page 4]. Before the pandemic, the NHS was hugely stretched and faced chronic understaffing [see vacancy statistics MHW/15 INQ000327694] as well as underfunding. This led to the catastrophic decision to discharge patients from hospital to care homes without testing in March and April 2020, effectively shunting such people off when the healthcare system could not meet these demands. It follows that the chronic underfunding of the NHS had direct implications for the care sector: the former's inability to cope led to an incredible amount of pressure on the latter.
22. In terms of the care sector itself, a decade of austerity prior to the pandemic had resulted in £7.7 billion in cuts being made to care budgets [see survey from the Association of Directors of Adults Social Services, MHW/16 INQ000514933 , page 7]. Local authorities and care homes had to deal with the increasing demands of an ageing population with fewer resources [see well referenced reporting at industry publication 'Community Care' for overview of the "austerity decade", MHW/17 INQ000506976]. While pay had dropped less dramatically in real terms for care workers as it had for those working in the NHS, the Trades Union Congress ('TUC') has explained that this was because care wages were already extremely low, with many workers paid at or close to the NMW [see their report into the link between cuts to public funding and pandemic resilience, MHW/18 [INQ000250949 , page 6]. The pay differential between care workers with less than 1 year of experience and those with more than 20 years of experience has reduced to just £0.15 an hour [See reporting from the Kings' Fund, MHW/19 INQ000506978, page 2]. This led to huge delays in assessment of patients' needs for social care and equivalent

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gaps in provision of care [MHW/20 INQ000217378, report and research by Age UK into the systemic deficiencies in providing domiciliary care for the elderly; see in particular the links between pay and availability and quality of home care at pp.16-17 and 35, the delays described at p.33]. Further, the austerity-led failure to adequately stockpile personal protective equipment (“PPE”) severely undermined preparedness for a pandemic in the healthcare systems, including the care sector [see expert report for the Covid-19 Inquiry by Dr Kirchhelle, ‘Emergencies & Omissions’, MHW/21 INQ000205178, pages 90-92.]

23. As explained by the Nuffield Trust in their research into how to increase resilience in the social care system:

*“Many small and medium-sized organisations that provide the majority of care in the sector entered the pandemic with few financial reserves to meet the sudden increase in costs stemming from staff sickness, PPE purchases and lower occupancy (in residential care), and minimal back-office support to cope with new administrative burdens”* [MHW/12 INQ000506975, page 7]

Exploitation of the private sector

24. The Group’s care sector members work outside of the NHS and Local Authority-run care homes in the marketised and profit-seeking formal care sector. Additionally, many work in the informal and non-regulated parts of the sector in private homes.
25. The 2019 pre-pandemic breakdown of the care sector workforce had an estimated 61% of care sector workers employed by private providers (a notable increase on 2012 figures) and 18% by voluntary providers, with just 7% employed by Local Authorities and 6% by the NHS [see care workforce planning body, Skills for Care, annual report 2021 into the “State of adult social care sector and workforce in England”, exhibit MHW/22 INQ000509517]. The average pay for the latter two categories of worker was just over £10 an hour. The average for those working in the private sector was around £8.79 an hour, which was around the national living wage, at the time, of £8.72 [MHW/22 page 98]. There was, and remains, a heavy reliance on outsourced (usually agency) workers, particularly in the private sector. Around 25% of workers in the sector and 35% of care workers were on zero-hours contracts [MHW/22, page 48]. One third of adult social care jobs in the private sector were classified as insecure. In domiciliary care, the numbers are far higher, with 56% of home care workers on zero hours contracts [exhibit MHW/22, page 49].

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Almost a quarter of the national care sector workforce are from ethnic minority backgrounds, with that figure rising to around 70% in London [Exhibit MHW/22, page 18]. Nationally, 82% of social care workers are women [MHW/22, page 17]. This is why we describe the care sector workforce as gendered and racialised.

### Pay

26. The low wages of precariously employed, migrant care workers contribute to their vulnerability to employer coercion, poor access to adequate housing and subsistence, and consequently worsened health outcomes.
27. A widespread lack of contracted sick pay, and reliance on the inadequately funded system of Statutory Sick Pay, led to some workers having no choice but to continue working when ill, exacerbating the wider public health risk. By way of example, one UVW member at a North London Care Home had to continue working throughout the pandemic, despite her 3-month-old son having a lung condition, because of low pay and the non-availability of furlough.
28. In a survey of 78 Filipino migrants conducted by Kanlungan in 2020, they reported earning on average £6.01 per hour [See Kanlungan's report, "*A chance to feel safe*" MHW/23 INQ000235265], while the contemporaneous NMW in the UK was £8.72 and the London Living Wage was £10.75. Fearful of being reported to immigration authorities, many undocumented respondents were unable to negotiate lawful levels of pay and better working conditions, as the following examples show (pseudonyms have been used). Shane described how she was made to work from 6.30am to 10 or 11pm as a for one UK employer and Jonels was paid just £200 per week to work sixteen hours a day, six days a week (just over £2.00 per hour). Peachybelle worked sixty hours per week as a live-in carer and is paid less than £500 a month, equating to an hourly wage of less than £2.00. Sometimes carers would not be paid for the care work that they performed and instead were only paid for the cleaning that they undertook.

### Casualisation and domestic carers

29. Many of the care needs of the British population are met by domestic carers. Kanlungan's experience also indicates that there is a high degree of overlap between domestic workers and domestic carers [see MHW/23 INQ000235265 page 6, reflecting that many research participants worked part-time as both carer and more conventional domestic work]. Some

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are “*live-in*”, in that they reside with their employers, others move from home to home. The International Labour Organisation predicts that around 81% of domestic workers worldwide work pursuant to informal arrangements, earning around 56% of average monthly wages of other employees, and are more likely than other workers to work either very long or very short hours. Despite their centrality to the care sector, their role is poorly understood and often overlooked. They are also vulnerable to violence and harassment, and restrictions on freedom of movement. [See generally, exhibit MHW/24 INQ000506979, noting that domestic workers provide “direct and indirect care services” and are “key members of the care economy”; as well the statistics cited in this paragraph.]

30. Many of the Group’s interviewees reported working pursuant to casualised, cash-in-hand arrangements. Many have irregular migration status, which further exposes them to exploitation by unscrupulous employers (this includes those who are here legally, for example those who have made in-time applications to extend leave and therefore have leave under s.3C of the Immigration Act 1971, but have not formally been granted it and remain vulnerable to this exploitation by employers as a result). Their roles often involve giving complex care to elderly and/or disabled people, and they often work long hours with little time off, and/or provide 24/7 live-in care. One interviewee, Lorena (who used a pseudonym) stated that she worked in an “*underground economy*” and an “*invisible world*”. She has lived in the UK as an undocumented migrant for decades, earning on average £250 per week for live-in work that occupied her time 24 hours a day, 7 days a week. When working as a live-in carer in people’s homes or in care homes, providing personal care to elderly individuals, she would work pursuant to a casualised, cash-in-hand arrangement where the individuals employing her would not recognise that they were precisely that: her employer. Given this, they felt able to dismiss her summarily or to impose a “*no work, no pay*” rule on her, but did not take responsibility for her safety nor the need for PPE during the pandemic. Often, employers and agencies are aware of the precarity facing their employees, and weaponise this against them by forcing them to work on low pay and poor conditions in the knowledge that they had nowhere else to go.
31. For live-in domestic carers, their living space and their workspace are the same. Workers accordingly had nowhere to go if a member of the household contracted Covid-19. Kanlungan saw on numerous occasions that some domestic carers were evicted from the household when they contracted Covid-19, thereby rendering them both homeless and jobless. Domestic care workers, i.e. care workers directly employed in individual

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households, faced perhaps the most precarious conditions related to worker protections and PPE.

32. Those trafficked into the country experienced intense exploitation, with increased workloads, and were often isolated from the community, not being allowed to go outside [see exhibit MHW/25 INQ000509518, research from the University of Nottingham into the “vulnerability of paid migrant live-in care workers in London to modern slavery”]. Kanlungan knows of trafficked workers in every part of the sector, including in care homes, but notes that most worked as domestic carers through the Overseas Domestic Worker visa, who then carried on working in precarious and exploitative environments after becoming undocumented. Survivors of trafficking who managed to escape their employers found themselves in precarious situations, with no access to support and, in many cases, no right to work. They were often forced into unstable jobs, further exacerbating their vulnerability. The live-in nature of their work meant that many domestic carers were compelled to work far beyond agreed hours, with little to no regard for their rights.
33. Such workers are particularly susceptible to abuse, as they often feel entirely unable to report any issues or to take action in response. As explained by one Kanlungan interviewee, during the pandemic, these workers faced a choice: *“do I stay locked down with employers who are abusing me, or do I leave and potentially become homeless in middle of pandemic, when I don’t know who would take me in or how I would access any services? The pandemic was about staying home. But when you’re being abused at home, then it’s like a death sentence.”* That interviewee noted that there has rightly been a lot of discourse about the inescapability of domestic abuse in households during the pandemic, but there has been insufficient focus on this abuse in the live-in care context. Many such workers were required to remain in what they later described as *“prisons”* 24 hours a day, 7 days a week, with their abusers.
34. Further, because of the lack of legal redress and accountability in such situations, cycles of abuse continued. When one live-in domestic carer was able to escape an exploitative/abusive situation, the abusive employer would simply hire another domestic carer, who would then be exploited. A total lack of reporting mechanisms or safety in raising complaints for such workers permitted abusers to carry on with impunity.
35. The lack of a contract or employment recognition and the lack of secure immigration status also meant that such workers could not unionise like other care workers because they did

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not have colleagues, managers and (often) recognisable employers. This means they could not collectively organise and bargain for better working conditions and pay. Such workers were isolated and relied on community and personal networks for advice and support. They reported that employers were able to dismiss them casually if they were concerned that they had Covid-19, and they were unable to fight against this due to the informality of their working relationships. For similar reasons, those who were concerned about shielding or needing to avoid the workplace due to having vulnerable family members felt unable to do so for fear of being dismissed.

Accommodation

36. Carers who did not live with their employers also faced great difficulties with their accommodation that were exacerbated by the pandemic. Due to low wages and the Hostile Environment policies, many care workers live with other care workers in very overcrowded accommodation [Exhibit MHW/26 INQ000506980, BBC report on conditions of undocumented workers, drawing on Kanlungan's work in the sector].
37. For undocumented workers, Kanlungan interviewees noted that due to housing scarcity, where individuals were able to find a landlord that would be willing to accommodate them despite their lack of status, many others would then join them there. Such accommodation was affordable and would not result in them being reported to the Home Office, but was often of very poor quality and hugely overcrowded. This led to clusters of undocumented migrants all occupying the same, small spaces. These clusters tended to be in deprived parts of London, where NHS services were most overwhelmed and underfunded. [See exhibit MHW/27 INQ000506981 for research from the King's Fund explaining the "inverse care law", i.e. "that those who most need medical care are least likely to receive it" hence the most deprived areas are least well served by health services; see also MHW/28 INQ000551238 regarding the increased odds of being infected by Covid-19 as a result of overcrowding in migrant households.]
38. When the pandemic kicked in, care workers were hugely vulnerable to contracting the disease and passing it on. This was not just because of the poor safety conditions and lack of social distancing, but also because many workers could not afford to stay at home (due to "no work, no pay" policies and a lack of sick pay) so that they would continue working while symptomatic. Undocumented migrants were also faced with misinformation, a lack of communication of safety standards, and inability to access healthcare. When

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combined with the overcrowded housing in which many care workers lived, it meant that those with the highest capacity to *spread* the virus also had the lowest capacity to *isolate*.

39. Further, due to these pressures, some members reported resorting to bed sharing during the pandemic because they could not afford rent, thus exacerbating their risks of contracting Covid-19. These problems with cramped accommodation worsened because some live-in workers had to move out of their employer's homes. At times, all members of a household would be very unwell and bedridden, as well as destitute due to a lack of sick pay, meaning that organisations like Kanlungan had to provide them with emergency food and supplies.

Workforce capacity: recruitment and retention

40. An understaffed sector cannot be resilient in times of crisis. The causes of understaffing are multi-faceted. Low pay is plainly a major consideration. The precarious nature of casualised employment is another. Before the pandemic, Group members undertaking bank and agency work in the private sector were frequently engaged to work for care providers who were understaffed. This was in large part due to profit margins and a desire on the part of employers to avoid long-term commitments such as permanent employee contracts. As one of the Group's interviewed workers put it: "*It's about profit, not about proper care*". It is noteworthy that the problem of low pay and other issues remain despite the persistence of understaffing [see exhibit MHW/06 INQ000551236 for recent analysis of the "crisis of recruitment and retention", e.g. at page 11, noting that the vacancy rate is "the highest of any major industry and more than three times higher than the national average", and page 12, arguing that the "workforce crisis in England's adult social care sector and the erosion of work conditions did not happen in isolation", that the "systemic roots" of the issue comprise marketisation and poor bargaining power as well as other issues].

41. The Group's care sector members report low staff retention and chronic understaffing pre-pandemic. Self-evidently, a lack of sufficient staff leads to unsafe working environments. This was inevitably exacerbated when the virus ripped through the care sector. One interviewee worked at a care home in Scotland. She was initially supposed to work 35 hours per week but was quickly expected to work 60 hours once the pandemic hit. It seems likely from this that Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and its requirement to deploy enough suitably qualified,

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competent and experienced staff to enable providers to meet all other regulatory requirements under those Regulations was routinely breached in many of the workplaces discussed in this Witness Statement. As set out in more detail below, the aspect of this provision that related to training was also frequently breached given the lack of appropriate levels of training regarding Covid-19 safety and protocols throughout the pandemic.

42. Outsourced workers, typically working through agencies, were frequently relied on to fill the gaps when pre-existing staffing shortages worsened during the pandemic. It was widely reported that they had to take on increased workloads and job variations without training or consultation, including, for example, the provision of medication to care home residents (as evidenced further below at paragraph 152 below by way of example). Care home workers with precarious contracts often worked in more than one care home, as they were sent to fill gaps caused by understaffing and staff sickness. This increased their travel times and further increased the risk of the virus spreading between care centres, particularly when infection control in care homes was not properly managed.
43. This lack of staff within the care sector created an environment of extreme stress which contributed to the exhaustion and poor mental health of the existing staff. In addition, the inadequate staffing levels had the effect that management often pressured workers to return to work before they were well enough. This had a disproportionate effect on members whose visa was tied to their job, as they reasonably feared they would lose their jobs and visa status, thus becoming subject to the Hostile Environment, if they refused their managers' requests. For the same reasons, many were afraid to take breaks or not come into work if they felt unwell. In other cases, interviewees reported that management were keen to avoid testing or checking for symptoms too closely, in order to avoid having to send workers home because they faced severe understaffing issues and the need to use relatively expensive agency workers.
44. Kanlungan's survey research, conducted by Dr Parry-Davies, found that more than half of the Filipino migrant workers surveyed in the UK had lost their jobs within the first two months of the pandemic [see exhibit MHW/23 for further detail INQ000235265]. Others saw their wages drop to less than £2 an hour.
45. UVW members recalled that low staffing caused significant problems. Care homes were regularly forced to engage agency staff to cover the gaps. As Camila explained "*agency staff don't know much about the residents. So it's more pressure on permanent staff,*

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*because we need to explain what they need to do. Also they come from other houses, other homes, so the virus spreads more”.*

46. Victoria recalls that she was often asked by nurses to deliver medication to patients when this was not her role, and when she was not trained to do this. She explained that this was a result of understaffing. Prior to Covid, four members of staff had worked on each floor of the care home Victoria worked in, plus an individual working a half-day. During Covid, this was reduced to two members of staff per floor, covering 20 residents with complex needs between them. She was often not permitted to take her 15-minute breaks due to the need for numbers. She explained that there were often heavy residents who she had to move around with a hoist. She added:

*“Most of the kit was not working properly: most of the hoists were broken, they were old. Sometimes it was very difficult. Sometimes they got stuck, and can’t go down or up. If you had more staff, you could make it work in 5 minutes. But in Covid it would take 20 minutes. You couldn’t have as many staff because some were ill, some left the country. One man refused the vaccine so had to leave.”*

47. The lack of staff inevitably had safety implications. She asked: *“How can we manage to do everything safely when before we did 10 rooms with another person, now you had to do 20 rooms?”*

### Structural racism and the Hostile Environment

48. The Government’s post-pandemic response to the shortage of workers in the care sector was to issue employment linked visas to 70,000 overseas workers in 2023, in effect outsourcing the problem internationally and subsidising the cost of care in the UK through low wages. This does not address the root cause of the problem. In the context of the Government’s Hostile Environment policies, it creates precisely the further sub-class of worker that the Group’s members have reported. Reliance on foreign workers who hold insecure immigration status builds in instability and undermines the capacity of the adult care sector to respond to a pandemic (and public health emergencies more generally). This is illustrated by the following:

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- a) Migrant workers being disproportionately allocated to higher risk working environments and unable to object because their immigration status is dependent on them maintaining their contracts of employment:
- b) Workers with NRPF conditions applied to their visas finding themselves suddenly destitute in the event of sickness. This applied with additional force in relation to domestic carers. Two problems regularly arose for such workers: (i) in the event of their service user(s) catching Covid-19, they would be forced to remain in the home providing care, because they had nowhere else to go and/or were forced to remain by the families, thereby risking their own safety; or (ii) in the event of contracting Covid-19, they would be summarily required to leave their workplaces, effectively making them simultaneously unemployed and homeless. The Government's eviction ban was thereby circumvented in cases where domestic carers lived in the home of their employer, as they rarely had leases or similar contracts outlining their living arrangements. There are other reports of domestic care workers being summarily dismissed as soon as they informed their employer that they contracted Covid-19. Due to the informality of their employment, they were often unable to seek any redress;
- c) Workers with NRPF being fearful of seeking medical treatment due to concerns that health care professionals would contact the Home Office and they would also be faced with NHS charges which, if unpaid, could result in removal from the UK. The public interest in ensuring that care workers have prompt access to medical treatment is obvious. By contrast during the pandemic, the systemic exploitation of migrant care workers relied upon by the Care Sector to provide essential care services militated squarely against those care workers both seeking and receiving medical treatment; and
- d) Sick workers, with work dependent immigration statuses, being pressured to return to work before they were well enough, in order to cover the staff shortages. This was compounded by the various overlapping precarities faced by migrant workers who often felt that they were unable to say no to their employers for fear that they would lose their jobs, and that they would have no redress or be required to leave the country as a result.

49. As stated above, domestic carers are typically poorly paid. Their financial vulnerability is worsened by the financial outlay caused by the Hostile Environment. The fees associated

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with remaining in the UK are often extortionate: involving visa fees, instructing a solicitor for assistance, the Immigration Health Surcharge and charges for secondary healthcare. On top of this, most workers with NRPF – which include most domestic carers who are often undocumented and without immigration status, as well as most migrant care workers generally who have NRPF conditions to their visas – cannot rely on the state for free school meals for their children, for childcare and for other benefits. During the pandemic, because of the informal nature of their contracts, they were ineligible for sick pay, the furlough scheme and often found the Self-Employment Income Support Scheme (SEISS) inaccessible due to having started trading after 6 April 2019. Accordingly, many could not afford to miss work if they contracted Covid-19. Alternatively, if they were incapacitated by Covid-19 and could not work, many found themselves effectively destitute because they could not rely on state support for housing, benefits or healthcare.

50. Two live-in domestic carers reported no longer being allowed to go outside for their days off during the pandemic and therefore having to work seven days a week. Another was about to start a live-in job when her employer terminated the job due to Covid-19. She was forced to seek temporary accommodation at short notice with friends, whereupon she was forced to share a bedroom with three other people.
51. Hostile Environment policies discourage precariously employed migrant workers from seeking healthcare from the NHS for fear of immigration enforcement consequences or healthcare charges, even once the Covid-19 exemption came into effect. As many of the Group's interviewees recounted, there is an endemic lack of trust in healthcare institutions as a result of years of Hostile Environment policies, where undocumented migrants were terrified of being reported to the Home Office by their GPs. Given the high concentration of migrant workers in the care sector, this led to many care workers avoiding healthcare provision and instead attending work while sick. This contributed to a vicious cycle whereby sick workers would avoid seeking treatment and instead attend work, causing other migrant workers to become ill and to in turn avoid accessing healthcare in the same way.
52. The Government's failure to heed the warnings of frontline migrant health workers put patients, the public and those same workers at greater risk. For example, such workers warned their employers about the need for social distancing and PPE long before this became standard practice, yet employers were unwilling to listen to them and instead were

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prepared to put them in harm's way. For example, at one Kent-based care home (discussed in more detail below), interviewees from Kanlungan reported that staff repeatedly asked their employers to implement an infectious disease protocol early in the pandemic. Management resisted this until an asthmatic nurse caught Covid-19 and died. Healthcare systems would not have been so overwhelmed had the concerns of frontline migrant health workers been taken seriously.

53. The visa regime itself forces many workers into severe precarity. For example, a married couple called David and Sara had a 17 year-old child, Filip, and were sponsored to come to the UK on a Health and Care Worker visa by family friends who ran an agency in the UK. David and Sara were told that Filip would be able to go to school and complete his formal education whilst the family worked. They arrived and were accommodated with the couple that owned the agency, who then themselves had a small child. Filip was forced to care for the baby and was not allowed to(?)attend education. David and Sara were qualified osteopaths in their country of origin, and whilst they had been told that they would be able to practice their profession upon arrival in the UK, they were instead forced to do care work. David would do one week on and two weeks off, sent to care homes around the country. He was made to doing everything from administering medication, to cleaning and cooking. Sara was also made to do care work, with very long hours, few breaks and with similarly diverse range of work unrelated to her qualifications. Both of their salaries were paid to the agency. The threats were explicit: if they did not do the work, they would be evicted, made homeless and placed in significant debt to the sponsor.
54. The pre-pandemic position of care workers meant that they were overworked, underpaid and vulnerable to exploitation. For domestic and undocumented workers in the pandemic, these issues were significantly compounded because the isolation required during the Covid-19 pandemic meant that they were rendered even more invisible and thus subject to greater abuse. Such workers made heroic contributions during the pandemic, yet they were rendered vulnerable, exploited and exposed to significant and negative health and financial risks and impacts. In order to understand the connection between the absence of employment protections and compromised care provision, it is necessary to review the regulatory environment.

### Regulatory failure

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55. The CQC is the main source of oversight of the formal care sector. Outside of the private, informal and unregulated settings described above, there are currently around 40,000 care locations regulated by the CQC, the majority of which (just under 30,000), are part of the Adult Social Care sector [see exhibit MHW/29 INQ000551239 , an analysis of CQC data published in tandem with the Dash review into the CQC, 17 October 2024; page 16 on the number of regulated “locations”]. With the outbreak of Covid-19 and the suspension of routine inspections in 2020, the number of inspections in 2020 (?) fell by 59.5%. According to the Dash review data analysis, the “volume of inspections and assessments conducted in more recent years has not yet returned to pre-COVID-19 levels”, with only 6,734 happening in 2023 compared to 20,888 in 2017 [see MHW/29 INQ000551239 page 17]. Unsurprisingly, “the average age of [CQC] ratings [of service providers] has almost doubled” [MHW/29 INQ000551239 page 20]. Due to the manner in which the CQC calculate ratings, the average age may in fact be older due to historic ratings being used to calculate current ones; and the time between ratings has also grown, from 114 days for providers rated inadequate and 243 days for those rated “requires improvement” in 2016, to 136 and 360 days respectively in 2024 [ibid]. The CQC itself estimated that 1 in 5 locations “have never been rated” [MHW/30 INQ000551240 , interim findings of the Dash review, page 6]. Ultimately, this estimation has been vindicated and the Dash review has arguably found the CQC to be unfit for purpose [see generally, MHW/31 INQ000551241 , the full review].

56. It is the Group’s position that care standards cannot be treated in isolation of care workers’ rights. Exploited workers will need to do more when they shouldn’t – for instance go to work when they are unwell – and they will do so at the expense of their own and clients’ health. Ultimately, poor employment practice can be taken into account for CQC registration and rating, but the ultimate power to deregister has nothing to do with working conditions. Whilst CQC regulatory action has dwindled, the Gangmasters and Labour Abuse Authority (GLAA) has reported a marked increase of severe exploitation within the care sector [see the GLAA’s recent press release, MHW/32 INQ000551242 , noting that “quarter 1 of 2024 (April to June) 61% of all reports made to the GLAA were concerning labour abuse within the UK care sector”]. As recent research into migrant care workers’ rights concluded, “the existing regulations simply do not adequately protect workers” [MHW/06 INQ000551236 ]; as a result, we can add, service users will suffer.

**Impact of the pandemic on recipients of care**

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57. Both UVW and Kanlungan interviewees reported that underfunding and the consequent understaffing meant that residents of care homes were frequently left alone for lengthy periods of time without any care or support. This was incredibly difficult for both the residents and the carers who wanted what was best for them.

58. As a result of most care homes being privately run, some interviewees reported that management would be very keen not to upset the families who paid for their relative's care home fees. Accordingly, when visiting these care homes, compliance with basic Covid-19 standards, principally the wearing of masks and practising social distancing, by such family members was often not enforced, but when care workers reported concerns, management ignored them and told them to drop it. As UVW member Victoria reported, in her care home there was:

*"No social distancing, no nothing. They were supposed to see the family through a screen, but families would just go around the screen. There was only supposed to be one person visiting at a time, but often the whole family would go there. One family had 6-7 children who used to bring them all. Most families would come without masks... I went to the manager, saying we have a problem. The manager said we can't do anything, we've done as much as we can. He wouldn't listen to us. I said: where are the rules for these people? There were no rules. The rules were only for us".*

59. This lack of compliance inevitably resulted in reduced Covid-19 safety protections for both residents and staff. Further, the lack of Covid-19 safety compliance that was exhibited by residents' families meant that care workers would often have to supervise them, which exacerbated understaffing problems and, in turn, reduced the level of care provided to residents. One interviewee reported that one care worker at a North London care home, who was diabetic, was knowingly sent into bedrooms by management to provide care before PPE became available, despite this not being permitted under the home's protocols. Inevitably, poor safety standards being adopted in relation to staff meant that recipients of care were also put at risk through the spread of the virus.

60. Another recurring theme in the interviews was that nurses frequently did not want to give medication directly to residents, fearing that they would contract Covid-19 in doing so. They often therefore pressurised medically untrained care workers to administer medication, in breach of protocols governing the administration of medication. This put the safety of residents at risk. The administration of medication in care homes is supposed to

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be recorded. These records (or at least a sample of them) are inspected by the CQC during an inspection. If medication was being given by staff who were not medically trained, it would appear likely therefore that the medication records were then falsified to show that they had been administered by a medically qualified staff member. There is likely to have been a breach of reg.12 (which is the fundamental standard of safe care and treatment) and of reg.17 (the fundamental standard of good governance).

Deaths

61. On 11 May 2020 the Office of National Statistics reported that care workers were among the occupations at the highest risk of death [exhibit MHW/33 INQ000503378 ]. Crucially, this ONS data only included the deaths of people who had been registered on the 2011 Census. Therefore no migrant who arrived after that Census was counted in the ONS data. Equally, any migrant who did not participate in the Census would not have been counted. Given the preponderance of migrant workers in the sector, the true mortality rate of care and home care workers must have been significantly higher than what was recorded.
62. Further, one of the main social determinants of health inequality is income. The poorer you are and the more precarious your employment, the more likely you are to suffer from poor health and the more likely you are to die [see generally exhibit MHW/34 INQ000506982, explainer from the King's Fund on health inequalities]. Care sector workers are some of the lowest paid workers in the country even when they have the benefit of a permanent employment contract. Within this group, migrant care workers are paid less than non-migrant care workers and non-documented care workers are paid the least. All non-domestic workers who were interviewed reported that they earned a figure at or around the NMW; all of the domestic workers interviewed reported that they were paid significantly below NMW. Outsourced and agency workers, who lack the contractual protection and bargaining power to demand safer conditions from their employers, were at particular risk to their health. Migrant care workers were all the more vulnerable; when immigration status is tied to employment, such individuals cannot refuse unreasonable demands from employers without losing both their jobs and their home. Migrant workers who were undocumented or had overstayed had no protections at all. As care work cannot be performed from home, this inevitably meant that, where conditions were unsafe they had little choice but to carry on, resulting in avoidable deaths.

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63. One interviewee, Elena, recalled that through her work with the Filipino Domestic Workers Association (“**FDWA**”) she became aware of numerous undocumented individuals who died of Covid-19 whose deaths were not reported. Other individuals who knew them decided against reporting those deaths for fear of being discovered by the Home Office. She described how such people were often buried without a name.
64. UVW, IWGB and Kanlungan do not have specific data relating to the number of deaths experienced by the communities they represent. Kanlungan notes that the widely-publicised overrepresentation of Filipinos in healthcare deaths during the early stages of the pandemic [see exhibit MHW/35 INQ000509521 for general reporting; and also exhibit MHW/36 INQ000506983] was also likely to be reflected in the care sector, though a lack of visibility and the private nature of many of these workplaces mean that less data is available on this. This is also borne out by in research for the Health Service Journal, which found that 83% of ethnic minority Health and Care Worker deaths were migrants and 36% of those were from the Philippines [Exhibit MHW/37 INQ000352887]. IWGB and UVW note the widely-publicised national illness and mortality statistics that demonstrate the disproportionate impact of Covid-19 on ethnic minorities [Exhibit MHW/38 INQ000506984]. Their members are migrants and from ethnic minority communities and are also disproportionately exposed to aggravating risk factors such as living in overcrowded and/or insecure housing, low wages and lack of access to free healthcare and public funds as precarious frontline workers.
65. Consequently, we note that our membership was among those exposed to the greatest risk of illness and death throughout the relevant period. We submit that mortality and illness data in respect of migrant care workers would have been crucial to understand the impact on this group. Insofar as such data is not available to the Inquiry, it is crucial that recommendations are made requiring the retention of such data.

Physical health

66. As a result of the systemic issues in place before and during the pandemic, migrant care workers were especially likely to contract Covid-19, and then to suffer profound physical effects as a result.

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67. Lorena, one of the interviewed undocumented care workers, experienced a particularly harrowing episode at the outset of the pandemic that demonstrates the overlapping vulnerabilities of undocumented care workers:

- a) Lorena was taken to an unregulated care home by a colleague/friend at the start of the pandemic. As far as she was aware, that care home was “*completely off the books; they weren't paying tax*”, nor were they CQC regulated. The employer knew she was undocumented and hired her for this reason. Other colleagues were also undocumented.
- b) Around 5 or 6 residents fell ill with suspected Covid-19. Lorena developed a fever, and her colleague also fell ill. The employer told them that they all had to stay and continue working. They were told that “*nobody would accept*” them if they left, and that the police would find them if they went outside.
- c) As a result, she made her own makeshift PPE and continued working while very unwell, unable to leave the care home. Food was very scarce: she recalls using the same teabag 10 times. She lived in a small shared space, and ate once a day. She did not have access to showers or toilet paper. It was only with the help of care packages delivered by Kanlungan that they were able to survive, as nobody came in or out.
- d) She was terrified that, if one of the residents passed away, there would be “*enquiries*”, and she said “*I would rather jump in the ocean than answer these enquiries*”. She said that most undocumented people are “*more scared of being discovered than dying of Covid*”.
- e) The residents and carers were stuck in the home for 6 days. When the police came by, staff were instructed to hide. As Lorena explained, the owners knew that they would be fined for hiring people like her.
- f) Eventually, three of the residents died. The family members of the other residents came to collect them and removed them from the care home. Once it was empty, the owner of the care home instructed all staff to leave. They said “*I don't care if you sleep on the street, though I'm sure you can stay with friends*”. Lorena asked them if she could stay for one more night: it was 6pm and very cold. The owner replied that “*I will call the police and they will deport you*”.
- g) As a result, Lorena slept on the street with nowhere to go, and no ability to contact services or seek healthcare. She thought she was going to die. The following day, she begged passers-by for money, and raised £10 to use for phone credit to call a

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friend, who permitted her to stay with them. At a time when she was struggling to breathe and in desperate need of healthcare, she said this took her “*pride*” from her. She was unable to access these basic services despite having worked in the UK for almost 20 years.

h) She was never paid for the work she did in that care home.

68. Poor standards resulting in deaths of those being cared for often then had knock-on effects for workers who looked after them. This was especially the case for undocumented domestic workers, who only had on one or two individuals to look after: when they died, they became unemployed. In “*A chance to feel safe*”, Kanlungan reports John’s experience of his primary client passing away just before the outbreak of Covid-19 in the UK and him not being able to find full time work for two months. This left him even more precarious for the rest of the pandemic, vulnerable to unscrupulous employers with consequent effects for his other, vulnerable clients. By excluding care workers from the social safety net and employment rights, the Hostile Environment policies that pushed John into precarious work directly created public health risks [MHW/23 INQ000235265, page 19, for the a full account]. Whilst in this case, John’s client died before the pandemic, it is indicative of the situation that persisted throughout the relevant period: “[s]ometimes you’re doing your best and you feel like you’re drowning.” [Ibid.] Inevitably, because of the gendered and racialised nature of care sector work in the UK, the burdens of this fell disproportionately on female and ethnic minority and migrant workers.

69. Further, once they contracted the virus, migrant care workers reported high levels of Long Covid within their communities. This is likely to be because of the high levels of exposure such individuals had to the “*viral load*” of Covid-19 [see academic paper exhibited at MHW/39 INQ000506985, page 8, line 214]. One interviewee suffered from profound memory loss, and at one stage had to be taken to hospital by her Kanlungan supporters due to being entirely unaware of where she was.

### Mental health

70. Before the pandemic, the Group’s membership had already experienced significant stress and pressure on their mental health caused by the conditions of their employment discussed above. It is well known that care workers suffered significant ill-health as a result of the pandemic and this was noted in the CQC’s State of Care 2020/21 published on 22<sup>nd</sup> October 2021 [MHW/40 INQ000551243 ; see also MHW/22 INQ000509517, Skills for

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Care's report into the adult social care workforce, noting the same, e.g. at pages 9, 57, 59 and 67]. Migrant care workers suffered the grief, fear and strain of their colleagues and patients. They cared for residents who should have been in hospitals, and they were with them when they died. They did so whilst exposed and unprotected themselves, taking the virus back home to their own families when they finished work. They did all of that on a wage that cannot be lived on.

*Kanlungan*

71. Kanlungan notes that its members were forced to work through constant anxiety and fear for their own safety, aggravated by the lack of PPE and the disproportionate allocation of migrant workers to high-risk areas within workplaces. For example, one interviewee reported that British-born staff in a Kent-based care home refused to work with residents who had been discharged from hospitals for fear of catching Covid-19. Filipina carers, including those with high-risk conditions like asthma, were then expected to carry out this work without adequate PPE (*"we were given surgical masks but that's it"*). When one asthmatic carer did not report for work one day, nurses requested that management send someone to check on her, but management refused, saying *"oh she'll be fine"*, and saying that they would call her shortly. That carer had been unable to call 999 due to her inability to breathe, and struggled to get her son, who had Special Educational Needs, to call an ambulance. She died in hospital. Her friend and colleague then also fell sick with Covid-19 at this time and developed Long Covid. She had a mental breakdown due to no longer being able to cope with being a single mother and had to be taken to a mental health institution. She has never recovered and has been unable to return to work since.

72. Kanlungan members reported isolation, stress and trauma due to dealing so frequently and intensively with death. One interviewee, Angela stated that she suffered from depression as a result of having to work all the time. She was an agency worker who was not guaranteed any shifts, and her lack of financial security meant that she constantly accepted whatever work was offered, as a result of being worried about the financial consequences should work fall away. This resulted in a constantly irregular pattern of work that caused mental ill-health and led to her taking a long time to recover from Long Covid after she contracted the virus. She said:

*"You have to fight for your survival - I felt if I stop fighting then I will not be here any longer. You have to fight to stay alive, and have to keep your mind alert all the time"*.

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73. Domestic carers in particular reported feeling isolation due to often working alone. We are aware of cases where workers have been diagnosed with Post Traumatic Stress Disorder as a result of their proximity to death and suffering. Elena said that though they “*had to be strong because they had to support others*”, they “*came to the stage of feeling like it’s better to die*”.
74. In addition to their own safety, Kanlungan’s members feared for the safety of their families and households who were at risk of exposure to Covid-19 via the members and also at risk of severe financial hardship if the member was unable to continue working. Consequently, many of Kanlungan’s members reported a severe decline in their mental health.
75. Whilst conditions would have been challenging in any case, the lack of support, precarity of employment, staffing shortages, lack of PPE and repeated surges of the virus aggravated the lasting impact on Kanlungan’s members. Many felt their complaints and concerns were not listened to which contributed to a feeling of powerlessness.
76. Further, many Kanlungan members had left family behind in the Philippines. Several interviewees stated that if they attained regular immigration status in the UK they would go home to visit family in the Philippines, but were prevented from doing so due to having irregular migration status. Those workers regularly sent money back home. This led to them feeling trapped. As one interviewee said “*lots of people said I don’t feel well, but if I don’t get paid I can’t send remittances*”, thus making them feel trapped and forcing them to remain in work while sick.
77. In addition to remitting money, many Filipino migrants in the UK retain strong ties with parents, siblings, children and extended family in the Philippines. Undocumented migrants must earn money to support their families’ education and healthcare, but when loved ones passed away or became sick during the pandemic, they could not return to the Philippines to join them. This inevitably affected their mental health. The pandemic compounded the anxieties and stress of living without legal status. Elena reported a friend being traumatised because of being unable to send money home: the poverty that ensued within the family meant that “*misery passes over the whole family*”.

UVW

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78. One UVW member, Camila, recalled feeling hugely undervalued during the pandemic. Prior to the pandemic she typically worked a 3-day week, but because of understaffing issues in the care home where she worked, she usually worked “every day” on a 12-hour shift. She said “*my mental health was not alright, I wanted to have a break from the care sector*” and that “*I [didn’t] feel safe*”. Every day, she got home from work exhausted, but had to immediately wash her uniform and get in the shower each day to protect her family. She recalled that people used to come to the care home to clap for the carers. On one occasion, her manager instructed that she to go to the window and wave at them. She refused, and said “*why? What I need is a pay rise. I need an increase in salary. I don’t need claps*”.

79. She lived in constant fear of falling sick with Covid-19, as staff at that care home were not paid contractual sick pay. When asked whether she ever got any thanks for her hard work, she said:

*“The only thing they gave to us to say thank you for the hard work was when one day they said come downstairs, come and see the trustees. There was a screen downstairs, they thanked us. Then they said we’ll offer you a pizza. I said why not give us more pay? Everyone went mad. So I ate my pizza. I couldn’t even eat my pizza because they came to shout at me to get back to work!”*

80. She said the period was “*very, very stressful. I feel very depressed, anxious, undervalued. I don’t feel consideration from [my employer, a North London Care Home] to me.*” She said it became too much and she ultimately left the care sector at the end of 2020, returning only once the pandemic had subsided.

81. Another interviewee, Victoria, recalled waking up at 6am each morning, leaving home before 7am, finishing work at 8.30pm and getting home at 9.30pm each day. She recalled arriving home “*completely exhausted*”. This inevitably had consequences for her mental health. She said that a normal day before Covid was hard, but during Covid it was much worse, adding:

*“You come from a place where you faced the risk of Covid. You go onto the bus. You arrive home, and you have to wash your hands, have a shower. Then you feel stupid because if you’ve got it, you’ve got it: washing your hands won’t make a difference. Sometimes you feel like, what a miserable life. I can nearly die for £9.10 an hour. Is it*

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worth it? My daughter said I should go back to PD It was pressure, your head went through so many things. Honestly I don't know - it was just that pressure.

82. UVW noted a marked difference in mental health deterioration between outsourced/agency and “in-house” workers. All members were exposed to increased risk, but outsourced workers bore an additional burden.

Financial issues: the consequences of low pay

*Sick pay*

83. It is the view of the Group that the statutory sick pay scheme (SSP) is not fit for purpose. Indeed, in the view of Kanlungan that SSP aggravated the disproportionate impact of the pandemic on precariously employed, migrant healthcare workers. During the relevant period, the majority of *eligible* workers didn't have access to contractual sick pay and relied solely on SSP which in 2020 was set at a rate of £94.25 per week. That was well below the cost of living. Even with the temporary amendment to SSP rules in March 2020 to allow SSP to be paid from the first day of illness, the rate of pay was insufficient to avoid the risk of destitution. [See MHW/06 INQ000551236 for recent research into the rights of migrant care workers and a detailed analysis of the failings of the SSP regime, noting that for research participants, “being sick for too long was simply not an option”, page 29.]

84. In any event, many domestic workers were unable to access SSP at all due to working pursuant to informal cash-in-hand or zero-hour arrangements. Furthermore, SSP was not available to those workers without employee status. The Group found that the Self Employment Income Support Scheme (“**SEISS**”) was inaccessible to many of its members due to language barriers and administrative burden. Many had started trading too recently to be eligible in any event. For undocumented care workers, there was no access to sick pay or financial support in the likely event of illness and they were entirely at the whim of their employers in this regard. This meant that people were caught between the dangers of contracting or spreading the virus at work, or falling into destitution. Where workers did take time off, they found that they were placed under pressure to return to work whilst still feeling ill, both from their financial pressures and from their managers.

85. When the SSP rules were extended in March 2020, they did not include “*limb b*” workers. 'Limb b' workers are those who fall under s230(3)(b) Employment Rights Act 1996 which describes those who are not employees but work under 'any other contract, whether

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express or implied and (if it is express) whether oral or in writing, whereby the individual undertakes to do or perform personally any work or services for another party to the contract'. They are typically more casual working contracts and often include cleaners and other outsourced roles.

86. IWGB actively took up the campaign, writing to then Prime Minister Boris Johnson on 19 March 2020 to request that SSP be extended to include “*limb b* workers and that the lower earnings limit be removed, but we received no response” [MHW/41 INQ000203413]. The IWGB initiated the judicial review pre-action protocol against this decision on 23 March 2020 [MHW/42 INQ000203418] and received a response from the Government Legal Department on 27 March 2020 [MHW/43 INQ000203419].
87. The Government’s response cited Employment and Support Allowance (“**ESA**”) and Universal Credit (“**UC**”) as alternatives to SSP during the relevant period on the basis that the seven-day waiting period and work capability assessment had been temporarily waived from ESA and that UC applicants could request up to one month’s advance. However, these schemes were exclusionary and/or inaccessible for many IWGB members for the following reasons.
88. First, ESA requires sufficient national insurance contributions in the previous two to three years which would exclude many of IWGB’s members who had started working within that time and therefore fell outside of these parameters. Second, both of these benefits are also exclusionary to those with no recourse to public funds – an already seriously at-risk group - which also applies to much of IWGB’s membership. Third, unlike SSP which is administered by the employer, both ESA and UC are administratively intensive for the applicant, making them inaccessible to many IWGB members because of language barriers and/or lack of available time. For this reason, some members would be deterred from applying for these benefits even if they were eligible.
89. For these same reasons regarding national insurance contributions, recourse to public funds and administrative intensity, ESA and UC are also inaccessible for self-employed independent contractors. It was essential that the government establish a scheme that would also facilitate sick pay for these low-paid self-employed independent contractors that would create a viable route to taking time off.

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90. In short, the government failed to realise that these benefits were simply not fit for purpose when it came to facilitating the safety of our members and managing the wider public health risk by ensuring frontline care workers could afford to take time off and/or isolate when they fell ill. They could not afford to rest or to self-isolate because the risk of destitution was simply too great. This devalued the lives of outsourced migrant workers and increased the public health risk given the increased exposure and broad range of contact these workers have.
91. “*Limb b*” workers were also excluded from the Coronavirus Job Retention Scheme (“**CJRS**”) which provided public funding to cover 80% of the wages of furloughed employees. This created a further barrier to financial stability for our members who were facing significant loss of income as a result of the pandemic.
92. The **SEISS** was introduced on 26 March 2020 and began accepting applications in May 2020 for a grant of 80% of three months’ average trading profits. The scheme was open to both self-employed independent contractors and “*limb b*” workers. The introduction of the scheme was welcome, but its limitations made it inaccessible to many of the Group’s members and its provisions were not equal to that of the CJRS. It covered fewer months than the CJRS and excluded those who began trading after 6 April 2019 or who derived less than half of their income from self-employment.
93. The government’s decision to exclude these workers from the SEISS left them with little to no safety net from severe financial hardship. In doing so, the government also failed to consider the disproportionate impact of this exclusion on people with no recourse to public funds who would be unable to fall back on benefits such as UC, further entrenching the existing inequalities for migrant workers. The scheme was also administratively intensive and inaccessible to many precarious workers facing language, technical and/or time barriers. Even those who were eligible often found that their financial hardship continued as a result of the costs and arrears they had already accrued by this date, and found that 80% of their already modest income was simply insufficient to cover their living costs.
94. The majority of UVW members could not afford to stay at home and/or self-isolate with only SSP to cover their living costs. Consequently, as frontline workers in care services

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they continued to work in conditions which had the potential to compromise their health. In March 2020, after consultation with their members, UVW launched a public campaign for an increase in SSP. The campaign was directed primarily at government but also at employers at a local level.

*Financial issues faced by care workers*

95. Elena explained that she worked as a live-in carer in a private household for £12 an hour with no pay for holidays or sick leave. She has asthma and a heart condition. When she was hospitalised with Covid-19, she was not paid anything. Because of her need to send money back home to the PD and having no money beyond that owed for rent, she wanted to come back to work early. The family did not let her because of worries about Covid-19. She said:

*“I felt such anxiety. You don’t know when it’s going to end. My family back home needs support - I have kids back home. So I was forced to borrow money with 20% interest just to have something to send home. I took that money with repayments not knowing when I’m going to get paid by that employer”.*

96. Despite having UK residency herself, she lived in an overcrowded house with undocumented domestic workers. She explained that it was a shared 3-bedroom house, with two workers sharing each room. During the Pandemic, when no one could go out, it became very crowded. They then accommodated two other migrants who were kicked out of their rented homes.

97. Undocumented workers were paid especially poorly, due to their lack of negotiating power and inability to unionise or seek redress. Gabriela, who has been undocumented previously, stated that:

*“If an employer sees you don’t have a visa, then they don’t pay you the minimum wage. They will often say: ‘you work for me this week, I’ll pay you £600’, not saying how many hours they will work. They work 100 hours. Compared to their previous work, that’s a lot of money, but it’s £6 an hour. They know they don’t have documents, so they effectively threaten them if they don’t want to take the money. They know they need to be paid that money”.*

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98. Kanlungan also notes other examples of live-in carers working a 60-hour week for £2 an hour. As one member put it “*When you have nothing, you cannot say ‘no’*”.

99. Pursuant to the “*no work, no pay*” arrangements detailed by many of the interviewees, such workers could also be dismissed without notice. This put domestic workers at great risk if they contracted Covid-19, as they would often be summarily dismissed by fearful employers. Camila, a domestic worker, lost her job when she contracted Covid-19 for the second time in January 2021. Although she had worked for her elderly employer for five years and they had a close relationship, she was dismissed without notice or care for her health and wellbeing. Afterwards, Camila had to survive on only 4-6 hours of part-time work per week and had to cut down to eating just one proper meal per day to save money. She was very distressed by her employer’s treatment and its impacts, and experienced depression as a result.

100. Many workers fell into debt. John, who supported his partner and their child (who is autistic and needs full time care), was unemployed for four months following the UK Covid-19 outbreak, with no income. He was a qualified nurse and later found part-time work as a carer for between two and four night-shifts per week. He recorded a register of his debt on his phone, which reached almost £2,500, owed to at least three different friends. The family share a bed in the living room of a shared flat, and use the borrowed money to pay for rent, food, and nappies. [See exhibit MHW/44 INQ000327678, Kanlungan’s report, “A chance to feel safe”, which provides this and other examples of the problems faced by migrant care workers during the pandemic.]

101. Other UVW interviewees recalled how low pay meant that their quality of life during the pandemic was poor, with restricted access to nutritious food, in particular during the winter when fuel bills were high and Covid-19 at its height.

### **Actions taken by government and management of the pandemic**

#### **The decision to discharge untested patients from hospital to care homes**

102. The important context to this decision is austerity in the public health sector. As explained in a blog post, the Nuffield Trust’s Leonora Merry and Sally Gainsbury wrote that “*austerity was a contributing factor to declining resilience in the NHS in the years leading up to the pandemic, hampering its ability to manage the shock of Covid*” (Exhibit MHW/46 INQ000506989 page 2). As explained by Diane Coyle, Kaya Dreesbeimdieck

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and Annabel Manley at the University of Cambridge, the NHS was underprepared due to severe capacity constraints, and the government's "*emphasis on short-term cost efficiency [in the NHS] has militated against having a capacity margin that would have limited the output fall during the pandemic, but more importantly would also have led to improved health outcomes compared to those the UK [has] experience[d], and thus improved productivity potential over the longer term*" [Exhibit MHW/45 INQ000506988, a report funding by the Economic and Social Research Council into "Productivity in UK healthcare during and after the Covid 19 pandemic", page 4].

103. The care sector was also in a "*fragile state*" as a result of a decade of austerity that squeezed council budgets and shrunk spending on care [exhibit MHW/12 INQ000506975, Nuffield trust research into resilience in the social care system, page 3]. This resulted from a "*sneaky accountancy trick that redefined "health" spending as "NHS" spending from 2015*", meaning that while NHS spending was "*ringfenced*" (i.e. flatlining) during austerity, health and social care budgets were cut [exhibit MHW/46 INQ000506989, reporting from the Nuffield Trust, pages 2 and 3]. The care sector was even more concerned with achieving short-term "efficiencies" (i.e. lower costs) than the health sector simply because of the fact that it is predominately market-led [see exhibit MHW/47 INQ000551244 , research from the IPPR, for a discussion of the result of efficiency seeking market behaviour in the context of wider financialisation in the care system, page 9]. Hence, the struggle for "efficiencies" meant the sector faced a "*range of deeply rooted systemic issues*", with many providers struggling financially [Exhibit MHW/12 INQ000506975, page 3; see also MHW/48 INQ000561031 generally for an influential academic paper discussing the impact of so-called "neoliberal", i.e. market-based, reforms of the care sector and, from page 18, its "Implications for care" on aspects of the care sector such as its "relatively high rates of [care] home closures"]. Workplace shortages were widespread [Exhibit MHW/49 INQ000090541 , paragraph 269 and 280 onward, noting a range of issues; echoed also in MHW/06 INQ000551236 , research focused on the issues facing the migrant care workforce specifically and linking these issues to the market-dominated nature of social care and the demand for precarious migrant labour].

104. The Government's decision of on XXXX DATE to discharge patients from hospitals to care homes without testing them, was made in the context of an under-funded and under-staffed NHS under pressure to free beds quickly. As a result care workers were placed under immense pressure to meet the needs that the healthcare system could not.

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Kanlungan reported that care workers regularly told them that they felt like the “*dumping ground*”.

105. As reported by the House of Commons Public Accounts Committee, before the policy of testing everyone before their admission to care homes was rolled out, around 25,000 people were discharged from NHS hospitals in England to care between 17 March and 15 April 2020. Around 5,900 care homes in England (38% of the total) reported an outbreak of Covid-19 between 9 March and 17 May [Exhibit MHW/50 INQ000087234 , House of Commons report into “*Readying the NHS and social care for the COVID-19 peak*”, page 6]. This peaked at just over 1000 care homes in the first week of April, with some regions such as the North East more affected than others. As explained in a study written in 2023, in England, there are approximately 320,000 care home residents, the majority of whom are aged over 85 with multiple health conditions and frailties [Exhibit MHW/51 INQ000509523 , academic paper for the Geriatric Society published by Oxford University Press]. In some care homes, 80% of residents have dementia. In the early stages of the pandemic care home deaths increased sharply.

106. This disastrous policy resulted, in part, from a systemic underappreciation of the importance of the care sector vis-à-vis the NHS. As explained by the Nuffield Trust:

*“Adult social care voices were not sufficiently embedded in decision-making structures. This rendered social care largely invisible in the early stages of the response. While all eyes and efforts were focused on the National Health Service (NHS), social care representatives struggled to raise the profile of the sector, despite its vast scale and critical role in the pandemic”* [Exhibit MHW/12 INQ000506975, page 4].

107. Between 2 March and 12 June 2020, there were 66,112 deaths of care home residents in England and Wales, of which 19,394 (or 29%) were officially attributed to Covid-19, though at this time Covid-19-related deaths were being counted for anyone who had previously tested positive and this may have led to the overestimation of other causes or to them being overlooked [exhibit MHW/52 INQ000509524 , Office of National Statistics].

108. The impacts of this policy on the Group were enormous. As set out above, a Kanlungan interviewee described how a Kent-based care home scrambled to cope with the mass influx of hospital patients when they were discharged into their care. That interviewee said that it was clear from the outset that some of the elderly people were presenting with

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symptoms of Covid-19. Yet the care home, due to a lack of preparedness and warnings from the hospital, refused to introduce an infectious disease protocol until after a Filipina carer died. That carer, who suffered with asthma, had not known that she should be concerned about the influx of patients; as detailed above, her colleague who suffered from Long Covid, has never returned to work.

### Visiting restrictions

109. As detailed above, numerous interviewees reported that visiting restrictions imposed on family members were poorly complied with. This was routinely ignored by management who were very concerned not to upset the families whose funding was keeping the care homes open. Others noted that care homes were poorly equipped to assist family members to have virtual meetings with their relative (for example over Zoom), resulting in depression and anxiety among many residents.

110. Moreover, restrictions on families being able to visit their elderly relatives often meant that domestic carers were forced to remain by the side of those relatives, and provide constant emotional support alongside their care roles. In addition, Kanlungan noted numerous examples in which domestic care workers were forced by families to remain by the side of elderly relatives when family members were not permitted to see them due to Covid restrictions. Elena recounted a particularly harrowing example of this:

- a) Her friend provided domestic care to one 90-year-old woman and her 94-year-old husband, who was bedridden. She had provided this for a number of years prior to the pandemic.
- b) At the outset of the pandemic, the family told her that if she left the home, she would not be allowed to come back in, as she might bring the virus in. As she was undocumented and had worked there for a number of years, she had nowhere else to live. She was then only paid half pay, on the basis that food and lodging was being provided to her by the family.
- c) She was forced to live full-time in this home, her workplace, without ever being allowed to leave. During this period the family continued to dock her wages for the accommodation despite forcing her to remain. Elena described this as “*pure exploitation*”.

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- d) The elderly husband then contracted Covid-19. The family forced her to take him to the hospital alone. She was terrified that if something happened to her employers, she would be investigated and reported.
- e) The elderly husband passed away in hospital. The family then forced her to return to the wife, despite the risk of Covid-19.
- f) Throughout this process, her agency employer was aware of her situation, including the fact that she was undocumented, was not allowed to leave, and was only receiving 50% pay because she was being accommodated. They continued to deduct “tax” from her salary at source, even though, Elena reports, they were not paying tax, on the basis that her friend was receiving far lower than the NMW.
- g) After the pandemic, Elena’s friend was traumatised. She had been terrified that if she complained, she might lose her job. As a result, she suffered from sleeplessness and would “cry all the time”.

111. Kanlungan supported one undocumented domestic carer, Jenny, who worked for an elderly person and lived in the employer’s home. When her employer got Covid-19, the family refused to come and see them for fear of contracting the virus, but Jenny was told that she could not leave the home and had to look after the employer/patient. Jenny then caught Covid-19 herself. The family delivered food for the elderly relative, but did not provide anything for Jenny. Kanlungan had to provide Jenny with food to help her survive. She reported feeling very worried because she had lived in this home for years, and if she was kicked out, she would have nowhere to go. It was Kanlungan who provided this person, and many others like her, with PPE by fundraising and using its own financial reserves to do so.

Shielding

112. The reality for many of the Group’s members was that they were never given a meaningful opportunity to shield. Undocumented care workers were never informed by the government that any pre-existing conditions meant that they needed to stay at home. As detailed further below, even those who could be seen by their GPs suffered from a severe lack of trust in health institutions that meant that they would not attend such appointments. Those who had leave to remain in the UK were often unable to stop working, due to the lack of sick pay and access to government support schemes, and so those with underlying health conditions like asthma and heart disease continued to work in any event. Because

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many domiciliary carers had multiple employers, or worked pursuant to casualised contracts, their inevitable decisions to continue working despite the risks were not noted by healthcare leaders and policy makers.

### Vaccination

113. Employed staff had increased access to the vaccination programme, whilst outsourced and agency colleagues, who worked alongside them, did not.

114. Moreover, mandatory vaccination for carers was imposed without considering that some carers were undocumented. Whilst Covid-19 was excluded from NHS Charging Regulations, research has demonstrated that undocumented migrants continued to be deterred from seeking medical care even where conditions were excluded, such as treatment for tuberculosis [see exhibit MHW/53 INQ000509525 , academic research from the University of Oxford; see also generally witness statement to Module 4 of the Covid Inquiry from the Migrant Primary Care Access Group, exhibited here as MHW/54 INQ000474407]. This was a consequence of the Hostile Environment. Despite this existing research/knowledge, there was little guidance or effort on the part of local or national governments to reach this community. Many GP surgeries still refused to register undocumented migrants even when policy changed [Exhibit MHW/55 INQ000551245 , reporting from the Bureau of Investigative Journalism highlighting this specific issue].

115. In response, Kanlungan had to set up vaccination hubs that did not require any registration or documentation to help fill this need. This scheme was later continued in conjunction with Hackney Council and then implemented nationally. In relation to this scheme:

- a) The COVID-19 Vaccination Pop-Up Clinic initiative was implemented in four rounds. The first two rounds were conducted in July and August 2021, with an 8-week interval to accommodate the waiting period between the first and second doses of the vaccine.
- b) During the first round, a pop-up clinic for the first dose was held over two days— July 3rd and 4th, 2021—at Pembury Community Centre, located at 1 Atkins Square, Dalston Lane, Lower Clapton, London E8 1FA. Eight weeks later, for the second dose, clinics were set up on 28 August, 2021 at Pembury Community Centre and on 29 August 2021, at the Round Chapel, 1D Glenarm Road, Lower Clapton, London E5 0LY.

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- c) Following these rounds, Hackney Council transitioned to walk-in pop-up clinics. Previously, Kanlungan had managed the clinic setup, but under the new approach, Kanlungan's community champions took on the responsibility of hosting walk-in clinics organized by Hackney Council. One notable collaboration involved Kanlungan partnering with Halkevi, a Turkish and Kurdish community centre. Together, they hosted a Walk-In Vaccine Clinic for Migrants on 22 February, 2022, at Halkevi Community Café & Centre, 31-33 Dalston Lane, London E8 3DF.
- d) From March 2022 onward, Kanlungan's community champions collaborated with a pharmacy-based walk-in vaccine clinic. This allowed them to refer service users in need of vaccination to a trusted location. Kanlungan actively promoted and supported Murray's Chemist & Travel Clinic at 96-98 Murray Grove, London N1 7QP, until the project concluded.
- e) In terms of the funding for this project, on 20 April 2021, the City and Hackney Public Health Community Champions ("PHCC") Program announced during their monthly forum that applications were open for the "Reducing Vaccine Health Inequalities" grant [Exhibit MHW/56 INQ000506994]. This grant provided £5,000 to individual organisations or up to £10,000 for collaborations between two or more organizations, aimed at vaccinating at least 33 Hackney and City residents. Prior to this, Kanlungan had already been working with the City and Hackney PHCC, receiving Covid-19 Information Grants totalling £19,989.14. These funds supported outreach efforts and the dissemination of Covid-19-related information within the community. Kanlungan applied for and was awarded £4,720.00 from the vaccine grant to organize the first round of pop-up clinics. On 3 September 2021, Hackney Giving launched the 'Coronavirus Response Fund: Equitable Vaccine Uptake - Round 2'. Kanlungan, in partnership with the Southeast and East Asian Centre ("SEAC"), successfully applied for this grant and received £17,000.00 to support outreach activities and clinics organized by Hackney Council.
- f) On 3 July 2021, 68 people were vaccinated in this way; on 4 July 2021, 51 people were; on 28 August 2021, 36 people were; on 29 August 2021, 41 people were. Data for the second Round is not available as this has been tracked by the PHCC.
- g) The take up for the first vaccination round was primarily requested and based on the call of Kanlungan with the existing communities they were working with. The following rounds were primarily led by Hackney Council.

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- h) Kanlungan were required to provide monitoring reports to the City & Hackney PHCC to track work on outreach and engagements, as well as gathering feedback on the program.
- i) The Public Health Community Champions program was implemented nationally UK-wide through its local councils.

116. Nonetheless, a consequence of the Hostile Environment policies, there was a widespread and persistent belief among migrant workers that GP surgeries and hospitals reported such individuals to the Home Office. Hence, even after vaccine access became widespread, many undocumented workers reported being too scared to engage with the NHS at all. The result was that they were unable to get vaccinated.

117. As Lorena explained, it took a long time for the government to work out that they also needed to give the vaccine to undocumented people. This was a huge oversight given the preponderance of undocumented people in the care sector, particularly in domestic care, such that the failure to vaccinate such frontline workers inevitably delayed the control of the virus. Another interviewee, Gabriela, put it this way:

*“Covid doesn’t care if you have documents or not - it can spread around anyone. How can we flatten the curve if you can’t convince them [the undocumented workers] that they need to get a vaccine?”*

118. Elena added that, even when *“there were vaccines, people were scared of getting them - what if I go to the GP and get the vaccine and then suddenly, the immigration police come for me or they report me. I will take the risk - so people decided against going to get the vaccine because of the fear. Took a long time to convince undocumented members to get a vaccine.”*

119. It was also unclear whether individual employers were supposed to be checking the vaccination status of their carers. As one interviewee, Christopher, reported: workers were permitted to carry on working in his private care home even after having refused to get the vaccine.

### **End of life care**

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120. As decisions regarding Do Not Attempt Cardiopulmonary Resuscitation (“DNACPRs”) notices were generally reserved to nurses within care homes, the Group’s members are unable to give specific evidence about how these issues operated in practice.

**The regulatory inspection regime**

121. As a result of the CQC pausing routine inspections at the outset of the pandemic, none of the care worker interviewees could recall their workplaces being inspected [MHW/31 INQ000551241 , Dash review into the CQC, full report, noting a stark drop off in inspection at pages 19 and 20, which we note has corresponded in a drop off in regulatory action: see exhibit MHW/57 INQ000551246 for incomplete picture of CQC violations drawn from Violations Tracker UK, data is obtained from analysis of press releases, not FOIs]. Victoria felt that the sector needed unannounced inspections by the CQC. The result was that carers “*felt like they were on their own*” with no support to promote safe practice for themselves and service users.

122. As identified by undocumented workers like Lorena, it should also be noted that there are unregulated care homes that are not inspected by the CQC at all. As Lorena’s own story makes clear, the absence of any regulatory oversight whatsoever can lead to very poor upkeep of standards for both residents and workers. One unintended consequence of the Hostile Environment is that the undocumented workers that these homes employ will be strongly disincentivised from reporting breaches of regulatory standards for fear of immigration enforcement. As such, as long as(?) workers remain too afraid to bring the existence and practices of these homes to the authorities’ attention, such homes will be able to continue to operate a risky environment with impunity.

123. Our members are not aware of the CQC taking any action to prosecute care home providers who operated without being registered with the CQC (despite this being an offence under s.10 of the Health and Social Care Act 2008). This anecdotal experience dovetails with the recent Dash review’s findings that CQC inspections have fallen starkly [MHW/31 INQ000551241 , page 20.] In the absence of routine inspections, the CQC was unable to prosecute or take enforcement action in respect of the poor practices observed by our members which have been detailed in this statement. These constitute breaches of the fundamental standards set out in Health and Social Care Act 2008 (Regulatory Activities) Regulations 2014, such as safe care and treatment (reg.12) and staffing (reg.18).

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124. The CQC stated that although routine inspections would be suspended, they would continue to carry out inspections where there were allegations of harm, such as abuse (see the CQC's letter to adult social care providers on 16 March 2020 [exhibit MHW/58 INQ000551248]). However, the CQC's focus appears to have been on reports of harm to service users rather than staff and reaffirms the vulnerability of the Group's ability to advocate for and protect the rights of particularly vulnerable workers. Further, the lack of any safeguards to protect migrant workers from Home Office enforcement action as a result of employer closure, let alone reprisals, raises a huge barrier to raising concerns [see exhibit MHW/06 INQ000551236], recent research into the rights and struggles of migrant care workers, noting at page 31, that "a Ghanaian care worker ... lamented how there are no mechanisms for her to securely report rights breaches to government bodies, where an internal grievance is ineffective or simply not an option. Workers must disclose their identity in order to prompt any meaningful action, so many fear that a report could be traced back to them, and they would face retribution from their employer."]

125. As stated above, the CQC assesses if adult social care providers are meeting the fundamental standard in relation to staffing (amongst other things). By reason of reg. 18(1), a part of the standard is that there must be:

*"Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements [set out in the Regulations, including the fundamental standards]"*

126. Despite the clear evidence from the Group's members that there was chronic understaffing during the pandemic (which was driven by a desire by private providers to continue to be profit-making), our members did not observe the CQC taking any action to enforce the staffing standard during the relevant period. This is just one example where the regulatory inspection regime failed to hold providers to account and take adequate steps to identify systemic risks to service users and workers and deficiencies endemic in private care provision. Again, this evidence is empirically bolstered by the recent Dash review [MHW/31 INQ000551241].

127. In addition, due to the fact that the CQC did not (and does not) regulate care provided to private individuals where those private individuals have engaged the carer (as opposed to the carer having been introduced or provided via a care provider), a key area of the adult care sector was wholly unregulated during the pandemic. This was the part of the sector

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in which large numbers of migrant care workers were engaged and experienced exploitation and exposure to unacceptable and unnecessary risk.

128. The experience of our members is that the regulatory inspection regime was inadequate during the pandemic. As discussed above, beyond concerning itself with staffing levels, the CQC (and its equivalent across Scotland, Wales and Northern Ireland) is fundamentally ill-equipped to deal with care worker exploitation. Instead, there is a patchwork regulatory landscape encompassing the Home Office for companies sponsoring visas, the Health and Safety Executive, and the Gangmasters and Labour Abuse Authority.

### **Infection prevention and control**

#### Ventilation

129. One UVW interviewee stated that the reality when caring for elderly residents was that they could not be allowed to remain cold. Windows were therefore frequently shut in the care home during the non-summer months. Her employer, a North London care home, never raised any concerns about this.

130. Sometimes space was such that having open windows made little difference. In the aforementioned North London care home, when workers were permitted to take their breaks at all, they had to take their breaks in a very small room. Although the windows were open, inevitably workers could not socially distance if a colleague was in the room at the same time.

#### Isolation

131. Care homes routinely failed to develop particular protocols for the isolation of patients/residents, and, when they did, these were often not enforced. The above-described issues in a Kent care home resulted from the home initially refusing to segregate symptomatic residents. An interviewee stated that management kept "*saying no, no, no they will be fine*", despite concerns being raised that such individuals were likely to require special attention. This failure to act resulted in the known death of one Filipina care worker and the serious illness of another.

132. Again, it should be reiterated that in unregulated care homes like the ones undocumented workers like Lorena found herself in, there was often no desire or capacity on the part of

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management to isolate residents/staff who had Covid-19. Due to the hugely precarious nature of these roles, staff were expected simply to carry on and put themselves at risk. Providers were thus able to exploit the workers' lack of redress and precarity to establish and prolong unsafe and unsustainable working conditions, putting both care workers and service users at risk.

### Movement within or between care settings

133. Kanlungan noted that during the Pandemic workplace allocation practices revealed significant disparities. Care workers and nurses from Filipino, Black, and other minority ethnic backgrounds were disproportionately assigned to high-risk areas. This placed them at greater risk of exposure to Covid-19. For migrant workers working in social care (like other sectors), the right to withdraw from discriminatory or exploitative situations was severely restricted by the conditions of the Health and Care Worker Visa [see exhibit MHW/06 INQ000551236 , pages 12 – 14 for overview, and section 6.2 from page 42 for specific areas in need of urgent reform; see also our client evidence cited above at paragraph 52]. Their immigration status, which was directly tied to their employment, left them with little choice but to continue working under these conditions. The fear of dismissal and the consequent loss of the right to stay in the UK forced them to accept these circumstances. This had deadly consequences: as described above, the fact that settled/British staff in a Kent-based care home refused to work with residents who had been discharged from hospitals for fear of catching Covid-19 resulted in the death of one asthmatic migrant worker who was required to work with them on fear of destitution and removal from the UK. UVW interviewees made similar points: often those on healthcare visas felt that they had no power to push back against unsafe practices of their employers. Further, because their employers were their sponsors, they often felt a sense of obligation to their employers, which was exploited by the visa (???) providers.

134. It should also be noted that in domestic care roles, many care workers were simply unable to socially distance or isolate away from their employers if either party contracted the virus. The limited space in most private homes frequently did not permit it. It was therefore hugely commonplace for one party to catch the virus from the other.

135. Separately, the control measures put in place in care homes often failed to appreciate how common it was for care workers to have more than one workplace. This meant that care workers frequently travelled between care homes on public transport and were unwittingly

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able to carry the virus from one care home to another. One interviewee noted that the phrase that was used at this time was “*the carers are the carriers*”. Yet little was done to address this because of the sector’s overreliance on casualised contracts and agency workers. As explained by the Nuffield Trust:

*“policies to limit movement of staff introduced in September 2020 did not adequately take account of the nature of domiciliary care, high levels of staff vacancies and the fact that, as a largely low-paid sector, many staff often work more than one job. Although some progress has been made to adapt policies to take account of some of these challenges, underlying issues of low pay and unstable contracts continue to be a problem and need to be addressed to ensure the sector can better withstand future shocks”* [ Exhibit MHW/12 INQ000506975, research into resilience of the social care system, page 6].

Training and guidance on infection prevention and control

136. UVW members reported problems with training and guidance, in respect of PPE and more generally. A significant problem was a lack of communication that was notably more prevalent for workers in care homes, as well as outsourced workers providing cleaning services. In the latter case, workplaces were issuing instructions but were communicating with the outsourced employers rather than with the staff who were directly engaged in frontline work. More often than not these individuals were not competent enough to accurately pass on what was often highly detailed work specific information. This led to unnecessary delay and miscommunication.
137. For example, various UVW interviewees noted that managers put notices around their workplaces about washing hands and staying at home when ill, but could not recall ever receiving any particular training or guidance from their employees about the specific approach to Covid-19 safety in a care home. Similarly, Kanlungan interviewees reported being unclear on what the protocol was if a care worker became sick.
138. Furthermore, many domiciliary carers, who provided essential care functions in private households, simply had no recognisable “*employer*” from whom they could expect training or guidance: they were required to work things out for themselves. This meant that Covid-compliance in these unregulated workplaces was hugely variable and often non-existent.

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139. These problems were compounded in the case of undocumented care workers, who could not turn to employers for assistance and information, less still central or local government. In these communities, misinformation was rife. One Kanlungan staff member noted that:

*“At the start of the pandemic, there was a sense of panic and misinformation. Lots of people were sharing information on facebook and on group chats, either causing panic in the undocumented community, or saying Covid isn’t that serious. It was because so many are undocumented - basically when no one is engaging with state services that leaves so much more space for false information. People were saying ‘we’re going to get an amnesty from the government’; some would contact Kanlungan saying that ‘a friend says a lawyer is getting her an amnesty, I just need to pay £5000, then I can get status’. People didn’t know what the rules were. Even once government and NHS got guidelines out, there was nothing for those who are domestic workers”.*

140. She explained therefore that the *“people who are most vulnerable are the least able to access information”* as they had *“no institutional back-up”*. This information gap resulted in many *“domestic workers who didn’t know anything travelling around houses without having an employer giving them guidance”*.

141. The minimal guidance that did exist was often proliferated in an exclusionary way: on its *“COVID-19: Migrant health guide”* webpages, the Government provided links to explanatory information translated into multiple languages which did not include Tagalog/Filipino [exhibit MHW/44 INQ000327678, Kanlungan research during the pandemic, page 8]. Other interviewees noted that migrant workers who had leave to remain in the UK also found the guidance proliferated in English to be inaccessible, particularly when rules and guidance were changing very frequently. This led to great difficulties around the vaccine when many migrant communities received misinformation spread online and felt distrustful. As one interviewee reported, the *“government took no adequate steps to tell the people who were most likely to get and spread covid in a language they understood”*. Another interviewee stated that many colleagues had to resign instead of getting the vaccine, because they feared taking it based on misinformation and a lack of trust in health institutions.

PPE

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142. Both UWW and Kanlungan worked with individuals who were forced to make their own makeshift PPE due to the failure of their employers to provide them with it [Exhibit MHW/59 INQ000506993], showing the makeshift PPE made by one interviewee with a string from her leggings and a piece of laminated plastic, along with a sign she made for UWW in subsequent industrial action]. As a result, each developed their own mutual aid schemes to provide PPE to their members. When PPE did become available, each member of the Group noted disparities in who was given access to it: outsourced and agency workers would not be provided PPE by their direct employers, whereas employed staff would, and domestic carers would often have no recognisable employer from whom to request PPE provision. Indeed, this disparity in access was legal and justified by the weaker employment rights of “limb b” workers - a status suffered by many of the Group’s workers in the care sector as well as at its periphery, such as the couriers and cleaners working in health and care settings – and which only changed as a result of the IWGB’s litigation, detailed further at paragraph 143 below. As such, workers represented by both UWW and Kanlungan had to make their own PPE. No interviewees were able to recall receiving proper training or guidance about PPE.

143. The inadequate provision of PPE was reinforced by the state of the law at the time at the outset of the Pandemic. This provided that while an employer was obliged to provide PPE to employees, they were not obliged to provide it to “limb b” workers, such as agency staff and other outsourced workers. It was only after successful legal action was taken by the IWGB against the government that law was changed in April 2022 to extend the duty to limb b workers (see *R (Independent Workers’ Union of Great Britain v Secretary of State for Work and Pensions and another* [2020] EWHC 3039 (QB) (Admin) and the subsequent Personal Protective Equipment at Work (Amendment) Regulations 2022) [see official summary, exhibited at MHW/60 INQ000551249].

144. In the view of the Group, the government’s failure to facilitate centrally the distribution of PPE to frontline workers or to make clear directions to employers that all workers must be provided with suitable PPE was the central cause of the lack of action on the part of employers. Whilst the IWGB’s ultimate success in extending the obligation to provide PPE to “limb b” workers through litigation was highly positive, it came very late in the crisis. More generally, the necessity of such legal action highlights the relevance of historic political decisions that undermined workers’ rights during public health crises.

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UVW

145. At a North London care home, UVW member workers took to making their own masks by laminating pieces of plastic, and then tying elastic that they took from their leggings to fix the plastic around their heads. These were made for multiple workers. Camila explained the process she came up with in her interview:

*"I used a machine to laminate. I then got some elastic from one of my leggings, as at that time we were not allowed to buy anything. So we put it around my head. And I had to help my colleagues with this - I had to use the laminator. Later I improved this with putting some foam around the head."*

146. She also recalled that *"we had to use plastic shoe protectors for our hair"*. At that stage, sanitiser gel was all that they were given, *"so it burned our hands given how much we used it"*.

147. When they were eventually provided with masks, they were given one single-use surgical facemask for each 12-hour shift. Camila and Victoria recalled that they were supposed to change their masks regularly, but they were unable to because of shortages. Many workers had to source and buy their own PPE.

148. When employed staff were finally provided with PPE, outsourced staff, without the employment protections of their in-house colleagues, were often forced to work without the same protection. When PPE was provided it was frequently in the face of employer intransigence, obstruction or refusal; after their employed colleagues had received theirs. It was often of a lower standard, inadequate and ill-fitting, and provided without guidance on usage.

149. As one worker explained:

*"I think for me I felt exposed to the virus because there wasn't the proper PPE. From the beginning we were exposed to the virus because usually the only thing that we got given they usually used gloves but nothing to protect our face...Everyone was exposed to the virus."*

Kanlungan

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150. Kanlungan reports that many employers of domestic carers simply refused to provide PPE, or were unable to source it. Elena, who worked as a live-in carer, was not provided with any PPE by the family for whom she cared. She said “*all they did was open the windows, and would not socially distance from*” her. Consequently, she had to sew masks for herself. She described going to Argos, buying some recycled fabric, and made masks using a sewing machine using YouTube videos. She then initiated a project with the Filipino Domestic Workers’ Association making around 50 masks to provide to other domestic carers.

151. Undocumented workers, like Lorena, never received any PPE, and also had to make their own.

152. Those who worked in nursing homes reported differential treatment. Angela recalled that while nurses were given full PPE, including a face shield and a gown, carers were not offered this. This was particularly problematic as nurses sometimes refused to deliver medication to patients who they feared would infect them with Covid-19, so care workers would be required to do this. Thus the most precariously employed were forced to conduct the most dangerous work either without PPE or with inadequate PPE.

153. Finally, Kanlungan’s clients and members were told not to wear PPE so as “*not to scare patients*”.

Compliance with standards

154. It is the view of IWGB and UVW that their members were well placed to identify the growing risk they were being exposed to. Yet their safety concerns were dismissed by employers, whose responsibility it was to assess and mitigate this risk, on the basis of their status as low-paid, precariously employed migrant workers.

155. There are frequent examples of direct-contact care staff raising concerns with their employers about chaotic mismanagement; in part arising from the fact that the care sector lacked the infrastructure that the NHS had, in part because of a lack of accountability and regulatory oversight in and over some parts of the private care sector. UVW members who worked in care homes reported a chronic lack of PPE and frequent failures to observe government guidance and regulations on preventing the spread of Covid-19, which they raised most vocally through their campaign for better working conditions at the North London Care Home mentioned throughout this statement, itself sparked by a dispute over

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the lack of PPE. They reported failures to observe regulations and protocols on preventing the spread of the virus; the refusal of staff requests to isolate patients and employers ignoring staff concerns about the admission of hospital patients who clearly should have remained in hospital. Care workers reported that management failed to enforce restrictions on visitors to care homes in regards to Infection Prevention and Control (IPC) guidance (e.g. paragraphs 129 and 130 above) as well as visitors (e.g. paragraph 109), putting residents and workers at increased risk, and demonstrating a concerning lack of regulation and oversight.

156. Camila reported that nurses were often scared to go into areas where those infected with Covid-19 were. As such, as a care worker, she was required to go and deliver medication to such individuals, despite this being contrary to protocol and not being provided with adequate PPE for the task.

157. On Kanlungan's part, Angela recalled how some staff in care homes regarded Covid safety rules as being essentially pointless: one nurse said to her "*we all die anyway*". The lack of trust and faith in management to keep staff safe meant that staff did not bother to comply with safety standards, as they felt those did not go far enough to keep them safe.

### Testing

158. A general unavailability of workplace testing forced the Group's members to seek out public testing facilities, further endangering their health through risk of contact. Additionally, those who tested positive often faced harassment, with relentless pressure to return to work despite their illness. For undocumented migrant workers, the situation was even more precarious. Many, fearing that their personal details might be exposed, hesitated in seeking testing or medication from pharmacies due to concerns that this could lead to deportation. These factors collectively created an environment of fear, inequality, and exploitation for those who were already vulnerable.

159. Kanlungan notes that members of the community it represents working for private households had to pay for Covid-19 tests out of their own pockets. Again, this issue was at least partly attributable to the fact that many employers did not consider themselves to be employers and refused to take responsibility for the wellbeing of their employees.

160. Once testing became widely available, access was not afforded equally. Undocumented workers and those with limited immigration leave subject to conditions were not initially

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able to access the vaccine as they were excluded from NHS primary care. This caused obvious problems: aside from the basic humanitarian need for such individuals to be protected, thousands of these workers carrying out vital frontline care work with vulnerable people were unable to minimise the risk of contracting and spreading Covid-19. As set out above, campaigns conducted by Kanlungan, Hackney Council and others eventually meant that the vaccine was made available to those communities.

161. Even once access to vaccines was opened up, uptake within undocumented communities remained low [Exhibit MHW/61 INQ000509527, an academic article with multiple authors published in *Environmental Research and Public Health*, 2022, citing intersecting barriers such as increased risk of infection through high representation of undocumented migrants in frontline roles, exclusion from social protection measures, data sharing between health and immigration bodies, etc.]. Misinformation was rife, due to the lack of readily available advice and guidance reaching these communities. Moreover, undocumented migrant communities retained a deep distrust of the medical sector after years of Hostile Environment policies. Of those who were interviewed as part of “*A chance to feel safe*” who were infected by Covid-19, one in four were too scared to ask the NHS for help in case it affected their immigration status in the future. As Camila explained:

*“You’re scared. Every step, you look back, because you don’t know. Are the doctors going to tell on you? They said it’s confidential, but you don’t really know if it’s true.”*

162. She added: “*that’s really a big, big part of being undocumented: fear. It does something to your brain, to your wellbeing. You try to face it, but it’s difficult*”. Lorena made a similar point: “*the trust issue is a big factor*”. The Hostile Environment’s objective, of warding undocumented migrants away from using NHS services, succeeded. This inevitably resulted in the death and serious illness of many migrants; in the pandemic, this became even more potent. [See also, exhibit MHW/54 INQ000474407, witness statement to Module 4 of Migrant Primary Care Access Group, explaining at length barriers in place resulting from Home Office policy.]

The impact of poor pay on the ability to isolate

163. Angela's experience is illustrative. She recounted how she worked as a live-in carer during the pandemic, working 7 days a week, with one 2-hour break per day. The agency paid her by the week, not by the hour, resulting in her effectively being paid £6.50 an hour. She

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also got a £30 food allowance, which was not enough to cover her meals for the week. The agency justified this low pay on the basis that she was provided with free accommodation, but she had to retain her home to house her son, and therefore still had her housing costs to pay.

164. The situation for undocumented migrants was materially worse. Lorena was paid £150 per week cash-in-hand in as a live-in carer. She had one day off a week (Sunday) and had to buy her own food, while the family provided food to the elderly person for whom she cares. She said *“if I asked for more money, they say if you don’t like our rules, then you can go.”*

165. As a result of this poor pay, such workers had great difficulties just surviving, living pay cheque to pay cheque and struggling to pay bills, immigration fees and remittances. This meant that they could not afford to take time off sick if they contracted Covid-19. Kanlungan interviewees almost exclusively worked pursuant to *“no work, no pay”* arrangements. A minority were able to access the nominal amounts provided under SSP if unwell; the majority, working in accordance with casualised arrangements, did not receive anything at all while off sick. There was sometimes a two-tier system, whereby inhouse or *“contracted”* workers were given some sick pay, whereas casualised and agency workers were not. This meant that those at highest risk of spreading Covid-19 (because they were frequently working in multiple care homes) were the least likely to take time off when sick.

166. UVW members had similar experiences. Camila explained that a North London Care Home did not offer any contractual sick pay to its employees while she worked there. She recalled *“some people would say ‘I feel sick, I don’t know if it’s covid or not but I have to pay my bills. With covid or not I have to come to work’. Some people said ‘I can’t do the test, I don’t care, I need to pay the bills, that’s it.’”* She explained that the home was not *“really trying to find out if people were sick”*, as the reality was that they needed staff to come to work as they could not afford the higher agency rates paid for cover staff. Camila contracted Covid 4 or 5 times during the pandemic, and had to rely on family support on each occasion to support herself. As a result of this, the care workers at that North London care home took the remarkable step of going on strike in late 2021, with the backing of their union, UVW. They campaigned under the slogan *“quality care deserves quality pay”*. Instead of engaging constructively with this, the owners of the care home shouted at and wrote aggressive letters to members like Camila, including while she was off sick, that

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resulted in Camila bringing a successful Employment Tribunal claim against them for trade union victimisation, which was heard in mid-2022. The strike ultimately resulted in the staff getting a pay increase to £13 an hour. Now, the nursing home has two workplace union representatives and, while issues remain, interviewees report that dignity and respect in the workplace have improved hugely, while abuses have reduced leading to a safer environment.

167. An additional matter that was raised up by Kanlungan interviewees in relation to Covid-19 isolation was that it was often challenging for them to isolate because most of them shared space with other Filipino nurses, carers or family members at home. A lot of Filipino nurses were unsure about where they contracted Covid-19 because most of them shared work and living spaces with other people. The fear of being infected with Covid-19 both during shift and after shift put a lot of Filipino nurses and carers on edge and highly anxious.

168. Further, for domestic carers, many of their employers were at greater risk of serious illness and death from Covid-19 which put additional pressure on domestic care workers' behaviour and movements, and in some cases, employers' expectations passed the threshold into coercive control and abuse. Kanlungan reports members who were coerced by their employers and/or employers' family to isolate with their employer whilst they had Covid-19, but provided no subsistence for the worker who as a result had no access to food, medicine and other essential items during this time. Kanlungan often had to directly provide subsistence during these periods. These workers were invisible to national statistics and so did not inform what were already significantly higher infection, and subsequently mortality, rates in ethnic minority communities.

169. In terms of this support, at the outset of the Pandemic, member organisations of Kanlungan led by the All Saints Church Battersea Filipino Community (formerly IFI Filipino Chaplaincy Battersea Park), Gabriela UK, and the FDWA initiated its community response, forming committees focusing on reachable areas in London to provide aid to affected community members, mostly domestic workers who do not have access to public funds, or are afraid to step forward to seek support in GP due to their immigration status. Through personal links they were able to reach COVID-19 infected members and provided them food supplies to support them during their quarantine. On 24 March 2020, Kanlungan started its donation drive to gather resources for this work. Kanlungan were also able to

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find grant resources for this initiative strengthening it models and widening its reach, they were able to work on the following:

- a) **Covid-19 Filipino response** - providing one-off food, grocery, and necessities to COVID-19-infected community members.
- b) **Filipino Food 4 NHS** - where Kanlungan collaborated with Filipino chefs to provide one-off hot food packs to Filipino nurses working in Queen Elizabeth Hospital, Royal London Hospital, and Leicester General Hospital.
- c) **Hackney NRPf Grant** – Kanlungan following the lead of Support When It Matters (SWIM) were able to distribute one-off cash support of £250 for migrants in need of support.

170. Separately, as Elena explained, there was a feeling amongst migrant domestic carers that “white people got furlough”. She explained that:

*“There is no furlough in our industry. Because it’s domiciliary, they go to houses for the work. They had no time to rest - basically they had to work for the whole time. They couldn’t even ask their employers for time off, for fear of losing their job and therefore their visa/lifeline. They said they had ‘no right to rest’.”*

**Mutual aid and support given during the pandemic**

UVW

171. To ensure that members had a basic level of protection, UVW sourced 2000 surgical masks from Hong Kong via a mutual aid network in May 2020 and was able to distribute the stock. They did so despite the apparent shortages within the health and care systems themselves. UVW then put together a team of volunteers and organised the logistics of distributing the masks across London to members who needed them, to help mitigate their risk of exposure. In effect, UVW assumed the responsibility of protecting workers at sites where employers and Government had failed them. They did so at a fraction of the cost of the, widely reported, failed contracts for PPE provision that the Government engaged in.

172. UVW also sourced and distributed hand sanitiser gel to members who needed it and where it was not provided by their employers.

Kanlungan

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173. Kanlungan worked tirelessly to provide direct mutual aid support to workers during this time, for example by purchasing and providing PPE, food, medicine and other essential supplies to workers who could not access it. Kanlungan advocated for their members and attempted to improve conditions by lobbying employers and the UK government to address the issues care home and domestic care workers faced. Regrettably, due to administrative changes within the organisation, much of the documentary record from this time is currently inaccessible. Some publicly available resources that evidence this work are exhibited below at paragraph 176. In addition to those materials, we note that Kanlungan also had interaction with the first minister of Wales and their input contributed to that government's "BAME Covid-19 Advisory Group" [see exhibit MHW/62 INQ000551250, report of the same, paragraph 35]. Lobbying issues comprised housing (which is generally of low quality and insecure for migrant care workers), social security for undocumented care workers and associated issues such as the visa system. These concerns are also reflected in the reports they have contributed to and which are referenced throughout this statement. Kanlungan developed the Covid-19 emergency response project which delivered groceries and other essentials to households affected by Covid-19 across the country to ensure people were staying home and self-isolating. Kanlungan provided extensive support to its care worker members, addressing both their immediate needs and broader challenges. They organized food drives for NHS workers, delivering culturally appropriate meals to Filipino nurses working long shifts. For those infected with COVID-19, they offered grocery vouchers and mobilized community members to run errands for them. Whilst Kanlungan is a national organisation and has worked across the UK, due to its small size and resources, their reach was limited and in practice this was England-based.

174. Kanlungan also hosted workshops for Filipino migrants to co-produce small magazines ("zines") to articulate wants, needs and hopes for life during or after the Covid-19 pandemic, and foster warmth and solidarity [see Exhibit MHW/63 INQ000506995, "Hear our Voices", zine containing testimony speaking to the issues examined in this witness statement]. They also provided mental health support via both one-to-one and group/peer support that ran throughout the pandemic. These sessions focused on providing weekly 30-50 minute phone calls to individuals they were supporting who experienced mental health issues during the pandemic. The need for this had been recognised before the onset of the pandemic, but became acute once it had begun. The monthly online group

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support was also provided throughout the pandemic. This provided space for care sector workers users to share their own lived experience during the pandemic and also a space for them to feel less isolated.

175. Other support they put in place included:

- a) Covid-19 vaccination clinics for hundreds of people: 3 and 4 July 2021, 28 August 2021 and 18 February 2022 in East London.
- b) Vouchers and other material support, including food, medicine and essentials deliveries for people who were sick or isolating.
- c) Befriending/mental health support in community languages.
- d) Support with registering with a GP.
- e) Access to immigration advice and fortnightly legal clinics with an immigration solicitor.
- f) Advocacy with local authority, NHS, and national government.
- g) Mini-grants for Hackney residents with NRPF. [Due to administrative difficulties at Kanlungan, they are not at present able to provide further information on the work conducted. We hope to resolve this, and will update this statement accordingly, though this may in fact not be possible.]
- h) Mask making and distribution (alongside the FDWA).

**Lobbying and advocacy****Kanlungan**

176. Kanlungan undertook the following lobbying and advocacy work during the relevant period:

- a) Contributing to a joint response from academics, politicians, professionals and organisations who come from and represent East Asian and South East Asian communities in the UK to the government's Call for Evidence on Ethnic Disparities and Inequality in the UK, which took place in January 2021 [Exhibit MHW/64 INQ000474439 ].
- b) In order to document and quantify the impact of Covid-19 on migrants with insecure status and undocumented migrants, Kanlungan published two reports ('A chance to feel safe' [Exhibit MHW/23 INQ000235265] and 'Essential and Invisible: Filipino irregular migrants in the UK's ongoing COVID-19 crisis' [Exhibit MHW/44 INQ000327678]). They also produced a zine, "Hear Our Voices" co-created with

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undocumented migrants [MHW/63 INQ000506995]. Kanlungan additionally co-founded the Status Now 4 All Network, a campaign calling for all undocumented migrants to be immediately regularised to guarantee access to healthcare, housing, and employment; this arose in part from Kanlungan's work in the adult care sector but was not limited to it [MHW/65 INQ000561033 , webpage captured, site comprises plethora of updates since launch in 2020 which are not exhibited].

- c) Kanlungan set up the first vaccine hubs to allow migrants to access vaccinations without fear of immigration repercussions. They then worked alongside Hackney Council to implement the hubs more broadly. This approach subsequently became national policy.
- d) At the outset of the pandemic it quickly became clear to Kanlungan that an exceptionally high number of Filipino frontline healthcare workers were dying from Covid-19. In response, they initiated a community monitoring project to track deaths amongst the Filipino migrant community across industrial sectors, but with a high density in the adult social care sector. Through monitoring of social media, news coverage, hospital and NHS trusts, and via their network of participatory organisations they pulled together early quantitative research of the impact of the pandemic on front-line staff. This was supported by qualitative research, as Kanlungan convened focus group discussions with Filipino healthcare workers and facilitated a mental health support group for workers who shared experiences of widespread discrimination and harassment, leading to disproportionate exposure to Covid-19.
- e) Kanlungan created an online collection of portraits of members who lost their lives as a result of the Covid-19 pandemic. The list is not exhaustive as it is only made up of those members whose families consented to their personal information being shared [Exhibit MHW/66 INQ000327677].
- f) In response to concerns raised about the inability of members to access Covid information, Kanlungan successfully lobbied for Covid-19 public health information to be translated into Tagalog. This culminated with the NHS setting up a Filipino language helpline for NHS staff on 19 May 2020 [See exhibit MHW/67 INQ000551253 ]. That this was limited to NHS employees is reflective of the group's concern that care workers are disadvantaged by the lack of national service.

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- g) Participating in meetings with NHS North East London that were coordinated by Hackney Council for Voluntary Service in 2020 and 2021 to discuss communication and translation of Covid-19 guidance into community languages.
- h) The following activities and meetings were convened with wider concerns in mind, such as the disproportionate impact of the pandemic on ethnic minorities *generally*. Nonetheless, Kanlungan's input consistently dealt with matters of direct relevance to the adult care sector, such as the fact that adequate housing is out of reach for many care sector workers due to levels of poverty in the workforce. [See exhibits MHW/68 INQ000561034 for email exchange between London Mayor's office; and MHW/69 INQ000551251 for London Mayor's final report, page 21 citing Kanlungan's evidence.]
- i. Participating in a Housing and Communities roundtable with the Greater London Authority's Housing & Land team to discuss their concerns on Thursday 19 November 2020.
  - ii. Meeting with the Mayor of London, Sadiq Khan, about their communities' experiences during COVID-19: Thursday 26 November 2020, chaired by Deputy Mayor Dr Debbie Weekes-Bernard.
  - iii. Participating in the London Assembly Planning and Regeneration Committee meeting on 7 September 2022, in which concerns were raised that the combination of Hostile Environment policies and low-wages meant that domestic carers were hugely vulnerable to housing insecurity during the pandemic. [See page 3 of exhibit MHW/70 INQ000551255 , regarding Kanlungan's input of direct relevance to the care sector.]
- i) Drafting and publishing an open letter with RAPAR (Refugee and Asylum Participatory Action Research, a human rights organisation based in Manchester that works with and for displaced people) calling for leave to remain to be granted to all undocumented migrants on 27 March 2020 [Exhibit MHW/71 INQ000509529], and working with RAPAR to prepare a report about how the Hostile Environment interfered with migrant communities' ability to be resilient and survive the pandemic in May 2021 [Exhibit MHW/72 INQ000506997].
- j) Drafting and publishing an open letter with StatusNow4All for Indefinite Leave to Remain in the UK to be granted to all undocumented migrants on 27 March 2021.
- k) Providing evidence of the negative impact of the minimum wage exemption for live-in staff to the Low Pay Commission, as part of their review into this matter in 2021

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[Exhibit MHW/73 INQ000506996, 'National Minimum, Low Pay Commission Report 2021', see in particular paragraph 8.22 at page 152]. The Low Pay Commission subsequently recommended that this exemption be scrapped, which it was on 1 April 2024, pursuant to regulation 2 of the National Minimum Wage (Amendment) Regulations 2024 (2024/75).

IWGB

177. In February 2021, IWGB launched a national campaign backed by 30 MPs calling for the indefinite extension of the CJRS and for compliance to be made compulsory for employers. Despite continuous efforts to engage with the government concerning the welfare of their members, the only responses received were those that were legally required under the pre-action protocol [Exhibit MHW/74 INQ000203415]. It also engaged with government in the following ways:

- a) Oral evidence session regarding 'the impact of coronavirus on businesses and workers' at the Business, Energy and Industry Strategy Committee on 17 November 2020.
- b) Meeting with Health and Safety Executive regarding 'research around the provision of PPE to "limb b" workers' on 24 June 2021 [Exhibit MHW/75 INQ000346796, Exhibit MHW/76 INQ000346791]. The meeting was part of a consultation process following the successful judicial review by IWGB [MHW/60 INQ000551249 ]. The High Court found that employers had a duty to provide 'limb b' workers with the same PPE as employees. This work arose primarily in respect of transport workers, such as couriers, who had provided key work during the pandemic delivering to and from health and care settings. However, the judgment and eventual change in the law were applicable across all sectors. It was particularly pertinent to the care sector, where one in ten workers are on zero-hours contracts (compared to one in forty across the workforce as a whole). 71% of ethnic minority and 59% of White British homecare workers in the private care sector were on zero-hours contracts in March 2020 [MHW/77 INQ000136934, Equality and Human Rights Commission research into experiences of migrant health and care workers, page 41].
- c) Letter to then Prime Minister Boris Johnson regarding additional protections needed for precarious frontline workers including PPE, safety guidance, sick pay

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and others – 19 March 2020 [exhibit MHW/41 INQ000203413]. No response was received.

- d) Pre-action letter to HM Treasury on 23 March 2020 regarding changes to statutory sick pay [MHW/42 INQ000203418]. A response was received on 27 March 2020 [MHW/43 INQ000203419]. This case was unsuccessful at court.
- e) Press release regarding Covid-19 demands on 23 March 2020 [MHW/78 INQ000203421].
- f) Letters were sent regarding protections for its members who fall outside the legal definition of “employee”, as is often the case with cleaners and couriers working in health and social care settings, as well as care workers themselves [see exhibit MHW/22 INQ000509517 for research into care sector workforce and employment status, at, for instance, pages 46 and 47, which indicates that such workers are highly represented in the *formal* care sector as at 2021]. These and their replies are exhibited at MHW/79 INQ000551257 and MHW/80 INQ000551256 .

UVW

178. UYW advocated strongly on behalf of their members in care homes for suitable provision of PPE, and were active in procuring and providing PPE to their members where it was absent. As evidenced throughout exhibit MHW/07 [INQ000551237 ], this advocacy took place in the national press in the case of the North London Care Home; however, they also advocated directly with employers on behalf of members. In the case of the North London Care Home, the ultimate outcome was positive, comprising increased pay and improved working conditions. In addition, the work comprised individual and collective casework to support its members and negotiations with employers to bring staff in-house and improve pay and conditions. The most note-worthy example of this is in regards of the North London Care Home campaign referred to throughout this statement, which began with individual casework, comprised a successful case at the Central Arbitration Committee after the Care Home refused to enter into a “recognition agreement” with the union [exhibit MHW/81 INQ000561035 ] and the aforementioned national press coverage [exhibit MHW/07 INQ000551237 ].

179. During the pandemic one of the major issues affecting the members of UYW was the lack of a full pay sick pay scheme available to them. As a result of Government complacency in this area, the UYW launched a public campaign following consultation with its members directed primarily at the Government but then that same demand was levelled against

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employers at a local level as well. This was set out in a comprehensive set of proposals and demands levelled at employers and Government [Exhibit MHW/82 INQ000327686 ].

### Lessons learned and recommendations

180. The pandemic has exposed the instability and unsustainable levels of risk to workers and service users inherent in the fragmented care sector, with obvious consequences for the spread of the pandemic through vulnerable migrant communities and the population at large. This has brought into sharp focus an important fact emerging from the evidence: the for-profit sector is not the answer to any of the big problems or challenges faced by the care sector. Rather it is part of the problem.

181. Given this, we, the representatives of the three major organisations, Kanlungan, United Voices of the World and the Independent Workers of Great Britain believe as a starting point the following broad recommendations should be made by the Inquiry:

***I. The introduction of a professionalised National Care Service which establishes national service standards in the adult care sector and brings outsourced/agency staff back in-house at equal pay and terms.***

The current arrangements are fragmented and unstable and the structure of the market leaves the care sector and its workforce open to exploitation by profiteering, driving down standards of care for service-users, employee protection and provider accountability. Downgrading of oversight mechanisms has compounded the instability of the sector rendering it volatile even without a pandemic. In such circumstances resilience is hardly to be expected. Marketisation and outsourcing have led to a two-tier work force and an increase in poor practice. Our members at the very sharp end of the pandemic, trying to keep themselves and the most vulnerable well and cared for, having faced significant exploitation in the pursuit of profit. Pay has been reduced and working conditions have deteriorated.

Had the sector been within the public sphere, the myriad coordination problems identified above, particularly regarding the distribution of PPE and the enforcement of Covid guidance, could have been significantly or avoided it altogether. The workers who

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needed PPE most would have had it provided to them. Instead, the private sector profited on the back of the lowest paid and the sector was dangerously uncoordinated. There are number of further benefits that would result from a national adult care service where the profit motive is replaced by value for money principles that the public sector well understands. These include adequate staffing levels, access to the local workforce, national standards, accountability and professionalising of the sector leading to raised standards of care. Combined with an adequately resourced oversight body, this would have made a big difference to the risks and outcomes borne by both service-users and workers.

**II. *Introduce a sufficiently resourced, expert and dedicated social care oversight process.***

Robust regulation including the capability to drive up standards is the key function of effective oversight. As Dash sets out in her final report into the CQC published October 2024, “Social care is predominantly privately provided. There are around 19,000 care providers (organisations). Of the 6,000-plus care home providers (organisations), the largest 10 comprise about 18% of the market” which is about 10% private equity owned [MHW/31 INQ000551241 , final report, page 13; see also exhibit MHW/47 INQ000551244 , research into the financialisation of the care sector from the Institute of Public Policy research]. The CQC is responsible for regulating some 49,000 social care locations – this in addition to health care providers (dentists, GPs etc) across the NHS, independent sector and regulated services provided and commissioned by local authorities. As Dash points out “These differences in governance structures and oversight mechanisms across sectors are significant. The regulation of services should reflect these differences.” The fragmentation and marketisation of the social care sector compounds these difficulties, in addition to impeding both contingency and long-term planning to ensure that the sector meets the needs of an aging population.

**III. *End “Hostile Environment” policies and overhaul the migration system which devalues the lives of migrants, exposes them to harm and increases the overall public health risk posed by a future pandemic or whole-system civil emergency.***

In the short term, steps such as the introduction of bridging visas and/or an ability to renew a visa in-country post expiration will significantly reduce the exploitation of workers tied to their employers. There is a need to allow all people living in the UK, regardless of

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immigration status to be able to access all levels of health services without fear of immigration enforcement. This will help exploited individuals to report abuse and wrongdoing without worrying about their own job security and consequent ability to remain in the country. In particular, we ask the Inquiry to recommend: (i) implementation of a “*firewall*” which prevents data-sharing between public bodies contacted for assistance and the Home Office; (ii) end the criminalisation of working while undocumented; and (iii) support safe reporting pathways to work inspectorates, immigration enforcement and police.

**IV. *End NHS charging, including the Immigration Health Surcharge and charging at 150% for secondary care for those who have not paid the Immigration Health Surcharge.***

**V. *Remove or significantly lower fees for in-country visa variation applications to move place of work or employer, thereby allowing workers to challenge exploitative conditions. This would of course also benefit service users within the care sector, as exploitative conditions are necessarily associated with lower standards of care.***

**VI. *End the “no recourse to public funds” conditions applied to visas.***

The NRPF rule leaves workers living in fear of losing their jobs and open to abuse should they seek to report exploitation or abuse. It leaves them at the mercy of employers, without a social safety net and thereby encourages exploitative work environments where lower standards of care are likely to flourish.

**VII. *Create pathways to regularisation for undocumented workers in shortage occupations, for example on a 5-year route, for people who are undocumented or on other visas where you cannot traditionally switch (e.g. tourist, student visa) to be allowed to apply for work visas.***

**VIII. *Reform the Overseas Domestic Workers’ (ODW) and the Health and Care Worker’s visas by re-instating the pre-2012 ODW visa and granting migrants on the ODW visa the right to switch to a different visa.***

More generally, permit workers on sponsored visas to leave a role or change their employer more readily, in order to avoid exploitation arising from workers being tethered to their

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current employer. This could be achieved through the introduction of “bridging visas” or the ability to apply to renew a visa in-country once expired.

- IX. Make the UK Code of Practice on ethical international recruitment enforceable so that unscrupulous employers and recruitment agencies cannot operate freely outside of it.***
- X. Overhaul the sick pay system to provide access to sick pay to all employed, ‘limb b’ and self-employed workers at a living wage rate. Sick pay should be paid at the full wage rate. Without this it leaves workers who become sick either working or with insufficient means to live on.***
- XI. Early engagement with unions and community organisations to inform decision-making and understand of the needs of workers.***
- XII. The Health and Safety Executive (“HSE”) to have the statutory power to enforce breaches and punish them, as well as to have its funding increased.***

The HSE has seen its funding cut. In 2021-22 it was 43 per cent down on 2009-10 in real terms and staff numbers have been cut by 35 per cent since 2010 on a like-for-like basis [Exhibit MHW/83 INQ000327687]. Due to the austerity programme it received just £123 million from government in 2019/20, compared to £231 million in 2009/10. Lower funding means fewer inspections: over the same ten-year period, the number of workplaces investigated by a safety inspector fell by 70% and over a twenty year period (2001-2021) the number of prosecutions has fallen by 91% [MHW/18 [INQ000250949 ]]. Research into the working conditions of migrant care workers identified that between 2020 and 2024, the HSE has “issued 68 notices and successfully convicted in 12 cases for health and safety breaches, including deaths and serious injuries to workers and patients caused by company or organisational negligence” [MHW/06 INQ000551236 , page 43]. Given the foregoing analysis of the HSE’s funding cut and the fall in inspections, as well as the Group’s evidence provided in this statement, we consider that this likely underestimates the scale of health and safety breaches.

- XIII. Listen to and factor in the views of migrant workers when developing policies which impact them.***

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**Statement of Truth**

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**Name: Francesca Humi, Kanlungan**

Signed: PD \_\_\_\_\_

Dated: 14 February 2025

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**Name: Alex Marshall, IWGB**

Signed: PD \_\_\_\_\_

Dated: 14 February 2025

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**Name: Petros Elia, UWW**

Signed: PD \_\_\_\_\_

Dated: 14 February 2025