

1 pandemic conditions.

2 Within those numbers, there are, we know, multiple
 3 losses from the same families or the same close-knit
 4 communities. Mothers and fathers, children,
 5 grandparents, aunts and uncles, wives, husbands,
 6 treasured friends lost. Shared grief must stand as one
 7 of the key impacts of Covid-19, and it is a consequence
 8 of the pandemic which cannot and will not be diminished
 9 in its examination by this Inquiry.

10 You have, my Lady, already recognised that there
 11 were failures both in the preparedness for this
 12 whole-system crisis and in the response to it. You have
 13 found that harm resulted not only from the pandemic but
 14 from the inadequate government response. You have
 15 recognised that the impact of the pandemic was unequal,
 16 that vulnerable groups, who were particularly
 17 susceptible not only to the virus itself but also to the
 18 decisions made by the UK Government and devolved
 19 administrations to reduce transmission.

20 Yet, in large part due to a lack of pandemic
 21 planning, limited consideration had been given to the
 22 indirect consequences arising from the response to it,
 23 decision makers had limited understanding of the need to
 24 plan to mitigate the worst impacts of, for example,
 25 a lockdown. It does not appear as if any of the

5

1 governments entered into a systematic consideration of
 2 how the decisions that they took to combat the virus
 3 would affect vulnerable sectors of the population.
 4 You have found that when it was important for there to
 5 be centralised oversight of the impact which the
 6 pandemic was having on society, there was none. It is
 7 in that recognition and against that background that the
 8 true value of this module lies.

9 Over nine modules, my Lady, you have considered
 10 evidence on the challenges faced as the Covid-19
 11 pandemic gripped the world. While this was a public
 12 health crisis, its scale meant that every area of our
 13 lives was impacted, from the decisions taken in the face
 14 of the immediate healthcare risk, to lockdown, test and
 15 trace, and vaccination.

16 The impact of those measures took its toll on daily
 17 life, on work and leisure, education, and on business
 18 and personal finances. Much of this has continued long
 19 after lockdown and the pandemic period ended.

20 In each of the Inquiry's earlier modules, you have
 21 considered where things went wrong. You have reflected
 22 carefully on steps that might be taken to better prepare
 23 for the next pandemic or whole-system crisis. Where, in
 24 your earlier conclusions, you have identified acts and
 25 omissions in the pandemic period that may have left

6

1 scars on society, this module looks at the shape and
 2 depth of those scars, and how the wounds that made them
 3 impacted on our communities and on individual lives.

4 Each of your public hearings has begun with voices
 5 of those impacted. Throughout, you have recognised that
 6 the story of Covid-19 cannot be fully appreciated
 7 without an understanding of how the pandemic was
 8 experienced beyond the rooms where decisions were taken.

9 In order to better plan to meet the direct and
 10 indirect impacts of the next pandemic or whole-system
 11 crisis, we need to appreciate how Covid-19 and the
 12 response to it was experienced in the UK. In this
 13 module and during these hearings we focus on what the
 14 Inquiry has learned about that impact.

15 Every community has its own narrative, every family
 16 has its own loss, and every individual has their own
 17 experience of Covid-19 which remains with them. For
 18 every addition carefully painted on the Covid Memorial
 19 Wall, images which surround us here as we work in
 20 Dorland House, there is the story of life and of loss
 21 which contributes to our understanding as to how the UK
 22 was impacted as a society.

23 It would be an impossible task to tell and to honour
 24 every single story, but during these short hearings we
 25 will explore powerful evidence, some of which may be

7

1 difficult to hear, including evidence of severe mental
 2 ill health and self-harm, evidence of fear, pain and
 3 suffering, death and bereavement. In order to put the
 4 voices of those most impacted at the heart of this
 5 module, while respecting the proportionality of your
 6 investigation, my Lady, your Inquiry team will take
 7 a range of steps.

8 First, we acknowledge the important evidence on
 9 impact which you have already heard in earlier modules.
 10 This is evidence which we know will have stayed with you
 11 and which is reflected in each of your published
 12 reports. I refer to some of this material in these
 13 opening remarks to avoid repetition later on.

14 Second, we welcome the continued participation of
 15 Core Participants who represent some of those most
 16 impacted by the pandemic.

17 Third, you will hear from a small group of bereaved
 18 individuals about their experiences.

19 Fourth, you will benefit from a wide range of
 20 contributions through the Inquiry's Every Story Matters
 21 Listening Exercise. In this module, there are three
 22 separate Every Story Matters records focusing on mental
 23 health and wellbeing, on key workers, and on
 24 bereavement. These records draw on 55,362 separate
 25 accounts shared with the Inquiry and also provided

8

1 during listening events which have taken place across
2 the UK. The Every Story Matters team travelled to 43
3 towns and cities in England, Scotland, Wales and
4 Northern Ireland where they listened to the stories of
5 many, many individuals. I will endeavour, where
6 appropriate, to introduce some of these stories in
7 opening these hearings.

8 Fifth, your consideration of the evidence will be
9 informed by the product of nine roundtable events
10 convened by the Inquiry, bringing together organisations
11 and individuals close to or representing experiences
12 important to this part of the Inquiry's work. These
13 conversations, as you know, have culminated in nine
14 separate reports concerning: faith and cultural
15 institutions; community level sports and leisure;
16 travel, hospitality and retail; business leaders, key
17 workers; housing and homelessness; justice; domestic
18 abuse; and finally funerals burials and bereavement
19 support.

20 Tomorrow, Ms Rahman King's Counsel will introduce
21 details from these roundtable reports headlining some of
22 the issues to which we will return with individual
23 witnesses and experts.

24 I now ask your permission, my Lady, to adduce into
25 evidence the three Every Story Matters records and the

9

1 nine Inquiry roundtable summary reports for Module 10 so
2 that they may be published by the Inquiry on its website
3 and addressed with such witnesses as may assist your
4 consideration of the evidence.

5 **LADY HALLETT:** They may be published.

6 **MS BLACKWELL:** Thank you.

7 Over the next three weeks you will hear evidence of
8 how the UK was impacted by Covid-19 and the measures
9 taken in response. As you have already made clear in
10 your opening remarks, this is not an opportunity to
11 revisit earlier issues of decision making or to raise
12 new criticism. That task has already been achieved by
13 this Inquiry.

14 However, the evidence in this module does not exist
15 in a vacuum. In order to understand the impact which
16 the pandemic had, you may have to consider context.
17 This will not involve a critical analysis of specific
18 policies or decisions beyond your earlier findings and
19 conclusions. For example, while you will consider
20 evidence on the experiences of those living in poverty
21 at the time the pandemic struck, it is outside the scope
22 of this Inquiry to scrutinise the underlying drivers of
23 poverty and policies on social welfare.

24 Your team and all Core Participants acknowledge your
25 earlier findings and conclusions and the earlier

10

1 evidence heard by the Inquiry which has led to those
2 being made.

3 It will be for you, my Lady, to consider what impact
4 that decision making had upon UK society.

5 In order to assist you in this regard, we have
6 drafted a factual chronology of key events during the
7 pandemic which has been provided to your Core
8 Participants prior to these hearings beginning for their
9 consideration and input.

10 I turn now to give an overview of our approach
11 before descending into the detail of the evidence. In
12 the course of these hearings we will call witnesses
13 whose evidence covers the themes central to your
14 investigation and in accordance with your terms of
15 reference.

16 First, we will examine the impact on the general
17 population of the UK by asking how their mental health
18 and wellbeing was affected during the pandemic.
19 Module 8 has already considered the impact on the
20 wellbeing and mental health of children and young
21 people. In this module, the Inquiry will focus both on
22 the wellbeing of the adult population as a whole and
23 also on the experience of those with pre-existing severe
24 mental ill health. Many of the stories in the Every
25 Story Matters mental health and wellbeing record may be

11

1 familiar to listeners. They may reflect their only
2 experience, that of their friends and family, or
3 experiences within their own communities which strike
4 cords of recognition. It is the task of this module to
5 bring together those stories and the learning from those
6 experiences.

7 The Inquiry has commissioned a systematic evidence
8 review, which I will refer to as the Evidence Review,
9 considering the impact of the Covid-19 panic on the
10 mental health and wellbeing of the UK adult population
11 completed by the Centre for Strategy and Evaluation
12 Services in 2025.

13 It considered over 5,700 sources of evidence on the
14 wellbeing and mental health of the adult UK population
15 during the pandemic period and examined a final list of
16 98 studies before reaching its conclusions.

17 As explained in the Evidence Review, we can view
18 mental health as a continuum, with severe mental health
19 conditions at one end, and positive wellbeing at the
20 other. Mental health is a dynamic state. People can
21 experience symptoms of psychological distress without
22 having a diagnosed condition or disorder. Similarly,
23 people with severe mental ill health may experience
24 periods of wellbeing. For the purposes of this module,
25 we take wellbeing to refer to the positive state of

12

1 feeling good and functioning well.

2 The Evidence Review is careful to acknowledge which
3 there may be gaps or weaknesses in the available data,
4 but it provides a considered basis on which to explore
5 our understanding of the impact of the pandemic on
6 wellbeing and mental health across the UK.

7 Second, we will hear from a range of experts
8 instructed to assist your investigation of impact. You
9 have heard from some of these expert witnesses in
10 earlier modules. We will endeavour, as in other
11 modules, not to repeat work you have done before. We
12 will seek to draw on their cumulative expertise to
13 explore shared themes and lessons to be turned.

14 Third, we will explore community impacts,
15 predominantly at a grassroots level, and the impact on
16 key workers who met the challenge of keeping the country
17 operational during the pandemic. You will hear evidence
18 from the Local Government Association and their
19 equivalent in Wales, Scotland and Northern Ireland in
20 Week 2. This evidence will focus on the impact of the
21 pandemic at a community level, and will not revisit
22 decision making either on a local or a national level.

23 Fourth, we will look at the experiences which made
24 some individuals and groups particularly vulnerable to
25 adverse impacts during the pandemic and of measures

13

1 taken in response.

2 You have recognised in each of your earlier module
3 reports that the impact of the pandemic was not felt
4 equally. We will seek to build on the understanding of
5 how this unequal impact was experienced, including by
6 some groups you have recognised were hit particularly
7 hard. Unequal impact is an issue which runs throughout
8 all of our investigations in this module.

9 Fifth, we will consider bereavement. The experience
10 of loss of life during the pandemic period must be
11 understood both as a national crisis and as personal
12 tragedy on a national scale.

13 Bereavement during the pandemic carried with it
14 a level of additional impact. So many events of the
15 pandemic and decisions taken in response were about
16 life, risk to life and managing loss. In this module,
17 you will consider particular experiences of bereavement
18 during the pandemic period.

19 Finally, and throughout, your investigation in this
20 module must necessarily be forward looking. We will
21 explore how our understanding of the pandemic of
22 Covid-19 might inform the actions taken in preparation
23 for and in response to the next pandemic or whole-system
24 civil emergency which the UK may face.

25 In Module 2, you identified a series of lessons for

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1 decision makers in the future. In doing so, you have
2 recognised that there are inevitable trade-offs between
3 competing interests in an emergency, and that those
4 responsible face intensely difficult decisions which may
5 be assisted by a framework that considers social and
6 economic consequences in the short, medium and
7 long term.

8 We will explore the extent to which evidence about
9 the impact of this pandemic can be used to inform the
10 response to civil emergencies in the future.

11 Now we will consider each of those headlines in
12 turn, my Lady, the first of which is mental health and
13 wellbeing in the UK.

14 It may be obvious or predictable that any national
15 crisis, let alone a global public health crisis, could
16 impact negatively on wellbeing and mental health. On
17 18 March 2020, a week after the World Health
18 Organisation declared Covid-19 a pandemic, it issued its
19 own guidance on mental health and psychosocial
20 considerations.

21 Social isolation, loneliness and declining mental
22 health were obvious and significant consequences of
23 social distancing. The potential implications of
24 lockdown for individual wellbeing and mental health were
25 clear before the first national lockdown on

15

1 23 March 2020, and by 24 June 2020, an internal
2 presentation at the Department of Health and Social Care
3 recorded that:

4 "Evidence and experience from previous crises
5 suggests that the Covid 19 pandemic is likely to lead to
6 an increase in mental ill health in the UK, as a result
7 of both the illness itself and the social, economic and
8 psychological impacts of the measures being taken to
9 protect people from the virus. The impacts are likely
10 to exacerbate existing inequalities and be felt more
11 acutely by particular 'vulnerable' groups including
12 young people, people who have been bereaved, and those
13 recovering from severe symptoms of Covid-19, health and
14 care workers, groups most affected by economic
15 downturns, and groups who are already at risk of poorer
16 mental health, including those with existing mental
17 health conditions ... [Black, Asian and Minority Ethnic]
18 communities and women."

19 Mental health remains a devolved responsibility
20 across areas of the UK. My Lady, you will hear that the
21 baseline for wellbeing and mental health in the UK
22 before Covid-19 hit was in fact precarious.
23 A substantial proportion of the population entered the
24 pandemic with pre-existing mental health difficulties.

25 Some people experienced improved wellbeing and

16

1 mental health during the pandemic period, principally
2 linked to increased time away from work, spent instead
3 with family and on hobbies and self-care. As
4 contributors to Every Story Matters have told the
5 Inquiry, the pandemic, for some, brought a moment of
6 unexpected positivity and opportunities for time beyond
7 their daily commitments to working life that they had
8 never before enjoyed. The following are contributions
9 that we have received:

10 "The lockdown restrictions were introduced and as
11 a result I was able to work from home and spend a lot of
12 very important time with my baby."

13 "Being furloughed and being able [to] try out new
14 hobbies, crafts and DIY, spending time with my loved
15 ones I lived with were incredible for my mental health."

16 "I had work life balance for the first time and my
17 physical and mental health and wellbeing were the best
18 they had been in years."

19 For some, the shift to life online provided new
20 opportunities for growth and social contact that have
21 continued beyond the pandemic. Professor Das-Munshi,
22 Professor of Social and Psychiatric Epidemiology at
23 King's College, London will explain that this positive
24 experience extended to some with -- some people with
25 pre-existing severe mental ill health. For some, the

17

1 isolation reduced sensory and social overload, and led
2 to a reported sense of solidarity and a reduction in the
3 social stress related to everyday life.

4 However, overall, the Covid-19 pandemic caused
5 a clear and evidenced deterioration in mental health and
6 wellbeing across the general adult population. You will
7 hear evidence later this week from Professor Sarah
8 Stewart-Brown, Emeritus Professor of Public Health at
9 the University of Warwick, who will speak to the work of
10 the Evidence Review and its findings in this regard.

11 The first national lockdown from 23 March 2020
12 triggered a sharp deterioration of mental health and
13 wellbeing across the general population with clinically
14 significant psychological distress rising by more than
15 half compared to pre-pandemic levels.

16 During the lockdown in spring 2020, people reported
17 pronounced difficulties with concentration, sleep, and
18 finding enjoyment in daily activities.

19 The proportion of individuals unable to enjoy
20 day-to-day activities nearly trebled, from around
21 17 per cent in 2019 to 46 per cent in April 2020 amid
22 strict lockdown conditions.

23 Overall, life satisfaction and happiness dropped,
24 while feelings of loneliness rose. There were marked
25 changes in the nation's psychological wellbeing albeit

18

1 that these impacts were uneven and experienced more
2 significantly by some groups.

3 Young adults, women, carers and people impacted by
4 existing inequalities including those with pre-existing
5 mental health conditions or other disabilities, those in
6 financial hardship and individuals from ethnic minority
7 groups experienced particular challenges.

8 As one Scottish contributor to Every Story Matters
9 told us:

10 "When the country locked down, my mental health
11 spiralled. At first, I was diagnosed with general
12 anxiety disorder and depression, then the longer the
13 restrictions were in place it progressed to clinical
14 depression and agoraphobia."

15 For those who were clinically vulnerable and
16 clinically extremely vulnerable and advised to shield,
17 prolonged and repeated restrictions were associated with
18 worsened mental health outcomes. We will turn to look
19 at some of their particular difficulties experienced
20 throughout the pandemic when we come to address the most
21 vulnerable in society later in this opening.

22 To assist your understanding of this topic you will
23 hear evidence from Professor Clare Herrick, Professor of
24 Geography and Global Health at King's College, London
25 and Professor Azeem Majeed, Professor of Primary Care,

19

1 and Public Health at Imperial College, London later this
2 week, from Lara Wong on behalf of Clinically Vulnerable
3 Families, from whom you have already heard in previous
4 modules, next week.

5 Almost 40 per cent of people experienced high or
6 repeatedly elevated levels of psychological distress
7 across multiple lockdowns. This consolidates the
8 earlier evidence heard by the Inquiry that one in five
9 adults reported experiencing depression between
10 June 2020 and early 2021, double the number before the
11 pandemic.

12 While increased psychological distress ranged from
13 elevated levels of anxiety or reduced wellbeing for
14 some, there was evidence of people developing new mental
15 health conditions as a result of their experience in the
16 pandemic. As one contributor to Every Story Matters
17 explained at a listening event in Belfast:

18 "Off the back of Covid, I have developed really bad
19 obsessive compulsive disorder. I still have it really
20 bad. If someone said to me they had a sore throat
21 I would shut down and tell them to leave. I don't want
22 to say it's post traumatic stress disorder but in a way
23 it feels like it."

24 Feelings of isolation and loneliness directly
25 contributed to the decline in mental health and

20

1 wellbeing experienced as people were isolated from their
 2 families, friends and wider communities. A Welsh
 3 contributor to Every Story Matters said:

4 "The uncertainty, the loss of freedom, the inability
 5 to mix and socialise, the negative/fearful atmosphere,
 6 the separation from loved ones, the general anxiety
 7 caused by the situation and uncertainty. I had never
 8 felt suicidal before the pandemic but reached a
 9 desperate state and have suicidal thoughts as a result
 10 of the restrictions, not the pandemic."

11 Fear and uncertainty, particularly in the early
 12 stages of the pandemic played a consistent role.

13 Contributors told Every Story Matters:

14 "I was worried about germs from parcels or letters,
 15 or shopping delivered; nothing felt safe. It began to
 16 affect my mental health, massive anxiety and inability
 17 to cope with stress. I developed agoraphobia which
 18 affected my [daily life]."

19 "The daily briefing on TV during Covid caused me
 20 severe anxiety, particularly the death statistics.
 21 I was too terrified not to watch it in case it contained
 22 vital information, but every day I got more anxious.
 23 I was utterly isolated and it gave me insomnia and
 24 nightmares when I could sleep."

25 Some people reported finding positive ways to cope,
 21

1 helped manage their anxiety and worry. Exercise,
 2 including walking, meditation and learning new skills
 3 were ways that people found to cope. However, as in
 4 life beyond the pandemic, experiences varied. Many
 5 reported being denied access to their ordinary coping
 6 mechanisms, their activities which supported positive
 7 wellbeing and some reported turning to reliance on drugs
 8 and alcohol.

9 One contributor to Every Story Matters said:

10 "Prior to Covid, I'd only been a social drinker and
 11 was able to control my drinking. In the initial
 12 lockdown starting in March 2020, there was nothing to
 13 do. I started drinking as it was the only thing that
 14 gave me something to look forward to."

15 Loneliness and isolation from networks of support is
 16 prominent in the risk factors addressed in the evidence.
 17 For example, one contributor to Every Story Matters from
 18 England said:

19 "When Covid hit, I had just been recently widowed
 20 and also lost both my parents very shortly after my
 21 husband. I was therefore incredibly isolated. All
 22 I could hear around me was my neighbours in their
 23 gardens and their families, laughing eating together and
 24 chatting, and this simply increased my feeling of
 25 loneliness."

22

1 You will hear from Professor Das-Munshi that the
 2 impact of social isolation due to lockdown or other
 3 measures in response may have led to a deterioration in
 4 mental health for people with pre-existing severe mental
 5 health.

6 One contributor to Every Story Matters said:

7 "Having no routine, no social interaction, no
 8 exercise classes, no distractions, my mental health
 9 issues got progressively worse. I struggled to adapt,
 10 felt isolated and became angry. I had no control over
 11 my external environment and didn't have any coping
 12 skills to manage my emotions. I fell back into patterns
 13 of self-harm, developed an eating disorder and started
 14 relying on alcohol to cope with the days."

15 Another contributor from Scotland told the Inquiry:

16 "I've struggled with my mental health since I was 11
 17 and lockdown only made it worse ... My depression
 18 worsened because of [a] lack of social connection and
 19 I wasn't really talking to my family. It all got really
 20 hard and I was self-harming multiple times a day, every
 21 day."

22 Inequities experienced by those who suffered from
 23 severe mental health were generally perceived to have
 24 deepened during the pandemic. Professor Das-Munshi will
 25 explain that people with severe mental illness were more

23

1 likely to die from all causes during the pandemic,
 2 including Covid-19.

3 Prior to the pandemic, heightened risks of mortality
 4 for people with severe mental illness was already a
 5 well-known concern. Across most diagnoses, the risk of
 6 death from non-Covid causes was at least double the
 7 population average, and this continued through the
 8 pandemic period. However, excess deaths from Covid-19
 9 were of particular concern, including for people with
 10 conditions such as schizophrenia, dementia and eating
 11 disorders, who experienced high Covid-19-related deaths
 12 at a rate greater than within the general population.

13 To the extent possible, we will explore with
 14 Professor Das-Munshi whether this was a predictable
 15 exacerbation of existing inequalities, attributable to
 16 the pandemic or to particular measures in response.

17 During the first wave of the pandemic, there was
 18 a decrease in psychiatric presentations to emergency
 19 departments, including fewer acute mental health
 20 presentations. Professor Osborn, a clinical professor
 21 of psychiatric epidemiology at University College
 22 London, has referred in his report to research from
 23 three teams and two centres in central London, showing
 24 a 22 per cent reduction in psychiatric presentations
 25 during the first week of the pandemic and a 48 per cent

24

1 reduction in emergency department presentations in the
 2 month following the first lockdown.

3 This aligned with the introduction of measures in
 4 response to the pandemic and public health messaging
 5 encouraging people to stay away from emergency
 6 departments where possible.

7 Professor Das-Munshi also refers to:

8 "... important changes to service use during the
 9 pandemic which may indicate some changes to symptoms
 10 during this period. For example, a UK study of primary
 11 care contacts in the early part of the pandemic ...
 12 suggested large reductions in people seeking primary
 13 care for a range of conditions, including severe mental
 14 health conditions.

15 Professor Osborn notes that reduced presentations to
 16 GP services were observed in the first wave of the
 17 pandemic, returning to pre-pandemic expected levels by
 18 September 2020. There was a decrease in prescriptions
 19 for medications for mental health conditions in the
 20 first wave of the pandemic, but these levels returned to
 21 pre-pandemic levels after the first wave (March to
 22 August 2020).

23 While there were fewer referrals in the initial
 24 lockdown period, this rebounded to some extent after the
 25 lockdown period. Moreover, the reduction was not felt

25

1 in crisis team referrals or the rates of police using
 2 powers of detention under the Mental Health Act 1983,
 3 suggesting that urgent mental health needs continued
 4 through the early wave of the pandemic.

5 While people did present -- when people did present
 6 to services, they may have presented with more acute
 7 symptoms. One contributor told Every Story Matters:

8 "I came close to ending my life. I was admitted to
 9 hospital following a suicide attempt. I feel the
 10 admission could have been avoided if I'd been able just
 11 to sit down and talk with a skilled counsellor or
 12 therapist or in a group environment."

13 There is some evidence that, during the pandemic,
 14 a greater proportion of patients were detained under the
 15 Mental Health Act. For example, in Scotland, there were
 16 9.1 per cent more detentions in 2020 to 2021 than in
 17 2019 to 2020. Possible explanations to be explored
 18 include whether patients were responding to Covid-19
 19 anxiety or public messaging to stay at home and were
 20 thus less likely to seek help.

21 Some inpatient wards were closed or converted to
 22 provide Covid care. The risk of infection in inpatient
 23 care was considered high and some patients were
 24 transferred home to reduce risk.

25 Professor Osborn notes some reports of an increase
 26

1 in rapid discharges with the focus on freeing up beds.
 2 There was a reduction in patient admission during the
 3 first wave of the pandemic, although there may have been
 4 some degree of variation across the devolved nations,
 5 and differences in local practices. Following lockdown,
 6 there were fewer discharges, but caseloads reportedly
 7 remained lower than pre-lockdown levels.

8 For those in hospital, visits were inevitably
 9 impacted. There was less face-to-face contact and fewer
 10 therapeutic activities for patients. There was a lack
 11 of opportunity for patients to participate in activities
 12 outside of the ward.

13 During the acute waves of the pandemic, there were
 14 reported staff shortages, which impacted service
 15 delivery. Some staff were redeployed to support
 16 Covid-19 care. There were also long-term impacts for
 17 the NHS mental health workforce, with a high level of
 18 burnout and elevated rates of mental health problems for
 19 healthcare workers.

20 A specialist mental health nurse told Every Story
 21 Matters:

22 "We were burnt out physically and emotionally.
 23 Every Covid test before a shift was an anxiety moment
 24 because you knew if you tested positive you'd be leaving
 25 your staff team dangerously short staffed. You'd end up

27

1 doing double shifts to cover staff sickness at detriment
 2 to your own mental health because you can't leave the
 3 patients in a dangerous situation."

4 Another contributor said:

5 "The staff I worked with gave their all on where
 6 there wards to keep patients and each other safe. Some
 7 suffered or are suffering with PTSD, others with anxiety
 8 and depression or worse. Burnout is evident from this
 9 profession. I am, along with others, in counselling to
 10 deal with the trauma and after-effects of working in
 11 these environments with the pressures described."

12 There was reduced access to community care across
 13 the NHS and voluntary sector services for people with
 14 severe mental illness during the first phase of the
 15 pandemic. Many stopped all in-person contact.

16 You will hear this had a particularly damaging
 17 impact for those with pre-existing severe mental
 18 illness. One contributor told Every Story Matters that
 19 they experienced a significant relapse in their bipolar
 20 disorder, having been unable to access their GP for
 21 face-to-face appointments.

22 Some patients described looking for alternative
 23 sources of support, including in online support groups,
 24 social media, self-management and support from community
 25 or faith-based services.

28

1 While the transition to life online and remote and
 2 online care during the pandemic was a positive step
 3 welcomed by some, this may have widened the inequity of
 4 impact for some particularly vulnerable groups. The
 5 rapid transition to remote consultation was seen as
 6 a success in the pandemic. However, it did not work for
 7 everyone and was reported to have generated difficulties
 8 for patients and staff alike.

9 As one contributor to Every Story Matters said:

10 "I have serious mental illness (schizoaffective
 11 disorder and the lockdowns hit me hard. I was limited
 12 to phone contact for a two-year period. In that time,
 13 I saw a mental health professional face-to-face only
 14 twice. I believe that period had a devastating impact
 15 on my mental wellness. I felt like no-one cared about
 16 me. I felt utterly abandoned by everyone."

17 As Professor Osborn explains in his report:

18 "Remote technology was viewed positively but there
 19 were major concerns that some groups of people with
 20 serious mental illness were unable to engage with remote
 21 interventions due to technological and physical barriers
 22 as well as digital skills. This raised concerns about
 23 widening inequalities in care provision including to
 24 older people. Staff were concerned that remote
 25 consultations diminished therapeutic relationships with

29

1 patients and were not suitable for assessing complex
 2 mental health issues including risk."

3 Further, he acknowledges that difficult decisions
 4 were being taken in facing the risk of infection:

5 "Staff reported a tension between trying to provide
 6 responsive and high-quality care with the need for
 7 infection control. Service users strongly preferred
 8 face-to-face conversations, and some felt suspicious or
 9 anxious about remote services. Staff also indicated
 10 that service users expressed the inability to engage
 11 with remote mental health care due to lacking equipment
 12 and sufficient internet connection, lacking skills or
 13 confidence to engage with tele-health or lacking
 14 suitably private environments for remote appointments."

15 A psychotherapist told Every Story Matters:

16 "In 2020, I was working in an NHS mental health
 17 service. When the first lockdown was announced we were
 18 told to switch all our patient appointments to online or
 19 telephone overnight. For some patients, for example
 20 those with poor hearing or people in domestic violence
 21 situations who didn't have a safe space to talk, this
 22 made the service inaccessible."

23 The historic issue of higher levels of involuntary
 24 admissions of black and other ethnic minority groups has
 25 been recognised, in England at least, in the independent

30

1 review of the Mental Health Act, pre-pandemic. There is
 2 some evidence of increased healthcare needs during the
 3 pandemic particularly for black and other ethnic
 4 minority groups.

5 Professor Das-Munshi notes one study which indicated
 6 that:

7 "During the first lockdown in the UK, although
 8 overall admissions to mental health units dropped,
 9 a larger proportion of admissions were compulsory
 10 detentions, which were mostly driven by higher
 11 compulsory admissions in Black Caribbean mental health
 12 service users. In the second lockdown, compulsory
 13 detentions were elevated in the Black Caribbean and
 14 Black African groups, compared to pre-pandemic periods.
 15 Higher levels of compulsory detentions in people with
 16 severe mental illness during the Covid-19 pandemic,
 17 against a backdrop of lower overall admissions, could
 18 suggest that a significant subset of the population
 19 experienced severe exacerbations of their mental health
 20 and were not able to access preventative timely
 21 interventions to prevent mental health relapses during
 22 the earlier stages of the pandemic. These findings may
 23 also suggest that pre-existing social, economic and
 24 health inequalities, alongside structural racism were
 25 further magnified during the pandemic, which was

31

1 associated with higher levels of compulsory admissions
 2 in Black Caribbean and Black African people."

3 Professor Osborn also notes that there was a higher
 4 incidence of first episode of psychosis in black and
 5 Asian groups prior to the pandemic, which may be
 6 explained by structural inequalities, however, the
 7 pandemic further exacerbated this already higher rate of
 8 incidence.

9 We will return to the issue of unequal impact and
 10 vulnerability as an issue of priority focus for this
 11 module as the impact on wellbeing and mental health was
 12 felt more keenly by some groups, not limited to black
 13 and ethnic minority people. The Evidence Review
 14 concludes:

15 "While the Covid-19 pandemic led to a widespread
 16 deterioration in mental health across the UK adult
 17 population, its impact was highly uneven. This
 18 unevenness served to magnify pre-existing social and
 19 economic inequalities with certain groups experiencing
 20 significant greater challenges and slower recoveries."

21 My Lady, when we come back after the break, I will
 22 continue to open these hearings relating to mental
 23 health and wellbeing.

24 **LADY HALLETT:** Certainly. Thank you very much. I shall
 25 return at midday.

32

1 (11.45 am)
2 (A short break)

3 (12.00 pm)
4 LADY HALLETT: Ms Blackwell.

5 MS BLACKWELL: My Lady, as part of the evidence on mental
6 health and wellbeing, you will hear concern over data
7 gaps in relation to ethnicity and other protected
8 characteristics and there may be inconsistency in the
9 availability of data and analysis across the devolved
10 areas of the UK. For example, Professor Das-Munshi says
11 her:

12 "... review of the evidence highlighted a dearth of
13 data and high-quality research around impacts, in people
14 with severe mental health illness with ethnicity and
15 other protected characteristics, and from devolved
16 nations.

17 The Evidence Review was also cautious in relation to
18 the data available, for example in relation to
19 transgender people:

20 "Transgender and gender diverse individuals are
21 notably underexamined due to data limitations (for
22 example, the lack of specific questions regarding gender
23 identity in large population-based surveys, small
24 population samples, and recoding/recording studies to
25 binary gender)."

33

1 The paucity of data to allow for the effective
2 understanding of impact is an issue already recognised
3 by the Inquiry and one to which we will return during
4 these hearings.

5 While periods of acute mental health crisis may
6 overlap with periods of greatest restriction, there is
7 evidence of adverse impacts on wellbeing and mental
8 health continuing throughout the pandemic period. While
9 there were signs of partial recovery in periods with
10 fewer restrictions, a significant proportion of people
11 were still struggling.

12 The Evidence Review concludes:

13 "Although overall mental health seemed to improve
14 for a while, studies that followed people over time
15 showed that almost 40 per cent of people kept feeling
16 high levels of stress or distress across several
17 lockdowns. This means that the general improvements hid
18 the fact that many people were still struggling. This
19 enduring impact highlights that the pandemic was not
20 merely a temporary disruption, rather it revealed and
21 exacerbated systemic inequalities in mental health
22 across the UK."

23 Levels of general mental ill health across the UK
24 population had not returned to pre-pandemic levels by
25 the end of the pandemic period, nor by mid-2023. We

34

1 will explore with witnesses the extent to which this may
2 or may not be attributed to the pandemic or measures in
3 response or to other factors. The effects of Long Covid
4 have been identified as one ongoing challenge. The
5 continuing impact of bereavement and loss remains
6 another consistent feature in the evidence heard by the
7 Inquiry.

8 It may be that the long-term and sustained impact of
9 the pandemic on mental health and associated services
10 are yet to be understood. We will consider what lessons
11 may be learned for the future from the experience of
12 individuals and the knowledge of the experts.

13 I turn now to our second topic.

14 Our second topic from our scope is community impact.
15 Some degree of disruption to community life for the
16 purposes of infection control in response to the
17 pandemic was unavoidable. Once lockdown became
18 inevitable, the degree of disruption was unprecedented
19 but not unpredictable.

20 This module does not attempt to consider every
21 aspect of how our communities, large and small, rural
22 and urban, were impacted by the pandemic and the
23 measures in response. However, this module considers
24 some key impacts on community life such as sport,
25 leisure and cultural institutions. There is also

35

1 evidence about the societal impact of the closure and
2 reopening restrictions imposed on the hospitality,
3 retail, travel and tourism industries and on places of
4 worship.

5 My Lady, the burden of ensuring that community life
6 could continue to the extent that it did rested in large
7 part upon the key workers who were entrusted with
8 keeping the country operational throughout the pandemic.
9 You will hear evidence about their contributions and
10 their sacrifices and the impact upon them of what they
11 were required to do.

12 You will also hear evidence about the impact of the
13 pandemic on our communities caused by disruption to
14 institutions such as the justice system.

15 But first, cultural institutions, retail,
16 hospitality, travel and tourism, community sport and
17 leisure. The impact on each of these elements of our
18 community life was devastating. The impact on the
19 economic life of our communities and, in particular, the
20 economic viability of businesses most impacted by the
21 pandemic, and the measures in response, were touched
22 upon in Module 9. We do not repeat that work, but we
23 consider the societal impact on the pandemic across
24 these sectors, and these are shared themes in the
25 evidence to which Ms Rahman King's Counsel will return

36

1 tomorrow in introducing the roundtable reports.

2 Lockdown in the early stages of the pandemic meant
3 total lockdown for many. As restrictions eased,
4 substantial change was often required to manage risk and
5 to give customers, consumers, members or service users
6 confidence to return. Behaviours changed and adapted
7 with the evolution of the pandemic and the measures in
8 response. The Business Leaders Roundtable discussed the
9 shift to greater support for local community retail,
10 with one attendee noting that:

11 "... there was some recognition about how important
12 it was to have retail services close to where you live
13 and I think that changed consumer behaviours."

14 However, another change observed was a shift away
15 from the late-night economy to more socialising at home,
16 with a reluctance on the part of younger people to
17 return, in the absence of habits formed during the
18 pandemic period.

19 A common theme throughout the evidence is that
20 guidance and communications issued in response to the
21 pandemic did not take a sufficiently sector-specific
22 targeted approach. UKHospitality told the Business
23 Leaders Roundtable:

24 "Government guidance was general and not tailored to
25 the specific needs or diverse hospitality subsectors,

37

1 thus making it challenging to apply effectively across
2 different types of businesses. The sector struggled
3 right with translating broad principles into practical,
4 actionable steps for the wider variety of hospitality
5 settings, like restaurants, hotels, and children's play
6 centres."

7 Variations in guidance across the devolved nations
8 caused confusion, particularly for businesses and
9 organisations operating nationally or across borders.
10 For example, VisitBritain raised the impact on UK coach
11 operators of coach tours which operated across borders,
12 and concerns that the confusion in guidance led to
13 businesses not following appropriate rules. The timing
14 of guidance and changes to guidance were cited as
15 a particular issue.

16 The Federation of Small Businesses said:

17 "There was a tendency for the smaller iterations [of
18 guidance] to be finished by end of day Friday, which
19 made it difficult for head offices [implementing]
20 knock-on processes. This meant staff would have to
21 translate the guidance to make it easier to understand."

22 Advantage Travel Partnership similarly emphasised
23 that guidance often came last minute and via social
24 media, without sufficient detail to allow for effective
25 implementation. There was a view expressed that, as

38

1 a more collaborative relationship developed, industry
2 and organisations improved guidance, leading to
3 a greater level of clarity. An example given was work
4 done by the British Retail Consortium and unions such as
5 USDAW on workplace safety, such guidance then being
6 adopted by government.

7 A particular concern was expressed over the
8 distinction between essential and non-essential business
9 being inconsistent or without a clear rationale.
10 Non-essential businesses that had to close at short
11 notice found their trade, consumers and staff were
12 immediately impacted, and their long-term financial
13 resilience was affected.

14 As businesses, organisations and clubs shut down,
15 this impacted significantly on staff and volunteers,
16 some of whom did not return when venues reopened.

17 Those attending the Business Leaders Roundtable
18 spoke the high levels of job insecurity across all
19 business sectors. There was an appreciation that
20 resource and talent had been lost. This was felt
21 particularly keenly by cultural institutions and
22 freelance workers.

23 The Paul Hamlyn Foundation told the Cultural
24 Institutions Roundtable that the pandemic supposed
25 exposed weaknesses in the sector:

39

1 "The issue of burnouts, leaders leaving the
2 industry ... with everything shut down and creative
3 attempts to keep different types of work going, it
4 really exposed the complex web of inequalities and
5 pressures of our sector."

6 Loss of talent extended into other sectors.

7 VisitBritain told the Business Leaders Roundtable:

8 "That whole bit about chefs going off and driving
9 for Amazon ... it did lead to a big drop off in terms of
10 talent we were able to hold on to, but also in terms of
11 talent we were able to attract."

12 Volunteers were also impacted, particularly in
13 community sports and cultural institutions.
14 Volunteering declined during the pandemic and many were
15 reluctant to return during the period of reopening while
16 still considered to be at risk.

17 As the pandemic restrictions continued, businesses
18 were required to innovate. Businesses adapted by
19 accelerating online capabilities, making use of outside
20 spaces and adapting to changes in consumer behaviour.
21 For example, as restrictions eased, pubs and restaurants
22 introduced the use of QR codes and apps to reduce direct
23 contact.

24 However, not all businesses and organisations were
25 able to adapt, whether due to opportunity, capacity or

40

1 resources. Those businesses who couldn't adapt found it
 2 difficult to survive.

3 The pandemic also led to innovation and opportunity
 4 in terms of how community sports and leisure was
 5 delivered. Clubs and classes moved online, providing
 6 free access to equipment for use at home and hosting
 7 social events outdoors. There was an increase in
 8 activities such as walking, running, cycling and "at
 9 home" fitness. Evidence suggests that net levels of
 10 physical activity fluctuated, decreasing but then rising
 11 again.

12 A statement from Sport England explained to the
 13 Inquiry that recovery to pre-pandemic levels of activity
 14 did not occur until mid-November 2021 into 2022. Again,
 15 there were disparities also across demographic groups
 16 and inequalities were magnified.

17 During the pandemic, cultural institutions also
 18 explored different kinds of innovation including through
 19 outdoor events and the use of digital platforms. There
 20 is some evidence that innovation and outreach led to new
 21 contact with communities who had not before engaged with
 22 the arts.

23 The Arts Council England told the Cultural
 24 Institutions Roundtable that:

25 "many organisations connected with their local

41

1 communities in a way they'd never done before."

2 For many, the impact of closure was more
 3 straightforward than reopening. The British Retail
 4 Consortium noted the operational complexity involved
 5 questioning:

6 "the idea you could tell the country we're opening
 7 on Monday and expect staff to be in place, things to be
 8 sorted. Closing down was much easier than opening."

9 As venues, services and facilities began to reopen,
 10 older people, disabled people and people who were
 11 clinically vulnerable remained concerned about the risk
 12 of contracting Covid-19. You will hear that concern
 13 over infection remains a substantial concern for those
 14 who live with clinical vulnerability.

15 Hospitality Ulster told the Business Leaders
 16 Roundtable that this impacted on both businesses and
 17 consumers:

18 "As we reopened, the more vulnerable people stayed
 19 away. Younger people came back because I think they
 20 thought they were invincible. We still have a legacy
 21 where more vulnerable people still don't feel safe to
 22 come back."

23 Turning to faith and places of worship. Many of the
 24 themes which we have just looked at are also reflected
 25 in the evidence on the impact resulting from the closure

42

1 of places of worship.

2 Ms Rahman King's Counsel will be drawing your
 3 attention to the descriptions given at the Faith Leaders
 4 and Places of Worship Roundtable of a profound sense of
 5 distress and loss. You will also hear from Daniel
 6 Singleton of FaithAction on how the closure of religious
 7 spaces had a significant impact on faith groups' worship
 8 practices. An inability to host religious festivals
 9 impacted religious practice. Some practices were less
 10 religiously meaningful when not carried out in person.

11 The evidence on the impact of places of worship
 12 closing raises particular questions of cultural and
 13 religious sensitivity and equality. The loss of
 14 religious community spaces has been linked to a negative
 15 impact on the wellbeing of those who had been regular
 16 attendees, especially older people.

17 There was resentment among some faith groups who
 18 believed that measures in response to the pandemic and
 19 associated guidance failed to consider different
 20 religions equally. Similarly, it was believed that a
 21 failure to prioritise faith over the reopening of
 22 non-essential retail, pubs and leisure facilities showed
 23 a disrespect for people of faith and the role of faith
 24 in daily life and resilience.

25 Some faith leaders felt it was difficult to engage

43

1 with the UK Government over pandemic policies and
 2 guidance so that these could be tailored to what was
 3 appropriate for their religious practices as far as
 4 possible within the confines of the scientific advice.

5 Restrictions on in-person community services
 6 normally held in religious buildings led to some faith
 7 groups providing pandemic-specific services to
 8 vulnerable people. The pandemic also had a mixed impact
 9 on volunteering through faith groups causing some to
 10 stop due to vulnerabilities while prompting others to
 11 start volunteering.

12 The closure of physical sites of worship led to an
 13 increase in online services and worship across
 14 religions. There is evidence suggesting an increase in
 15 attendance with this format despite experiences of
 16 technological difficulties, the theological
 17 implications, inequality of digital access and religious
 18 restrictions on the use of technology. For example,
 19 Daniel Singleton of FaithAction told us:

20 "Our women's multifaith group, particularly those
 21 who were Muslim, reported an increased attendance in
 22 women when services moved online because it made
 23 services more inclusive from a female perspective,
 24 increasing discretion and privacy. Buddhist groups
 25 noted that online services allowed them to connect with

44

1 others that they couldn't normally interact with, as
 2 well as build an international community. For example,
 3 online services enabled over 1.5 million people to watch
 4 teaching from the Dalai Lama."

5 You will hear from FaithAction that, at a community
 6 level, there was some constructive collaboration between
 7 community groups and local authorities. There were also
 8 positive contributions being made by non-profit
 9 organisations including in the setting up and running of
 10 food banks as reflected in the evidence of the Joseph
 11 Rowntree Foundation. We will explore evidence that
 12 innovation in the approach to maintaining community and
 13 community relationships including through the expansion
 14 of digital technology, was positive, but excluded those
 15 without access to digital technologies or otherwise
 16 incapable of accessing digital life.

17 My Lady, I turn now to key workers whose
 18 contribution and resilience is a significant chapter in
 19 the story of how Covid-19 impacted the UK as a nation.

20 You will hear that the definitions of key, essential
 21 and critical workers varied over the pandemic, and
 22 indeed that the approach to definitions and
 23 categorisation created some confusion and frustration.

24 By any definition, the pandemic significantly
 25 impacted key workers across all sectors, not least due

45

1 to the fear of contracting Covid-19 themselves, or
 2 passing it on to others.

3 Module 3 addressed the unique experience of
 4 healthcare workers, and Module 6 the experience of those
 5 working in the care home sector. However, key workers
 6 included many: from bus drivers to cleaning operatives,
 7 from those carrying out emergency services, to teachers,
 8 from those working in factories, to those stacking food
 9 on our shelves.

10 At the Key Workers Roundtable, an initial sense of
 11 pride was described, as people were recognised for their
 12 important roles in the early stages of lockdown,
 13 particularly in the retail, police and justice sectors.
 14 However, this early experience was not shared in all
 15 sectors and was short-lived in others.

16 Key workers may not, for the most part, have
 17 experienced the same financial or job insecurities
 18 experienced by the general workforce during the
 19 pandemic. But they faced their own substantial risks
 20 and fears. One key services worker in England summed up
 21 their experience for Every Story Matters:

22 "Colleagues were literally terrified from the
 23 outset ... We felt 'disposable', made to continue to
 24 bring in the revenue despite the known risks. Families
 25 of colleagues were anxious and worried about loved ones

46

1 out there and when you came home, what were you bringing
 2 in? Arguments and questions put enormous strain on
 3 families and relationships. The risk assessments
 4 implemented by the company were not adequate or
 5 reflected the work we did. Many felt let down, failed
 6 and used."

7 Key workers may have faced higher infection and
 8 mortality risks, but this varied by occupation. As you
 9 will hear, mortality data is held by profession, not
 10 specific key worker status. Transport and mobile
 11 machine drivers and operatives had the highest
 12 age-standardised rates of Covid-19 mortality --
 13 78.7 Covid-19 deaths per 100,000 person-years -- amongst
 14 the occupational data collected by the Office of
 15 National Statistics.

16 Yet teaching and educational professionals had the
 17 lowest age-standardised rates of Covid-19
 18 mortality: 16.9 Covid-19 deaths per 100,000
 19 person-years.

20 Anxieties and tensions impacted negatively on the
 21 mental health of key workers. While the individual
 22 experience of key workers varied, there was shared fears
 23 and concerns. First, as to risks of infection. You
 24 will hear concerns about accessibility and effectiveness
 25 of PPE and as to the methods of safe working. For

47

1 example, that social distancing requirements did not
 2 take into account the close proximity in which
 3 firefighters would be required to work.

4 Social distancing was impossible for nursery workers
 5 providing care for young children, prison officers who
 6 needed to restrain prisoners, and police officers
 7 visiting Covid-positive households.

8 A prison officer told Every Story Matters:
 9 "I work in the prison service so continued, as I was
 10 a key worker ... we felt like we were cannon fodder as
 11 no-one seemed to care about our welfare, no social
 12 distancing in work, we were scared of what could happen
 13 while trying to do our jobs."

14 There were particular fears over physical working
 15 environments. Key workers in education discussed how
 16 air filtration systems were available but were not
 17 installed when needed. A police officer said:

18 "It was never mentioned on television ... police
 19 officers catching Covid and spreading it among
 20 colleagues and probably the public due to a mostly
 21 windowless building."

22 The Welsh Local Government Association have told us:
 23 "Impacts on key workers were many and various; all
 24 workforce groups needed to conform with adjustments --
 25 to a lesser or greater extent -- to well-established

48

1 work practices ... Many of these working methods were
 2 unfamiliar; at times they led to some employees feeling
 3 uncomfortable and/or isolated."

4 Second, as to confusion over guidance, and working
 5 requirements which extended to the definition of key
 6 workers and when they were considered to be acting in
 7 that role. Retail workers and council officers
 8 described how guidance was difficult to understand and
 9 often changing. Uncertainty over guidance on the part
 10 of key workers extended to those who were responsible
 11 for interpreting and implementing the guidance in the
 12 course of their own work.

13 A priest in England told Every Story Matters:

14 "Doing funerals was the hardest thing I did,
 15 explaining the rules and how I was going to interpret
 16 and enforce them. How our building would be prepared.
 17 Holding the anger of people was really difficult
 18 emotionally."

19 Third, as to privacy and the boundaries between work
 20 and home, one teacher has told the Inquiry:

21 "The second lockdown ... I spent all day at work
 22 teaching the ones in school then setting all the online
 23 work and communicating with the home school group after
 24 work in my own time. I didn't have any energy left to
 25 home school my own children."

49

1 Fourth, staff shortages and pressure to continue
 2 working rather than self-isolate or shield, including
 3 for clinically vulnerable key workers and key workers
 4 from clinically vulnerable families.

5 A firefighter explained:

6 "I was a front-line emergency services worker during
 7 the pandemic. I felt that little was done to protect
 8 us. Staff were regularly in close contact with staff
 9 from other areas as a way to cover shortfalls in
 10 staffing and external contractors were brought onto our
 11 premises in large numbers throughout lock down. Yes,
 12 shortfalls needed to be covered, but arrangements were
 13 given little thought meaning that staff from a 70 by 30
 14 mile geographical area regularly intermingled."

15 A funeral director said:

16 "The pressure was relentless. With the surge in
 17 deaths my colleagues and I found ourselves working
 18 70+ hour weeks, often without a break. There was no
 19 respite, no downtime, just an endless stream of services
 20 to organise, people to prepare and families to console."

21 Finally, key workers expressed fears over infection
 22 and transmission of infection to family members. The
 23 fear of spreading Covid-19 to loved ones was very real
 24 for key workers, particularly those who were clinically
 25 vulnerable or who had vulnerable family members. Many

50

1 described actions taken to protect family, and for some
 2 those actions became habitual, with some developing
 3 anxiety or OCD-like symptoms.

4 One cleaner told the Every Story Matters that her
 5 daughter was pregnant and her son had mosaic Down
 6 syndrome, rendering them both clinically vulnerable.
 7 She described her fears when her family caught Covid-19.
 8 Staff at her workplace had been reusing PPE.
 9 Tragically, her son died in hospital from Covid-19. She
 10 said:

11 "My son died without any family member being with
 12 him. I will always carry the blame for causing his
 13 death as I took Covid into our home ... I reported
 14 incidents to my employer and to the workplace both
 15 before and after my son's death ... Eventually
 16 I contacted health and safety through the local council
 17 who took matters very seriously and dealt with every one
 18 of my concerns and complaints which were upheld and
 19 which of course led to my resignation at the workplace
 20 ... my employer wanted to sack me."

21 Many key workers said they did not feel appreciated
 22 for the personal sacrifices they made and the risks they
 23 took during the pandemic. One council worker told Every
 24 Story Matters:

25 "Quite frankly, we were used as lambs to the

51

1 slaughter and the staff did their best to keep
 2 everything running while the management hid away and
 3 basically glory-chased. As long as they could say they
 4 provided a service while they were safe at home, they
 5 were happy. We had to fight to get the full PPE we
 6 needed. We had to fight to get hand sanitiser."

7 One teacher said:

8 "On top of this stress, the media portrayed teachers
 9 as lazy. The reality was far from that. This led to
 10 huge amounts of stress. I did not sleep. I developed
 11 OCD around cleaning and hand washing and lived in
 12 absolute fear of contracting Covid. I would cry every
 13 day before having to go to work and spend my day in
 14 a high state of anxiety."

15 Frontline workers said they faced anger and abuse,
 16 including some physical violence from members of the
 17 public when enforcing measures in response to the
 18 pandemic. This was not limited to police and emergency
 19 service workers. A supermarket worker in Wales told
 20 Every Story Matters:

21 "While in work we would be subject to abuse daily.
 22 I've been spat on for refusing entry without a mask.
 23 I've been called racist for enforcing the same rules
 24 I enforced on everyone else and I would have people
 25 every day tell me that [Covid's] not real, it's a joke."

52

1 Key workers described long-lasting and detrimental
 2 impacts on their mental health. However, for some,
 3 continuing to work during the pandemic provided purpose
 4 and routine, helping to alleviate anxiety and stress.
 5 Some key workers said the pandemic had brought greater
 6 recognition to the work they did and gave them a sense
 7 of pride in the contribution they made to the pandemic
 8 response, including, in particular, key workers in the
 9 transport, food and retail sectors.

10 A funeral director told Every Story Matters:

11 "Yet through all this, we kept going. We showed up
 12 every day, often without the support or recognition we
 13 deserved, because it was our duty to help families in
 14 their darkest hours. We provided compassion, dignity
 15 and care when it was needed most. Working as a funeral
 16 director during the pandemic was a trial by fire, but it
 17 also reaffirmed the importance of our work and our
 18 commitment to serving others, even when no-one was
 19 looking."

20 You will hear that there is evidence of a particular
 21 prevalence of Long Covid among key workers in the
 22 education sector. ONS data records that:

23 "The number of education staff self-reporting Long
 24 Covid symptoms rose by over 15 per cent between
 25 December 2021 and January 2022, from 3.09 per cent to

53

1 3.79 per cent of the total workforce."
 2 One childcare worker told the Inquiry:
 3 "I and the members of the team I work with are
 4 suffering with symptoms of Long Covid. We have lost
 5 staff at a dramatic rate due to the lack of concern or
 6 respect by anyone in authority of the childcare sector."
 7 We will consider lessons that may be learned from
 8 these experiences. My Lady, you will hear evidence from
 9 experts and from the TUC -- four witnesses representing
 10 different areas of the UK workforce, here to recount
 11 their experiences of how the pandemic impacted upon
 12 them. You will be able to reflect on what they have to
 13 tell the Inquiry but cross-cutting themes already
 14 emerging include a lack of clarity in government
 15 messaging and the confusion which this caused.

16 Turning to institutional impact and to users of the
 17 justice system. The impact of the pandemic on our
 18 communities includes that felt by many of our
 19 institutions. Taking one example, we consider the
 20 changes in the justice system as experienced by its
 21 users, from police officers to legal and administrative
 22 staff working at courts, including volunteers. There
 23 was a reported lack of clarity over key workers and
 24 others working within the system. Those who qualified,
 25 and were not prevented from working for health reasons,

54

1 bore a heavier than usual burden.

2 You will hear from Christopher Minnoch, chief
 3 executive of the Legal Aid Practitioners Group, that the
 4 pandemic had a:

5 "significant and adverse impact on the mental health
 6 and wellbeing of those -- of both those seeking legal
 7 advice and those providing legal advice. Throughout the
 8 pandemic, many practitioners were forced to spend more
 9 nights in police stations and cover more remand hearings
 10 in the day. Members were required to have meetings with
 11 vulnerable clients conducted over video but reported
 12 significant variations in the reliability of technology.
 13 Members reported the additional strain of trying to
 14 assist distressed remand prisoners who were locked in
 15 their cells for 23.5 hours a day."

16 As you are aware, my Lady, there were widespread
 17 delays to legal proceedings caused by courts not sitting
 18 at all at the beginning of the pandemic and the
 19 resulting later shift to remote hearings. The pandemic
 20 made it harder for some victims of crime to access
 21 support from families, friends and organisations. Court
 22 delays during the pandemic may have undermined victims'
 23 confidence including in whether they would achieve a
 24 timely outcome. For example, in the Domestic Abuse and
 25 Safeguarding Roundtable, the Inquiry heard:

55

1 "The pandemic restrictions led to challenges for the
 2 court system and this was said to have affected domestic
 3 abuse cases. Courts were shut down with limited
 4 emergency processes in place. This created longer
 5 waiting times and unclear expectations on whether
 6 hearings would take place in person or online and led to
 7 a reduced trust in the justice system. It caused some
 8 victims and survivors to question whether to continue
 9 with cases. The court delays also had a negative impact
 10 on the wellbeing and feelings of safety for victims and
 11 survivors. Representatives felt that these challenges
 12 highlighted the need for greater flexibility and
 13 innovation in the court system to better support victims
 14 and survivors of domestic abuse."

15 Vulnerable people found it harder to access justice
 16 beyond the criminal courts, including in matters of
 17 family law and immigration hearings. These issues were
 18 addressed in the evidence of the Domestic Abuse Group
 19 and Migrant Rights Consortium respectively. Effective
 20 justice became more difficult in the face of pandemic
 21 restrictions. The pandemic had an immediate and adverse
 22 impact on the justice system itself, those who worked
 23 within it, and on the ability of members of the public
 24 to obtain access to justice. Christopher Minnoch has
 25 told the Inquiry:

56

1 "The pandemic intensified existing strains on
 2 practitioners already struggling after more than a
 3 decade of fee cuts, falling prosecution rates and a
 4 declining provider base, undermining public access to
 5 advice ... but ... the most significant impact on those
 6 affected by the operation of the criminal justice system
 7 (defendant, victims and witnesses) has been the large
 8 increase in court backlogs and delays in listing and
 9 hearing trials."

10 The introduction of digital technology-based
 11 solutions led to positive outcomes for some in the
 12 justice system. Victim Support Scotland told the
 13 Justice System Roundtable about positive feedback from a
 14 pilot scheme for remote hearings in criminal cases that
 15 indicated that online hearings removed the fear of
 16 seeing the accused in-person at court which made the
 17 victim feel safer and better able to engage in the court
 18 process.

19 The Justice System Roundtable recorded that
 20 participants considered that the shift towards remote
 21 court hearings:

22 "had some positives, improving efficiency, and
 23 enabling the courts to maintain legal processes in
 24 exceptional circumstances."

25 However, the introduction of digital solutions left

57

1 some users vulnerable and unsupported with the same
 2 level of support not offered as in face-to-face
 3 hearings. The response in the courts was managed
 4 differently across the distinct and separate justice
 5 systems across the UK.

6 Representatives from Scotland in the Justice System
 7 Roundtable described a reluctance in Scotland to
 8 transition to online hearings which, it was said,
 9 contributed to court delays.

10 However, this is an area where it appears that
 11 innovation driven by the pandemic, whilst initially
 12 viewed with hesitancy and caution, has resulted in
 13 lasting change beyond the pandemic for users of the
 14 justice system.

15 The pandemic had a significant impact on the
 16 functioning of the coroners service, which affected
 17 access to inquests, including how and when inquests were
 18 conducted.

19 Unlike other areas and divisions of the UK justice
 20 systems, these impacts were felt by every person who
 21 lost a loved one during this period.

22 You have received written evidence from the
 23 Chief Coroner of England and Wales, Her Honour
 24 Judge Alexia Durran, Mr Patrick Butler, on behalf of the
 25 Presiding Coroner for Northern Ireland, and the Crown

58

1 Agent and Chief Executive of the Crown Office and
 2 Procurator Fiscal Service, Mr Stephen McGowan.

3 Each of them have explained that access to coronial
 4 investigations or, in the case of Scotland, fatal
 5 accident inquiries, changed as a result of the pandemic.
 6 This included an explanation of how legislative changes
 7 were introduced by all governments in order to pause or
 8 relax certain procedural rules, thereby enabling the
 9 legal systems to continue to function.

10 At the time that the pandemic struck, in England,
 11 Covid-19 was notifiable disease under the Health
 12 Protection (Notification) Regulations 2010, but a death
 13 from Covid-19 did not require a referral to be made to
 14 a coroner. This meant that during the pandemic, such
 15 deaths were only referred if they fell within the
 16 notification obligations set out elsewhere in the
 17 relevant legislation, or if someone was concerned about
 18 the death and chose to contact a coroner.

19 The Lord Advocate instructed the same approach to be
 20 taken in Scotland consistent with that taken in relation
 21 to previous significant outbreaks of infectious disease,
 22 although this advice changed as the pandemic progressed,
 23 in the light of significant public anxiety around deaths
 24 in care homes and of those who contracted Covid-19 at
 25 their place of work.

59

1 In order to receive and investigate reports of
 2 deaths related to Covid-19, a deaths investigation team
 3 was set up, which then worked together with the
 4 Health & Safety Executive, local authorities, the Care
 5 Inspectorate and Police Scotland to ensure that
 6 appropriate investigations were undertaken.

7 The purpose of these investigations was to ensure,
 8 so far as possible, that the full facts of the
 9 individual deaths were brought to light, and to consider
 10 what, if any, further action was merited.

11 Guidance from the Chief Coroner of England and Wales
 12 confirmed that, subject to the coroner being satisfied
 13 that there was no duty to investigate, deaths from
 14 Covid-19 were to be dealt with via the medical
 15 certificate of cause of death process, signed by
 16 a doctor and registered by the coroner.

17 Furthermore, on 25 March 2020, the Coronavirus Act
 18 2020 took effect, introducing a number of easements to
 19 the circumstances in which other deaths needed to be
 20 referred to the coroner.

21 The Chief Coroner has told the Inquiry:

22 "This helped the coroner service to function because
 23 the pandemic caused both a substantial increase in the
 24 numbers of deaths, and a change in the way doctors cared
 25 for patients. Without the easements, many more natural

60

1 deaths would have been referred to coroners because the
 2 legal requirements for those deaths to be certified by
 3 doctors, and/or registered without a coroner referral,
 4 would not have been met. The pressure on the coroner
 5 service, which was already intense, would therefore have
 6 been even greater. However, it is possible that there
 7 were cases that ought to have been referred to a coroner
 8 but were not because the scrutiny was less stringent
 9 during this period."

10 One of the changes was to remove the mandatory
 11 requirement for a jury to sit on inquests into deaths
 12 which were suspected to be caused by Covid-19. Jury
 13 cases tend to be more practically complex, cannot be
 14 conducted remotely, and, at the time, required extremely
 15 large court spaces to allow for the requirements of
 16 social distancing.

17 Increasing the number of such cases within the
 18 coroner service would, therefore, have increased
 19 backlogs at a time when the service was already under
 20 immense pressure.

21 As the pandemic progressed, regular guidance was
 22 issued by the Chief Coroner of England and Wales to
 23 coroners on topics such as adjourning complex inquests
 24 and using technology to enable participation in those
 25 which were proceeding.

61

1 However, not all coroner areas had sufficient
 2 video-conferencing facilities. Many inquests had to be
 3 adjourned. In addition, although coroners, coroner's
 4 officers, and staff were classed as key workers, those
 5 who were vulnerable or had vulnerable family members
 6 could not attend their workplaces. Their inability to
 7 work from home reduced the capacity of coroner areas to
 8 deal with death referrals and the early stages of death
 9 investigations, thereby increasing delays.

10 Higher numbers of excess deaths put pressure on the
 11 death management system. In most parts of the country,
 12 mortuary storage capacity was anticipated to be
 13 seriously insufficient, affecting all deceased persons,
 14 not just those whose deaths were under the investigation
 15 of the coroner and, in some parts of the country, that
 16 risk materialised.

17 As the Chief Coroner told the Inquiry:
 18 "How bereaved families experienced the investigation
 19 process will have been affected by the change in
 20 approach, although how they felt about it will have
 21 varied. For example, some families do not want a
 22 post-mortem examination to be conducted for emotional
 23 and/or religious reasons, but others are desperate for
 24 there to be as extensive an investigation as possible."

25 She added:

62

1 "Coroners played an important role in identifying
 2 and managing the demands the pandemic placed on the
 3 wider death certification system. Coroners in each area
 4 worked as part of their Local Resilience Forum, which
 5 brings together all relevant local individuals and
 6 organisations including the police, ambulance service,
 7 GPs, hospitals, local authorities, et cetera) to manage
 8 the pressures, including setting up temporary mortuaries
 9 to mitigate the risk that existing provision would
 10 become overwhelmed, and working to ensure that bodies
 11 were released promptly."

12 Where appropriate, a coroner has a duty to issue a
 13 "Prevention of Future Deaths" report. During the
 14 pandemic, such reports were issued by coroners covering
 15 a variety of issues relating to Covid-19, for example,
 16 ambulance delays and the insufficiency of PPE.

17 As was happening across the whole of the court
 18 estate, imaginative solutions were found in some areas
 19 to enable jury inquests to proceed. For example,
 20 Pitman's Parliament in Durham, a huge historic debating
 21 chamber and headquarters of the Durham Miners
 22 Association, was adapted for use by coroners for
 23 inquests as it was large enough to seat jurors and
 24 participants two metres apart. New arrangements like
 25 this improved access to inquests by enabling hearings to

63

1 proceed that otherwise would have been adjourned.

2 Similar arrangements were also made to increase
 3 capacity and alleviate the pressure on criminal and
 4 civil courts and tribunals with the setting up of
 5 Nightingale courts across England. However, as my Lady
 6 will be well aware, the inevitable backlog caused by the
 7 pandemic remains at a high level.

8 My Lady, I'm about to move to deal with our third
 9 topic of vulnerability and impact. I notice the time,
 10 and it's a little earlier than we would normally break
 11 for lunch but ...

12 **LADY HALLETT:** No, I am entirely in your hands. It's a lot
 13 of talking for you. So why don't we take a break now
 14 and I shall return at 1.50.

15 **MS BLACKWELL:** Thank you.

16 (12.49 pm)

17 (Luncheon Adjournment)

18 (1.50 pm)

19 **LADY HALLETT:** Ms Blackwell.

20 **MS BLACKWELL:** My Lady, in our third topic of scope we will
 21 cover vulnerability and impact. The Inquiry has learned
 22 that the impact of Covid-19 was not shared equally. As
 23 Peter Matejic of the Joseph Rowntree Foundation
 24 expressed it to the Inquiry, "We may be in the same
 25 storm but we are not in the same boat."

64

1 Certain groups in society were at greater risk of
 2 acquiring Covid-19, of suffering severe illness, of
 3 dying from Covid-19 or of suffering long-term symptoms.
 4 While society as a whole suffered as a result of the
 5 social, economic and cultural consequences of the
 6 pandemic, and the measures taken in response, the people
 7 who suffered most were those who were socially,
 8 economically and medically disadvantaged before the
 9 pandemic hit.

10 You have already concluded that there were people
 11 who were particularly vulnerable, whose position was not
 12 considered adequately and speedily enough in the context
 13 of the pandemic. You have identified failings and harms
 14 which resulted, proposing tools for the future. These
 15 tools include a recognition that consideration of impact
 16 ought to inform any principled approach by future
 17 decision makers as to strategy.

18 In this short opening, we cannot possibly attempt to
 19 replicate the spectrum of evidence gathered by the
 20 Inquiry as to the unequal impact of the pandemic whether
 21 by reason of protected or other characteristics, by
 22 demographic or additional factors beyond brief
 23 headlines. The evidence in this module points to impact
 24 and inequality being predictable, with the pandemic and
 25 measures taken in response compounding existing

65

1 inequalities across the board.

2 The intersectionality of vulnerabilities further
 3 exacerbated this effect. By way of example, people with
 4 mental health problems are more likely to experience
 5 homelessness, social deprivation, domestic abuse and
 6 substance abuse. The mental health charity Mind's 2021
 7 report on poverty called this a "spiral of adversity".

8 You have recognised significant data gaps in all
 9 four nations which may undermine helpful comparison,
 10 including by ethnicity, occupation, religion or
 11 disability status. We repeat, because it warrants
 12 repetition, there was a lack of comprehensive
 13 equality-disaggregated data that led to a general
 14 failure by the UK Government and devolved
 15 administrations to understand who was the most
 16 vulnerable to the pandemic and how the governments'
 17 interventions could be better calibrated.

18 There is evidence that risks were heightened both as
 19 a result of pre-existing structural and societal
 20 inequalities, and as a result of limitations in the
 21 planning and response.

22 Throughout these hearings we will consider, with the
 23 assistance of expert evidence and contributions from
 24 Core Participants, how you might build upon the lessons
 25 already identified and changes to systems and structures

66

1 that have already been put in place to better ensure
 2 that those most vulnerable to harm are protected in any
 3 future pandemic or whole-system crisis.

4 I turn now to set out those vulnerabilities and
 5 provide some examples of the evidence that you will
 6 hear, turning first to race.

7 Those in ethnic minority groups faced some of the
 8 highest mortality risks from Covid-19. You will hear
 9 once again from Professor Nazroo, Professor Emeritus of
 10 Sociology at the University of Manchester, and Professor
 11 Bécares, Professor of Social Science and Health at
 12 King's College, London, on the experience of people from
 13 ethnic minority communities and how their inequalities
 14 were exacerbated by the pandemic.

15 They will say that prior to Covid-19, ethnic
 16 inequalities in health were largely ignored and there
 17 were no appropriate monitoring systems in place.
 18 Factors leading to increased risk of infection and
 19 mortality included the greater likelihood of ethnic
 20 minority people living in areas and working in jobs that
 21 increased their exposure to infection. Furthermore,
 22 ethnic inequalities in health, driven by these social
 23 and economic inequalities, also increased the
 24 vulnerability of ethnic minority people to infection, to
 25 the risk of Covid-19 complications, and to mortality.

67

1 In England, black and South Asian women and babies
 2 were approximately 25 per cent more likely than white
 3 women to sustain adverse outcomes in maternal and
 4 perinatal health during the pandemic. Rates of major
 5 complications from anaesthesia during the period from
 6 1 July 2020 to 31 March 2021 were higher than
 7 pre-pandemic rates for all women from ethnic minority
 8 groups compared to white women, and especially for women
 9 in the black ethnic group.

10 You will also hear about increased inequalities in
 11 palliative care, with ethnic minority patients being
 12 referred later, by about four days, to palliative care
 13 compared to white patients.

14 Policies around visiting restrictions for family
 15 members and lack of professional interpreting services
 16 in palliative care, as well as restrictions around
 17 access to the bodies of loved ones after death, had an
 18 adverse impact on ethnic and religious minority groups.

19 Many services reported that they had been treating
 20 ethnic minority groups no differently than any other
 21 groups but a one-size-fits-all approach disregarded the
 22 needs and practices of some ethnic minority families.

23 The pandemic significantly impacted social cohesion
 24 and community relationships among ethnic minority groups
 25 in the UK, with notable variations across individual

68

1 ethnic groups. While overall neighbourhood-level social
 2 cohesion declined during the pandemic, this reduction
 3 was particularly pronounced in the most deprived areas,
 4 among Pakistani, Bangladeshi and black ethnic groups,
 5 compared to white populations.

6 Migrants' Rights Consortium have provided evidence
 7 of the significant mental health challenges faced by
 8 migrant communities during the pandemic. Unfamiliar
 9 social structures, financial insecurity, travel
 10 restrictions, pre-existing conditions, and trauma
 11 arising from distressing circumstances which had led
 12 them to being in the UK, were prevalent, and those
 13 within migrant communities encountered barriers in
 14 accessing mental health support.

15 In the post-pandemic period to May 2023, mental
 16 health symptoms among ethnic minority groups remained
 17 higher than pre-pandemic levels. The Evidence Review
 18 confirms that the different levels of poor mental health
 19 were "persisting and, in some cases, becoming more
 20 pronounced".

21 Professors Nazroo and Bécares raise the issue of
 22 vaccine uptake in their report, which the Inquiry has
 23 already covered in Module 4. It is perhaps just worth
 24 reflecting that there were differences in uptake levels
 25 across sectors of the community. They explain that the

69

1 fact that ethnic minority people were not engaged in
 2 trials was once of the factors the led to greater
 3 hesitancy in being vaccinated, others being a lack of
 4 trust in the government, in the pharmaceutical industry,
 5 and in public health.

6 Unequal treatment by the police and law enforcement
 7 agencies towards ethnic minority people was exacerbated
 8 during the pandemic. Pre-pandemic figures showed that
 9 they were over-represented in many stages through the
 10 criminal justice system, including in relation to stop
 11 and search, arrests, custodial sentencing and within the
 12 prison population. We shall examine how unequal
 13 policing practices during the pandemic included
 14 disproportionate use of fixed penalty notices, increased
 15 stop and search activities, and racialised enforcement.

16 These practices were reported to have created
 17 additional psychological trauma and health risks for
 18 ethnic minority communities, ultimately contributing to
 19 significant higher rates of anxiety and mental health
 20 challenges compared to the white population.

21 Now to gender. You will hear impact evidence from
 22 Dr Clare Wenham, Associate Professor of Global Health
 23 Policy at London School of Economics, on how the
 24 pandemic and the measures put in place by UK governments
 25 affected women and men differently.

70

1 For example, although women were more likely to test
 2 positive for Covid-19 in the early stages of the
 3 pandemic, partly due to higher exposure through
 4 frontline roles in health, social care, retail and
 5 education, and greater access to testing, overall
 6 infection rates between men and women were relatively
 7 similar, men were at higher risk of severe illness,
 8 hospitalisation and death from Covid-19.

9 There were a number of suggestions as to why this
 10 might be, ranging from biological factors, such as
 11 hormone effects or differences in immune response, to
 12 higher prevalence of underlying health conditions, such
 13 as cardiovascular disease, to social effects, including
 14 delayed health-seeking behaviour.

15 Women were more likely to experience adverse impacts
 16 on mental health and wellbeing. Women's activity
 17 levels, which initially appeared more resilient, took
 18 longer to recover and you will hear that the longer-term
 19 decline may be harder to reverse.

20 Pregnancy increased the risk of adverse outcome of
 21 Covid-19 infection. Pregnancy was also a factor likely
 22 to result in increased reports of mental distress during
 23 the pandemic and in the face of measures introduced to
 24 manage risk of infection.

25 One contributor to Every Story Matters said:

71

1 "During pregnancy [my] partner was not allowed to
 2 attend any appointments. As a first time mother this
 3 was unnerving and lonely. This made me feel much more
 4 anxious about 'routine' appointments."

5 Existing financial inequalities were reflected in
 6 women's experience of work and furlough during the
 7 pandemic. Women were more likely to lose their jobs and
 8 were more likely to be furloughed, with more women
 9 represented in the groups most at risk. You will hear
 10 from Dr Wenham that the pandemic not only worsened
 11 existing inequalities, it generated new, gender forms of
 12 financial disadvantage. Most notably the collapse of
 13 childcare became a unique cause of job loss for mothers.

14 Furlough for caregiving was not formally introduced
 15 until late 2020, by which point many mothers had either
 16 exited the workforce or reduced their hours. The
 17 pandemic sharply intensified existing gender
 18 inequalities in unpaid care work within households
 19 across the UK.

20 Women disproportionately absorbed the additional
 21 care responsibilities brought on by school closures,
 22 the suspension of social care services and increased
 23 health needs within families. Caring responsibilities
 24 and, in particular, primary care for children was
 25 identified as a particular risk factor in adverse mental

72

1 health and wellbeing outcomes.

2 But it was not only women, of course, who stepped up
 3 to take on additional and burdensome care requirements.
 4 One young man told Every Story Matters about his brother
 5 with learning disabilities who, before the pandemic, was
 6 cared for by their dad. The young man also has a son
 7 with autism and care needs. Their Dad died early in the
 8 pandemic. As day centres closed, the young man became
 9 the full-time carer for his brother and his son. He
 10 told the Inquiry that managing these changes and the
 11 family's grief during the pandemic was stressful.

12 You will also hear that one aspect of the pandemic's
 13 impact was an increase in the numbers of people
 14 providing care for others who experienced a
 15 deterioration in their mental health. Caregivers
 16 supporting more than one person had particularly high
 17 levels of mental health problems and those caring for
 18 both children and older adults saw their psychological
 19 distress increase and mental health decline, with carers
 20 doing more intensive hours experiencing a greater
 21 decline.

22 Socio-economic inequality. My Lady, has already
 23 recognised that poor outcomes for Covid-19 infection in
 24 deprived areas remained after adjusting for age, sex,
 25 religion and ethnicity. Mortality rates for these

73

1 people were at least double, intensifying grief and
 2 trauma disproportionately. Poverty and socio-economic
 3 deprivation was in and of itself an indicator of poorer
 4 outcomes during the pandemic.

5 You will hear evidence from Mr Peter Matejic of the
 6 Joseph Rowntree Foundation on the experiences of people
 7 living in poverty during Covid-19 and lessons that might
 8 be learned to improve their future. He will tell the
 9 Inquiry that from the very start of the pandemic, people
 10 living with poverty were already at significantly higher
 11 risk of poor mental health due to financial stress,
 12 insecure housing, stigma and reduced access to services.

13 A recurring theme in their research was that
 14 families already on the edge and navigating challenging
 15 circumstances were less able to absorb additional
 16 shocks. In essence, they describe Covid-19 adding
 17 another layer of inequality. Communities already facing
 18 structural disadvantage bore greater emotional burden as
 19 a result.

20 Professor Clare Bambra, Professor of Public Health
 21 at Newcastle University and Professor Sir Michael
 22 Marmot, Professor of Epidemiology and Public Health at
 23 University College London, from whom you heard in
 24 Module 1, are returning to tell the Inquiry about their
 25 examination of socio-economic inequalities in some of

74

1 the key social determinants of health during the
 2 pandemic period.

3 In the year 2020-2021, inequalities in housing costs
 4 increased and further increases in debt and rent
 5 arrears, the erosion of savings and severe financial
 6 difficulties were most likely to be experienced by those
 7 in the most deprived areas across all four UK nations.

8 There were protections put in place by the
 9 governments which helped mitigate the health
 10 inequalities. The first national lockdown helped reduce
 11 the gap in Covid-19 mortality rates between the most and
 12 least deprived areas by 25 per cent. Food insecurity,
 13 poverty and income inequality well as a result of the
 14 Universal Credit uplift and protective housing policies
 15 such as the "Everyone In" campaign which helped mitigate
 16 Covid-19-related deaths.

17 However, despite the mitigating effects these steps
 18 might have had on protecting some of the most vulnerable
 19 in society, socio-economic and health inequalities
 20 remained present during the pandemic and impacted
 21 substantially on people's experiences, including food
 22 insecurity and the impact on mental health and
 23 wellbeing.

24 The return of the Covid-19 restrictions during the
 25 winter of 2020-2021 led to a resurgence, and in some

75

1 cases, intensification of mental health challenges
 2 across the population but financial hardship remained a
 3 key driver of poor mental health outcomes.

4 Professor Bécares has provided a report on the
 5 inequalities experienced by LGBTQ+ groups. She will
 6 tell you that the UK lacks comprehensive data on
 7 Covid-19 infection and mortality outcomes for this group
 8 of people. However, although coverage was uneven due to
 9 underrepresentation and limited data in many studies,
 10 there is evidence that they saw a deepening of
 11 pre-existing mental health disparities and experienced
 12 particularly adverse impacts.

13 LGBTQ+ people experienced a significant
 14 deterioration in health outcomes and health care access
 15 during the pandemic, compounding pre-existing health
 16 inequities. Access to HIV preventative medications was
 17 compromised, with widespread misinformation around
 18 availability, unclear government messaging regarding
 19 permissible travel for accessing such time-critical
 20 medication, and inconsistent prescribing practices,
 21 which left many without reliable access.

22 A large proportion of LGBTQ+ people, and in
 23 particular young and trans people, experienced lockdown
 24 in housing environments where family members or
 25 flatmates were not supportive of their sexuality and/or

76

1 their gender identity.

2 An online study conducted during the first lockdown
3 on the experiences of 18-35-year olds found that
4 26 per cent of respondents felt either very
5 uncomfortable or extremely uncomfortable where they were
6 living, and 19 per cent also reported feeling very, or
7 completely, suffocated due to not being able to express
8 their LGBTQ plus identity at home.

9 The risk to mental and physical safety experienced
10 by LGBTQ+ people living in unsupported housing
11 situations was so high that the charity akt, a national
12 charity supporting LGBTQ+ people aged 16-25 who are
13 facing or experiencing homelessness, advised young
14 people to be cautious about coming out to family due to
15 the risk of homelessness.

16 Refuge, the largest domestic abuse organisation in
17 the UK, reported that during the week commencing
18 30 March 2020, calls for the National Domestic Abuse
19 Helpline increased by an average of 25 per cent. The
20 LGBT Foundation's domestic abuse programme also
21 experienced unprecedented demand for support since
22 lockdown measures were introduced. This included
23 a 38 per cent increase in domestic abuse calls to the
24 helpline and an 820 per cent increase in domestic abuse
25 web page views.

77

1 Turning now to older people, the vulnerability of
2 older people to infection is well documented. The
3 position of residents in care homes was addressed in
4 Module 6, and we do not seek to repeat that work here.

5 While older people were more vulnerable to infection
6 and more likely to die of Covid-19, they were also more
7 vulnerable to loneliness and isolation. We will hear
8 evidence from Professor James Nazroo on the wider
9 experience of later life and Covid-19.

10 His evidence supports the conclusion that the
11 experiences of older people during the pandemic, aside
12 from clinical vulnerability, were particularly
13 difficult. We have already touched upon the impact on
14 older people of digital exclusion and the closure of
15 places of worship. Professor Nazroo's conclusions are
16 that while access to healthcare and support during the
17 pandemic period became difficult for everyone, this was
18 more significant for some groups of older people who
19 were reliant on care.

20 Professor Nazroo will say:

21 "There was an increase in unhealthy behaviours
22 during lockdown among older people. Analysis of data
23 from the English Longitudinal Study of Ageing, which
24 covers those aged 50 or older, shows that 40 per cent of
25 respondents reported spending more time sitting, and

78

1 about one-third reported watching more TV and engaging
2 less in physical activity.

3 However, older people were less likely than younger
4 people to experience a significant decline in their
5 mental health and wellbeing. The Evidence Review
6 concludes older adults aged 50 and above, whilst still
7 affected, often showed smaller increases in mental
8 distress compared to younger adults, or sometimes they
9 experienced no significant increase beyond pre-pandemic
10 trends. This may be linked to greater stability and
11 access to economic resources or established social
12 networks for some older people and a greater change for
13 younger people. We will explore this in evidence.

14 Turning to disabled people. The term "disability"
15 is defined by the Equality Act 2010 as someone with
16 "a physical or mental impairment which has a substantial
17 and long-term adverse effect on their ability to carry
18 out normal day-to-day activities".

19 In March 2020, the National Institute for Clinical
20 Excellence (NICE) published a short pamphlet entitled
21 'COVID-19 rapid guideline: critical care in adults'.

22 In the first draft of this document, NICE
23 recommended the use of the Clinical Frailty Scale as
24 a tool for helping to make decisions on whether or not
25 a potential patient should be considered as being

79

1 eligible for critical care.

2 The scale, which ranged from 1, very fit, to 9,
3 terminally ill and expected to die in less than
4 six months, suggested that any individual "completely
5 dependent for personal care, from whatever cause"
6 scored 7. According to the scale, for anyone scoring
7 higher than 5, there was said to be uncertainty around
8 the benefits to them of critical care. This was taken
9 by many as suggesting that those with learning
10 disabilities, stable long-term conditions or autism
11 should not be considered as eligible for such care.

12 Campaigning groups including Mencap and Learning
13 Disability England pointed out the inequality inherent
14 in such a statement and on 29 March 2020, NICE re-issued
15 its guidance to modify the use of the clinical frailty
16 scale. Despite the rapid revision of the guidelines,
17 the original documents continued to cause considerable
18 disquiet among disabled people and their organisations.
19 These anxieties were not helped when news of the
20 inappropriate use of do not attempt cardiopulmonary
21 resuscitation notices with disabled people began to
22 emerge. Mencap, for example, reported that in the early
23 months of the pandemic they heard from their members
24 that these notices had been applied to them without
25 their knowledge.

80

1 A review of DNCPR policies carried out by the Care
 2 Quality Commission found that there had been
 3 "unacceptable and inappropriate DNACPRs being made at
 4 the start of the pandemic" in relation to disabled,
 5 clinically vulnerable and clinically extremely
 6 vulnerable people.

7 My Lady has already recognised the specific risk
 8 posed by Covid-19 to people with disabilities and that
 9 many disabled people suffered more severe consequences
 10 as a result of steps taken to limit the spread of the
 11 virus. Many disabled people lived in fear of infection,
 12 lost access to support networks and felt forgotten.
 13 Gaps in the knowledge about direct and indirect impacts
 14 of the pandemic on disabled people contributed to the
 15 failure across the UK to speedily mitigate those risks
 16 and harms.

17 We will consider evidence including from Professor
 18 Shakespeare, Professor of Disability Research at the
 19 London School of Hygiene and Tropical Medicine, and
 20 Professor Watson the Chair of Disability Studies and
 21 Director of the Centre for Disability Research at the
 22 University of Glasgow, who are returning to talk about
 23 the overlapping inequalities experienced by disabled
 24 people who were often living with underlying medical
 25 conditions and in socio-economic deprivation.

81

1 During the pandemic, disabled people were more
 2 likely than their non-disabled peers to experience
 3 higher levels of loneliness, anxiety and depression,
 4 poorer wellbeing and their access and communications
 5 needs were diminished.

6 The Third Sector -- that is charities and community
 7 groups -- played a key role throughout the pandemic and
 8 without their contribution outcomes for disabled people
 9 would have been considerably worse than transpired. You
 10 will hear that there were regional differences in the
 11 way governments worked with the Third Sector.

12 There is evidence that governments in Scotland,
 13 Wales and Northern Ireland were more likely to work with
 14 disabled people's organisations than was the case in
 15 England.

16 In Scotland, for example, the Minister for Health
 17 and Social Care set up a group and met regularly with
 18 the major disability organisations. However, while
 19 there was more consultation in the devolved nations, its
 20 impact on service development has been questioned. Jim
 21 Elder-Woodward of Inclusion Scotland has told the
 22 Inquiry that in relation to evidence provided to the
 23 Scottish Government by his organisation, there had been
 24 "little dedicated response outlining how that evidence
 25 had been used and what difference it had made" and that

82

1 "another recurring theme was that Inclusion Scotland was
 2 increasingly presented with near final draft policies
 3 and plans at meetings and, therefore had only minimal
 4 scope to influence key decisions."

5 Similarly in relation to Northern Ireland, Nuala
 6 Toman from Disability Action Northern Ireland has told
 7 the Inquiry that this organisation was not properly or
 8 appropriately consulted during the pandemic. The impact
 9 of a lack of consultation with the Third Sector was that
 10 the voices of those they represented were not heard and
 11 so they had to "step in and fill the gap" left by
 12 unclear guidance such as with British Sign Language.
 13 Outcomes for disabled people were better where local
 14 authorities and service providers worked closely with
 15 the third sector and took account of local needs.

16 You will also hear oral evidence from Pauline Nolan,
 17 on behalf of the Disabled People's Organisations, on the
 18 experiences of disabled people and the lessons that may
 19 be learned for the next pandemic.

20 In March 2020, the UK Government delineated two
 21 groups who were perceived to be at elevated list of
 22 increased morbidity or mortality from Covid-19. Those
 23 who were described and defined as "clinically
 24 vulnerable" and those as "clinically extremely
 25 vulnerable".

83

1 Those defined as clinically vulnerable were
 2 considered to be at moderate risk and included people
 3 with pre-existing health conditions: pregnant women,
 4 those aged over 70, and people with a BMI of greater
 5 than 40. Approximately 25 per cent of the UK population
 6 were included in this category.

7 The term "clinically extremely vulnerable" was
 8 applied to those with conditions that placed them at
 9 high risk of complications or death if infected with
 10 Covid-19. This included people with certain types of
 11 cancers, those who were immunocompromised or
 12 immunosuppressed, solid organ transplant recipients, and
 13 people with severe respiratory conditions.

14 The experts will tell you that the four
 15 UK administrations applied different criteria in
 16 defining the category. Initially, the criteria for
 17 inclusion on the shielding list in England was
 18 exclusively clinical. People were informed by letter
 19 either from their GP, other health provider, or through
 20 digital cohorting, when they were included on the list.
 21 These groups were amended and changed throughout the
 22 course of the pandemic as new information emerged.

23 For example, in autumn 2020, people with Down
 24 syndrome were added to the list, and in February 2021,
 25 this was extended to include all people with a learning

84

1 disability. By the summer of 2021, it was estimated
 2 that the total number of people defined as clinically
 3 extremely vulnerable was 3.7 million in England, 213,000
 4 in Scotland, 138,000 in Wales, and 80,000 in
 5 Northern Ireland.

6 You have already recognised that the specific risk
 7 for clinically vulnerable people went beyond the
 8 immediate threat of infection. Extended shielding,
 9 repeated disruption for healthcare access, and prolonged
 10 exclusion from everyday activities meant that risk
 11 management became a constant feature of daily life. You
 12 will hear from Lara Wong, on behalf of Clinically
 13 Vulnerable Families, who has given evidence before you
 14 in previous modules and will explain that existing
 15 challenges for those deemed clinically vulnerable were
 16 often compounded by pre-existing health conditions,
 17 which created new barriers to social connections and
 18 disrupted access to sources of emotional support.

19 This group was strongly advised to avoid any social
 20 mixing in the community, to work from home, avoid public
 21 transport where possible, be particularly stringent in
 22 following social distancing guidelines, and to try and
 23 stay at home as much as possible.

24 Clinically extremely vulnerable people sometimes
 25 reported difficulties in obtaining antiviral drugs after

85

1 testing positive for Covid-19, and they reported delays
 2 in routine care, such as blood tests or cancer
 3 screening, leading to worsening of chronic conditions.

4 Professors Shakespeare and Watson will explain how
 5 the Covid-19 pandemic and the various lockdowns had
 6 a significant impact on the health and wellbeing of
 7 clinically vulnerable people. Rates of antidepressant
 8 prescriptions were approximately 50 per cent higher for
 9 clinically extremely vulnerable people than those who
 10 fell outside of the designated definition.

11 In Module 2 you have recognised the known
 12 psychological risks associated with shielding for
 13 clinically vulnerable people. The Evidence Review
 14 confirms that shielding or consistently staying at home
 15 was associated with an increased risk of elevated
 16 depressive symptoms, anxiety, and decreased quality of
 17 life.

18 Prolonged or repeated shielding was strongly and
 19 consistently linked to poorer mental health and quality
 20 of life. Clinically extremely vulnerable people
 21 consistently reported poorer mental health and
 22 wellbeing. The evidence on the wider experiences of
 23 those who were clinically vulnerable but not clinically
 24 extremely vulnerable remains complex, and we will
 25 explore gaps in data and the understanding of their

86

1 experiences with the experts and with Lara Wong.

2 Turning now to homelessness and housing insecurity.
 3 You have considered the particular risks associated with
 4 socio-economic disadvantage, and have made
 5 recommendations in connection with the appreciation in
 6 future pandemic planning of all harms including
 7 deprivation.

8 People's housing situations had a profound impact on
 9 how they experienced the pandemic. For instance, those
 10 in overcrowded houses experienced greater increases in
 11 psychological distress. The likelihood of spending the
 12 pandemic in poor quality or overcrowded housing was high
 13 for those renting and for those in more deprived areas.

14 Overcrowding rates were especially high for certain
 15 ethnicities. Poor housing and housing insecurity was
 16 a risk factor for poor mental health outcomes. This was
 17 perhaps predictable in any crisis to which a necessary
 18 response was an instruction to stay at home.

19 Housing conditions were recognised as a structural
 20 driver of poorer mental health, particularly in more
 21 deprived areas, and this was disproportionately
 22 experienced by socio-economically disadvantaged and
 23 ethnic minority households.

24 In the coming weeks, you will hear evidence on the
 25 particular vulnerabilities, risks and disadvantages

87

1 experienced by those living with housing insecurity and
 2 homelessness during Covid-19, including from Tim
 3 Gutteridge of Shelter, Nicola McCrudden from Homeless
 4 Connect, Northern Ireland, and Ruth Power from Shelter
 5 Cymru.

6 The "Everyone In" programme was welcomed, but the
 7 management and ending of the programme may have had an
 8 adverse impact on homeless people while the pandemic
 9 continued and its impact continued to be felt.

10 There were divergent experiences for those who moved
 11 from street homelessness to Covid-secure accommodation.
 12 The transition from face-to-face to remote contact with
 13 support workers was a particular challenge. This was an
 14 area where overlapping inequalities were particularly
 15 pronounced for those with complex needs, care leavers,
 16 people with mental health conditions, people at risk of
 17 domestic violence and migrant people.

18 There were sometimes additional challenges for those
 19 key workers running the hostels charged with the
 20 responsibility of managing the influx of people.
 21 Shelter told the Housing and Homelessness Roundtable:

22 "People were put in budget hotels, with no support
 23 whatsoever. They didn't know how long they'd be there,
 24 people were having terrible mental health crises ... In
 25 some cases there were skeleton staff in the hotels, so

88

1 [there were] hotel staff dealing with people who wanted
 2 to take their own life, having severe reactions because
 3 they couldn't obtain drugs or alcohol, and they were
 4 complete untrained."

5 You will hear that migrant people experienced the
 6 pandemic through a combination of health risk, housing
 7 insecurity and legal uncertainty, with impacts cutting
 8 across healthcare, housing and immigration systems.

9 Many entered the pandemic already facing restricted
 10 access to public funds, financial insecurity and limited
 11 access to support. Covid-19 did not create these
 12 conditions but you will hear evidence that it
 13 intensified them.

14 There were protections introduced during the
 15 pandemic which you will hear helped mitigate the impacts
 16 on migrant people. These included the Covid-19
 17 concession schemes Coronavirus Extension Concession and
 18 the Exceptional Assurance Concession. These schemes
 19 allowed those whose leave to remain would have expired
 20 during the pandemic to stay in the UK while pandemic
 21 restrictions on travel were in place.

22 However, participants in the Justice System
 23 Roundtable said that the absence of clear guidance for
 24 these schemes and the restrictions on them made it
 25 difficult to for immigration law practitioners to advise

89

1 migrants.

2 In relation to healthcare, fear and uncertainty
 3 about entitlement acted as a significant barrier to
 4 access. Some migrant individuals delayed or avoided
 5 seeking treatment altogether because of concerns about
 6 charging, data sharing or immigration consequences.

7 A representative from the Joint Council for the
 8 Welfare of Immigrants in the Justice System Roundtable
 9 explained:

10 "Migrants who were discouraged from accessing
 11 healthcare for a long time were cynical at the prospects
 12 of accessing it suddenly during Covid-19 pandemic."

13 You will hear from Francesca Humi, on behalf of the
 14 Migrants' Rights Consortium, about the experiences of
 15 migrant people and those in the immigration and asylum
 16 systems, including as to health risks and the impact on
 17 mental health and wellbeing, and the lessons that may be
 18 learned for the next pandemic.

19 Turning to prisons and other places of detention,
 20 for people in prison and other places of detention, the
 21 pandemic fundamentally altered daily life, with
 22 considerable impacts on physical health, mental
 23 wellbeing, case progression and access to healthcare
 24 services.

25 Restrictions introduced to limit the transmission of
 90

1 Covid-19 resulted in unprecedented levels of
 2 confinement, isolation, and loss of contact with family.
 3 This was compounded by overcrowding, poor conditions and
 4 high levels of vulnerability. Deaths in custody
 5 increased over the pandemic period.

6 Beyond an increase in deaths attributed to Covid-19,
 7 there was also a concerning spike in self-inflicted
 8 deaths, which, in the 12 months to December 2021,
 9 represented a 17 per cent increase from the previous
 10 12 months.

11 For many prisoners, the most immediate impact was
 12 the prolonged time spent locked in cells. The
 13 introduction of the Exceptional Regime Management Plan
 14 confined most prisoners to their cells for 22 to
 15 23 hours a day, a practice that persisted for months.

16 As His Majesty's Chief Inspector of Prisons
 17 described in February 2021, nearly a year after
 18 restrictions were introduced in prisons, the most
 19 disturbing effect of the restrictions was the decline in
 20 prisoners' emotional, psychological and physical
 21 wellbeing. They described being drained, depleted,
 22 lacking in purpose, and, sometimes, resigned to their
 23 situation.

24 Some said they were using unhealthy coping
 25 strategies, including self-harm and drugs, whilst others

91

1 reported using mundane routines to pass the time and
 2 cope with their confinement and associated anxieties.

3 You will hear from Andrew Neilson on behalf of the
 4 Howard League for Penal Reform, from Pia Sinha, on
 5 behalf of the Prison Reform Trust from Charlie Taylor,
 6 on behalf of His Majesty's Inspectorate of Prisons, who
 7 will all speak to the direct experiences of those in
 8 prisons and other places of detention, the wider
 9 inequalities exacerbated by the pandemic, and lessons to
 10 be learned.

11 His Majesty's Inspectorate of Prisons noted that
 12 many prisons suffered from overcrowding going into the
 13 pandemic. Where prisoners continued to share
 14 overcrowded cells, often in poorly ventilated spaces,
 15 this exacerbated the impact of restrictions and made
 16 preventative measures such social distancing
 17 particularly difficult if not impossible. Prison
 18 inspectors also described conditions which were
 19 characterised by extreme restrictions, with prisoners
 20 often denied access to showers, exercise, or meaningful
 21 human contact and that such impoverished regimes were
 22 likely to discourage people who had symptoms from
 23 reporting them, posing a significant risk to public
 24 health within the prison estate.

25 The availability of healthcare provision evolved
 92

1 over time and between prisons. You will hear that while
 2 urgent and emergency care continued, routine services
 3 were curtailed, delayed or suspended leading to backlogs
 4 and longer waiting times.

5 Digital access was welcomed as social visits were
 6 suspended, but such access varied across the prison
 7 estate. The UK National Preventive Mechanism is an
 8 organisation made up of 21 statutory bodies that
 9 independently monitor places of detention across the UK.

10 Their representative explained in the Justice System
 11 Roundtable:

12 "When that access to families worked, it really
 13 worked. It really had an impact on people's wellbeing
 14 once they could see their family members and talk to
 15 their family members."

16 Comparable impacts were experienced in immigration
 17 detention. The uncertainty inherent in immigration
 18 detention, combined with pandemic restrictions,
 19 intensified anxiety, distress and feelings of
 20 powerlessness particularly for people with prior
 21 experiences of trauma. Participants in the Justice
 22 System Roundtable reported that the pandemic had
 23 a substantial negative impact on the mental health and
 24 wellbeing of detained migrants.

25 The charity Bail for Immigration Detainees described
 93

1 detainees as being subjected to extended periods of
 2 solitary confinement in an effort to reduce the spread
 3 of Covid-19 within detention facilities. They reported
 4 that some people were confined for over 23 hours each
 5 day. They highlighted the lack of clear communication,
 6 including as to the expected duration of detainees'
 7 confinement, as resulting in increased fear and anxiety.

8 I turn now to domestic abuse.

9 My Lady, you have already recognised that
 10 significant risks associated with the pandemic and, in
 11 particular, lockdown, for those at risk of domestic
 12 abuse and have concluded that it should not have taken
 13 the reports of traumatic experiences during the first
 14 lockdown for the UK Government to recognise and act upon
 15 these risks.

16 You will hear evidence from experts who will reflect
 17 upon the Evidence Review and the Domestic Abuse and
 18 Safeguarding Roundtable report, both of which record the
 19 particularly heightened risks associated with domestic
 20 abuse including for people living in rural areas and for
 21 those who experienced digital exclusion. It was
 22 particularly difficult for those who experienced
 23 overlapping inequalities, including as a result of
 24 disability, immigration status, language, or other
 25 barriers.

94

1 The DA Group, one of Module 10's Core Participants
 2 is made up of the following groups: Southall Black
 3 Sisters, an organisation supporting black, minoritised
 4 and migrant women and girls, particularly those fleeing
 5 violence; Solace Women's Aid, a service provider for
 6 victim-survivors of violence against women and girls in
 7 the UK; and Latin American Women's Rights Service,
 8 supporting migrant women facing intersectional violence
 9 and discrimination. They have told the Inquiry of how
 10 lockdown conditions created the perfect storm for
 11 abusers to take further advantage of their victims.

12 Solace Women's Aid told the Inquiry's Roundtable on
 13 Domestic Abuse and Safeguarding:

14 "The weaponisation of every facet of restrictions
 15 was used as an instrument of pain and suffering by
 16 perpetrators."

17 The Latin American Women's Rights Service told the
 18 Roundtable:

19 "One of the different ways through which
 20 perpetrators abused victims was data control -- if
 21 you're providing services only remotely and you don't
 22 have credit on your phone or no access to Wi-Fi or your
 23 perpetrator turns this off, victims would be isolated
 24 and could not contact statutory services."

25 These difficulties were confirmed by a service user
 95

1 who reported that:

2 "During lockdown everything got so much worse.
 3 I would usually at least have some breathing space when
 4 I went to work, but this was taken away from me when I
 5 had to start working from home. My perpetrator would do
 6 things like pull the Wi-Fi out of the wall to make it
 7 difficult for me to work. They would scream whilst
 8 I was having work meetings and colleagues called the
 9 police because they were concerned for my safety. I had
 10 a really good job which I have now lost because of the
 11 abuse."

12 You will hear from Gisela Valle, speaking on behalf
 13 of the three organisations that make up the DA Group,
 14 that these organisations observed that the most
 15 significant increase in direct contact from
 16 victim-survivors occurred when lockdown restrictions
 17 were eased. This indicates that many were unable to
 18 safely engage during the initial lockdown period and
 19 only began to make contact when circumstances allowed
 20 even a small window of opportunity.

21 Prior to the pandemic, disabled women were already
 22 three to four times more likely to experience domestic
 23 abuse than their non-disabled counterparts.

24 The pandemic presented further opportunities for
 25 perpetrators to control them, including restricting
 96

1 access to PPE, testing, and vaccines that would have
 2 helped them lower their risk of infection.
 3 Perpetrators' coercive control, combined with
 4 victim-survivors having to balance the health risks of
 5 leaving their homes, left disabled and older women even
 6 more vulnerable. This was compounded by the fact that
 7 their perpetrators were often their carers, and during
 8 lockdown would often be their only carers.

9 My Lady, you will hear harrowing evidence about an
 10 increase in the scale and intensity of physical and
 11 sexual abuse during the pandemic. One woman reported to
 12 accident and emergency department that her partner had
 13 punched her in the head and tried to strangle her. She
 14 said that he had been physically aggressive to her
 15 before, but matters had escalated during lockdown as
 16 they were quarantining together.

17 Others reported that incidents of marital rape had
 18 increased during lockdown. Some victim-survivors were
 19 forced into pregnancy, while others, unable to access
 20 contraception or support, experienced unwanted
 21 pregnancies.

22 Substance abuse by perpetrators increased, which, in
 23 turn, led to further offending against their partners.
 24 A report by Refuge on their National Domestic Abuse
 25 Helpline service for 2020-2021 noted that:

97

1 "19 per cent of women had experienced threats to
 2 kill, 10 per cent had weapons used against them
 3 and 16 per cent had been strangled."

4 In addition to what I have just set out, tomorrow
 5 Ms Rahman King's Counsel will summarise the impactful
 6 evidence contained in the Roundtable reports which
 7 describe the pandemic experiences of the vulnerable.

8 Already it will be apparent to you, my Lady, that
 9 there are themes developing, patterns emerging of shared
 10 experiences across those in society who entered the
 11 pandemic period living with vulnerabilities, of
 12 suffering and impact unequal to those better off, of
 13 lacking vital access to digital devices which
 14 substituted face-to-face services, of a lack of clarity
 15 and, therefore, heightened confusion around rules and
 16 regulations imposed by the government, of
 17 a deterioration in mental and physical health which
 18 continues to this day, of a feeling of being lost and
 19 ignored through a lack of data, the presence of which
 20 would have better alerted those who needed to know about
 21 the detrimental effects that the pandemic and measures
 22 imposed were having on their lives.

23 My Lady, I am going to pause again for another break
 24 before turning to the final section of the opening,
 25 which will deal with bereavement and loss.

98

1 **LADY HALLETT:** Very well. We will give you a little longer
 2 to save your voice, Ms Blackwell.

3 **MS BLACKWELL:** Thank you.

4 **LADY HALLETT:** I shall return at 3.05.

5 (2.46 pm)

6 (A short break)

7 (3.04 pm)

8 **LADY HALLETT:** Final leg, Ms Blackwell.

9 **MS BLACKWELL:** My Lady, the pandemic and measures in
 10 response had a profound and negative impact on the
 11 experience of bereavement, increasing feelings of grief,
 12 pain, isolation and trauma. This was an outcome that
 13 was foreseeable in the event of any pandemic or public
 14 emergency. You will hear the moving evidence of eight
 15 individuals who have suffered first-hand from
 16 bereavement due to Covid-19 and the impact of these
 17 experiences on them and their families, which are still,
 18 inevitably, ongoing.

19 Bereavement due to Covid-19 compared with other
 20 types of loss was complicated by many people being
 21 unable to say goodbye and having a lack of contact with
 22 the person who died. People experienced profound
 23 feelings of anger, sadness and guilt that they could not
 24 be with or comfort their loved ones at the end of their
 25 lives. Uncertainty about what happened to their loved

99

1 one in the final days of their lives had a detrimental
 2 impact for many.

3 One contributor to Every Story Matters from Northern
 4 Ireland said:

5 "We lost our daddy early [in] 2021. He was 68, life
 6 and soul of the party ... it was the most surreal
 7 experience and over three years on I have nightmares.
 8 Did he suffer? Was it him in the coffin? Did we
 9 cremate the right person? Amongst a dozen more
 10 questions we will never get the answers to."

11 Another contributor to Every Story Matters from
 12 Wales said:

13 "The pain and stress we are still going
 14 through ... I can't live life not knowing how our mum
 15 died or knowing how we can find out those answers. It's
 16 hell not knowing why she died ... it's frustrating and
 17 soul destroying not knowing answers to questions we have
 18 and we can't even grieve properly for her."

19 Many people experienced, and still experience,
 20 ongoing guilt and anxiety as to whether they did
 21 everything they could for their loved one at the end of
 22 their lives.

23 A contributor to Every Story Matters from Scotland
 24 said:

25 "On the day dad died I received a phone call in the
 100

1 afternoon to say he was very unwell. At this point
 2 I wanted to come in and be with him but was told that
 3 would not be allowed ... I have not really come to terms
 4 with this and feel extremely guilty that my brother and
 5 I were not there to comfort him in his passing."

6 For some, this led to an exacerbated fear of the
 7 virus and that they or other family members might die as
 8 a result. One contributor told us:

9 "My mental health became very horrific over this
 10 period. Watching my grandfather pass away from Covid
 11 made me extremely more anxious regarding catching Covid
 12 or another family member matching it."

13 As the restrictions were relaxed to allow brief
 14 visits at end of life in controlled circumstances,
 15 including wearing PPE or through window visits, bereaved
 16 people reported continuing to feel confused, angry and
 17 guilty over the circumstances of their loved ones'
 18 death.

19 One contributor told us:

20 "I was then not allowed to visit until they felt she
 21 was imminently about to die and to visit once to say
 22 goodbye. She was barely conscious and didn't recognise
 23 me with all by double mask on ... I ended up actually
 24 seeing her twice as she lasted longer than they thought,
 25 but basically, she was dying in a room on her own for

101

1 three weeks with no-one she loved there to hold her hand
 2 and talk to her. I really struggle with this and the
 3 guilt even though I had no power to change the rules,
 4 I feel a lot of anger that this was allowed to happen.
 5 It is not humane. And not logical ... if I was all
 6 masked up, why could I [not] go in every day."

7 Many people experienced multiple losses in close
 8 succession, within the same family. This took a
 9 particular toll. One person who suffered such a loss
 10 told us:

11 "It's sudden, completely unexpected -- if it's
 12 caught in hospital, you thought your loved one would be
 13 safe, obviously. So it feels like it was completely
 14 avoidable. You're angry, it's unjust. And surreal,
 15 completely surreal. One minute my parents were fine,
 16 living their own life. And the next minute, less than a
 17 month later they're both dead ... The sense of overwhelm
 18 that I felt with all of these factors going on, and
 19 I was shielding as well. So, I was like, obviously my
 20 parents died from Covid, and I'm terrified of catching
 21 anything. I did have thoughts of suicide and self-harm.
 22 I'd never in my life experienced thoughts of self-harm,
 23 it was incredibly scary."

24 It's apparent that those were shielding reported
 25 particular feelings of fear, guilt and isolation.

102

1 Contributors to Every Story Matters who were shielding
 2 shared with us that they struggled without social
 3 support and physical contact. One of the bereaved
 4 impact witnesses from whom my Lady will be hearing told
 5 the Inquiry that shielding led to a further
 6 deterioration in her mum's health and wellbeing; her
 7 mother having to shield meant that they lost much of
 8 their personal contact.

9 Restrictions on funeral and mourning rituals had
 10 a damaging impact for many. It was felt that there was
 11 a consistency in the guidance offered and the rules
 12 which applied in different parts of the UK and at
 13 different times during the pandemic. This was said to
 14 cause resentment, confusion and difficulty for those
 15 planning for funerals and mourning.

16 The Inquiry has already considered the impact of
 17 high-profile failures to observe restrictions since
 18 Module 2, considering, amongst other events, the funeral
 19 of Bobby Storey in Northern Ireland. Covid Bereaved
 20 Families for Justice Northern Ireland told the Inquiry
 21 that this impacted directly on bereaved people:

22 "In Northern Ireland there was a prominent funeral
 23 that broke all the rules. That impacted people about
 24 following the rules. You can hold a memorial a year
 25 down the line, but that is not the same as the

103

1 celebration of life."

2 As choices needed to be made within families, this
 3 put pressure on relationships at a time of considerable
 4 emotional difficulty. A representative from Scottish
 5 Covid Bereaved described this to the Roundtable on
 6 Funerals, Burials and Bereavement Support, confirming
 7 that choosing which members were allowed to attend
 8 a loved one's funeral caused rifts within the family.

9 The nature of some communities' and religions'
 10 rituals meant that they were more impacted by
 11 restrictions than others. However, evidence from the
 12 Roundtable on Funerals, Burials and Bereavement Support
 13 indicates that a common theme was the distress caused by
 14 the imposition of restrictions. Evidence from bereaved
 15 people in Northern Ireland spoke powerfully of the
 16 impact of restrictions on the holding of wakes for the
 17 dead:

18 "We normally have wakes as part of our culture,
 19 a time for people to reflect, share memories, bring
 20 positives to your life at a time when it is sad. That
 21 was completely lacking and missed."

22 The negative impacts of bereavement impacted
 23 disproportionately on ethnic minority groups. Mind told
 24 the Roundtable on Funerals, Burials and Bereavement
 25 Support that some communities struggled to understand

104

1 why they couldn't run funerals as per their cultural
 2 norms. Covid Bereaved Families for Justice UK
 3 highlighted the role of wakes and the coming together
 4 for funerals for African and Caribbean communities:

5 "A Covid death is not a normal death, you can't do
 6 the important things. For Afro-Caribbean families, the
 7 coming together, the wake is so important ... people
 8 could not be there."

9 The loss of many the aspects of choice in mourning
 10 rituals or in the celebration of life robbed many of
 11 a sense of closure following the death of a loved one.
 12 From the abandonment of family members' pre-arranged
 13 funeral plans, to the inability to choose a casket, or
 14 bury a loved one in their favourite clothes, or to have
 15 flowers at a service, bereaved people felt they were
 16 unable to give their loved ones the send-off that they
 17 deserved. This exacerbated feelings of guilt. Where
 18 funerals had been preplanned and paid for, this created
 19 a particular sense of injustice, sadness and anger.

20 A positive reflection is that innovations to allow
 21 for remote attendance at burials and funeral services
 22 provided a new accessibility which has continued beyond
 23 the pandemic period, allowing family and friends to
 24 participate in mourning rituals in a manner that
 25 previously would have been impossible. Some people told

105

1 the Inquiry that they were grateful that requirements to
 2 isolate allowed them time alone with their grief.

3 Allowing services to be viewed online was repeatedly
 4 cited by funeral staff as integral to offering an
 5 adequate service during the pandemic. Funeral staff
 6 have continued offering this service when the pandemic
 7 was over, some stating that the streaming of funeral
 8 services is:

9 "... brilliant for people who have maybe got family
 10 that live out of the UK ... That's something that's
 11 definitely improved. I'm not sure if it would have
 12 happened as quickly without Covid."

13 However, a lack of clarity in the guidance on
 14 restrictions, including as applied to different
 15 communities and religions, exacerbated the negative
 16 impact on their experience of bereavement.

17 A representative from Mind explained that:

18 "Some communities struggled to understand why they
 19 couldn't run funerals as per their cultural norms.
 20 There was a lack of thought and understanding about how
 21 the impact on different cultural ways of bereavement was
 22 happening. It led to a white, Western understanding of
 23 Covid-19 restrictions."

24 Separately, some bereaved people have described an
 25 enduring sense of injustice where there was uncertainty

106

1 as to the circumstances of their loved ones' deaths
 2 during the pandemic and where they felt there was no
 3 obvious route for complaint, investigation or
 4 accountability while Covid restrictions remained in
 5 place.

6 One bereaved person told the Inquiry that they only
 7 found out the circumstances of their mother's death,
 8 through the complaints process, approximately one year
 9 later and the fact that they were not informed at the
 10 time and had to complain made them feel angry. Another
 11 said that while her husband was in hospital she was
 12 "sick with worry" and telephoned the hospital to try and
 13 updates as to how he was but did not get an answer.

14 The general administrative process of managing a
 15 bereavement was made more difficult during the pandemic.
 16 After a loved one died, family members had to manage
 17 processes like closing bank, utilities and other
 18 accounts while dealing with their loss. The
 19 restrictions in place as a result of the pandemic made
 20 this more complicated for many. Witnesses told the
 21 Inquiry that companies and organisations did not adapt
 22 to take into account the circumstances of the pandemic
 23 for those were experiencing loss. There was
 24 insufficient support for bereaved people and businesses
 25 to navigate what was required and processes lacked

107

1 compassion.

2 One contributor to Every Story Matters said:
 3 "Banks, building societies, offices ... all of them
 4 were working from home on limited hours. I spent days
 5 on hold. I repeat that only those who suffered
 6 a bereavement at the time know how difficult it
 7 was ... I wanted peace and all I got was frustration,
 8 obstacles, excuses from these companies."

9 Another contributor to Every Story Matters from
 10 Wales said that the processes of death administration
 11 compounded the impact of their loved one's death upon
 12 them:

13 "For me, the hard thing was actually picking up the
 14 phone and shutting down all the accounts ... I almost
 15 felt I was complicit in their death, and then I felt
 16 their deaths were unnecessary and I was trying to fight
 17 that. But at the same time, I was having to go along
 18 with it and shut them down and close them down like they
 19 never existed ... That was a real, personal struggle for
 20 me, was to put their lives down, where I kind of felt
 21 their lives perhaps weren't ready to end."

22 Some felt that there was limited information on how
 23 to deal with the administrative aspects of a death
 24 during the pandemic and bereaved people felt that there
 25 was insufficient signposting or support. The Inquiry

108

1 has heard that families searched for guidance after a
 2 death, that this information was not easily accessible
 3 and that this added to the stress and grief experienced.

4 There was limited opportunity to access different
 5 forms of bereavement support during the pandemic for
 6 many people. You will hear criticism of delays
 7 experienced when people got in contact with support
 8 services, and also in relation to the quality and
 9 effectiveness of the support that was available. Some
 10 found online services helpful, others thought they were
 11 inaccessible, impersonal and unhelpful.

12 One contributor to Every Story Matters told the
 13 Inquiry:

14 "When I contacted them, basically I was just on a
 15 waiting list for, I don't know, it must have been about
 16 a year. And then I had Zoom sessions with this lady,
 17 and she was a lovely lady, but I felt that I didn't
 18 really get that much out of it because I was that much
 19 further on and she was more about the basics of grief
 20 and that type of thing."

21 We will explore evidence on bereavement support,
 22 including from those working within the system who
 23 reported a drop-off in referrals in the early part of
 24 the pandemic with assumptions perhaps being made that
 25 the service would not be available.

109

1 Cruse Bereavement Support, from whom you will hear,
 2 told the Roundtable on Funerals, Burials and Bereavement
 3 support:

4 "There were some real challenges, the rapid shift.
 5 Cruse is primarily volunteer delivered and was very
 6 local and face-to-face and to virtual using technology
 7 that was new to us. Upskilling thousands of volunteers
 8 ... that can be tricky at the best of times, so at
 9 speed, that's harder."

10 You will hear evidence that those working in
 11 bereavement services did not feel that they were
 12 equipped to support people through a pandemic. The
 13 volume of high-pressure work, with many more unexpected
 14 the deaths than was typical, and many more people
 15 dealing with traumatic grief, took its toll on the
 16 mental health of those working to support bereaved
 17 people, in funeral services, in bereavement support, and
 18 beyond.

19 One contributor to Every Story Matters, working in
 20 hospice care during the pandemic, told the Inquiry:

21 "The impact of dealing with frightened families and
 22 patients, coupled with my own worries about my
 23 health ... led to me experiencing burnout. I am a
 24 counsellor by trained, specialising in bereavement and
 25 loss. There was an expectation in my role of holding

110

1 other people's grief and fear, it came to a point when
 2 I could no longer do that and I started losing my
 3 voice."

4 The need for support to meet the financial impact of
 5 bereavement during the pandemic was also significant.
 6 The National Bereavement Alliance told the Inquiry how
 7 difficult it was for people to experience grief during
 8 a time of more general fear and economic instability.
 9 They thought that financial worries people experienced
 10 during the pandemic were likely to have intensified
 11 peoples' experiences of bereavement. Some people told
 12 the Inquiry about the individual financial shocks
 13 associated with bereavement and the ongoing adequacy of
 14 bereavement support payments which were available. One
 15 widow told Every Story Matters:

16 "I am struggling with losing my husband at 31.
 17 I have had huge stress trying to manage financially to
 18 maintain my house and take care of my daughter. I am
 19 not entitled to any benefits as my house is owned and
 20 bereavement support only lasts 18 months."

21 Peer support and involvement in supporting others
 22 who were bereaved by Covid-19 helped some to process
 23 their grief and to feel less alone. Another bereaved
 24 widow told us:

25 "I found peer support ... people who understand

111

1 because they've been through something similar or even
 2 the same situation sometimes ... there's that general
 3 overall understanding of the emotions, the guilt, the
 4 whole thing and I think that is really important. I ...
 5 think, yes, until you're in it, you don't know
 6 about it."

7 However, the impact of bereavement was widespread
 8 and there were secondary and indirect impacts of
 9 bereavement as people reported how painful it was to see
 10 family members and friends isolated and overwhelmed with
 11 grief while being unable to assist or offer support as
 12 they ordinarily would. One bereaved grandson told Every
 13 Story Matters about the pain of supporting his mother
 14 through her loss:

15 "My mum has always dealt with mental health
 16 [issues], in one way or another but this really, really
 17 did affect her. Just not actually [being] able to be
 18 there in person for her ... Like if I'm phoning Mum and
 19 she's constantly there in tears there's only so much
 20 I can say. Where, like, a hug can go a long way."

21 This had a wider and, in some cases, detrimental
 22 impact on relationships. One contributor told us:

23 "We were all a really close family, and for, like
 24 the head of the family not to be there all of a sudden,
 25 and for us not to be able to be there ... it's changed

112

1 us as a family. I don't know if for the better, but
 2 definitely there's movements, with kind of, distancing
 3 ourselves from each other."

4 You will hear evidence suggesting that a lack of
 5 clarity and compassion in communications, including the
 6 handling of end-of-life care, had a significant and
 7 exacerbating impact on bereaved people. Examples are
 8 drawn from interactions with clinicians responsible for
 9 end-of-life care and the handling of the belongings of
 10 the bereaved after their death, which some believed to
 11 involve a diminution of dignity.

12 Social isolation during bereavement and prolonged
 13 grief as a result of the pandemic and measures in
 14 response have led to mental ill health and poor outcomes
 15 for many bereaved people. One contributor told Every
 16 Story Matters:

17 "Usually people come and visit you and you have that
 18 community around you. That wasn't there during Covid at
 19 all ... It was isolated, you felt so isolated."

20 You will hear how this isolation translated into
 21 long-term mental health impacts. One contributor told
 22 the Inquiry:

23 "Two years after, being isolated from everyone ...
 24 I still grieve and along with other health issues I now
 25 suffer from depression."

113

1 Additionally, the place of death was strongly
 2 associated with prolonged grief disorder symptoms.
 3 Grief outcomes were better when a death occurred in
 4 a care home compared to other settings. Although the
 5 study did not definitively identify the reasons for
 6 this, Dr Harrop suggests that this may be due to
 7 anticipatory grief, that is, the death in a care home is
 8 often more expected and less sudden.

9 The experience of grief was affected by demographic
 10 factors such as socio-economic status, ethnicity and
 11 medical conditions. Dr Harrop told the Inquiry that
 12 while the study cannot confirm the position:

13 "... wider literature suggests that such inequities
 14 may reflect a poorer quality of service provision in
 15 socially disadvantaged areas generally, or different
 16 abilities of people to engage with healthcare
 17 professionals and the healthcare system. However, they
 18 might also relate to the unequal impacts of the pandemic
 19 on poorer communities across the UK, potentially
 20 affecting community-level mental health and resilience,
 21 and in turn a more limited capacity for health grieving
 22 and adaptation amongst people living in the worst
 23 locations."

24 The impact of bereavement during the pandemic
 25 continues to take its toll on many. To take an example

115

1 You have received evidence from Dr Emily Harrop,
 2 a senior research fellow at the Marie Curie Research
 3 Centre at Cardiff University, whose work found that:

4 "Although it is generally expected that most
 5 bereaved individuals will adequately cope with their
 6 grief and slowly readjust to life without the deceased,
 7 it is recognised that significant minority of bereaved
 8 individuals will experience more complicated and
 9 problematic grieving processes, including [the]
 10 development of Prolonged Grief Disorder (PGD)."

11 Particular circumstances which were specific to the
 12 pandemic increased the prevalence of prolonged grief
 13 disorder symptoms in the bereaved. These included
 14 factors such as unexpected deaths, feeling unsupported
 15 by healthcare professionals immediately following
 16 the death, suboptimal communication with families by
 17 healthcare providers, being unable to visit, care for
 18 and say goodbye to family members as expected, perceived
 19 suffering and shock at sudden, traumatic deaths, and
 20 unanswered questions and doubts.

21 This led to people suffering feelings of
 22 powerlessness, guilt, anger and injustice, finding it
 23 hard to grieve and begin to accept the death.
 24 Disruption to longer-term support and coping processes
 25 further added to the anxiety.

114

1 of one of the impact witnesses who will share their
 2 personal experience with us in week 3, she has suffered
 3 from depression, with a knock-on effect on her physical
 4 health, she has become "completely introverted" and her
 5 memory has been affected.

6 Another impact witness will explain that it is only
 7 recently that she has been able to move forward with the
 8 aid of a journal. When pandemic restrictions were
 9 lifted, some said that this worsened their grief and
 10 they found themselves re-visiting the trauma of a loved
 11 one's death. I touch on their evidence only briefly, my
 12 Lady, as it is important that they have an opportunity
 13 to tell their stories to you themselves.

14 The contributions to Every Story Matters also
 15 powerfully underline that for many grief and its
 16 associated mental health impacts continue today. One
 17 person told the Inquiry:

18 "My partner's death and the circumstances
 19 surrounding his death affected my mental health which
 20 spiralled down and I was diagnosed with depression due
 21 to complicated bereavement as I blamed myself for not
 22 looking after him. I still suffer even today and it's
 23 something that will take a long time to get over."

24 A bereaved wife and daughter from Scotland added:
 25 "Understand that the impact of not being able to

116

1 grieve fully, properly, in a supported way, in your
 2 family, in your community and the traumatic impact of
 3 that, impacts on your physical and emotional wellbeing
 4 going forward. So it's actually impacting on society in
 5 a much longer-term way."

6 Bereaved families told the Inquiry about the
 7 particular anger they felt over alleged rule-breaking by
 8 public figures. They followed the rules and therefore
 9 the allegations of those within the government flouting
 10 those rules increased their pain and distress.

11 You have, my Lady, already considered the impact of
 12 rule breaking by decision makers and the huge distress
 13 this caused to members of the general public and to
 14 bereaved people in particular. The evidence in this
 15 module underlines the impact of this behaviour and the
 16 publicity surrounding such for those who were bereaved
 17 and struggling with guilt over their own compliance with
 18 the rules in the face of their continuing grief.

19 One contributor to Every Story Matters said:

20 "Every news bulletin, Partygate revelation,
 21 political denial ... it all cuts so deeply. It doesn't
 22 go away, and to have it constantly referenced everywhere
 23 I look and go is an unrelenting reminder of the
 24 insulting trauma so many of us have been needlessly put
 25 through. All of us suffering this Covid grief have

117

1 little to no chance of moving on from it."

2 Another said:

3 "The revelations of Tory parties which took place
 4 around the time Mum was dying have hit me very hard.
 5 I can go for a while thinking the pain of losing Mum is
 6 lessening, but then Partygate rears its ugly head in
 7 a news bulletin and I have to leave the room as I cannot
 8 watch. The anger is simmering most of the time."

9 These sentiments are reflected in the written
 10 opening statement provided to the Inquiry on behalf of
 11 Covid Bereaved Families for Justice Cymru in the
 12 following way:

13 "And those who followed the rules to their detriment
 14 continue to be outraged at that behaviour of those in
 15 privileged positions who did not."

16 Bereaved people say they have felt left behind and
 17 forgotten as society works to move beyond the pandemic.
 18 One bereaved daughter told Every Story Matters:

19 "Pretending that life is the same, it's
 20 not ... I lost Dad, and we all went through the
 21 pandemic, and I think the pretence we're back to normal
 22 is nonsense, because I definitely feel there's a bit of
 23 me that went into hibernation and never fully came out."

24 When looking to the future, some bereaved people
 25 highlight the importance of remembrance and

118

1 commemoration for their loved ones. As one contributor
 2 to Every Story Matters said:

3 "Our loved ones didn't have dignity in death so we
 4 must make sure that they have dignity now in
 5 remembering ... we need to look at ways in which it can
 6 be remembered, you know in a beautiful way for us, for
 7 them and make sure they're not forgotten and what they
 8 went through."

9 You may wish to consider among lessons which may be
 10 learned for the future how loss may be effectively
 11 memorialised. We hope that the work of your Inquiry and
 12 its reports will form a part of that process.

13 Throughout this Inquiry, my Lady has repeatedly
 14 stated that the purpose of these hearings is not only to
 15 understand the impact of the pandemic and the measures
 16 taken in response but to learn lessons for the future.

17 I turn now to deal with those.

18 The Inquiry has asked experts and witnesses to
 19 consider what lessons might be learned from their
 20 experience of the pandemic. Each of the Every Story
 21 Matters records and roundtable reports seeks to be
 22 forward-looking, and so also asks what lessons can, and
 23 should, be learned. In drawing this opening to a close,
 24 we reflect on the following cross-cutting themes which
 25 are emerging from the impact evidence heard in this and

119

1 earlier modules.

2 First, the extent to which the unequal impact of the
 3 pandemic or whole-systems crisis may be further
 4 exacerbated without careful consideration and planning.

5 In Module 2, you recommended that there be
 6 a framework to proactively consider those at risk of
 7 negative impact and to consider steps in mitigation. In
 8 due course, you may consider that the evidence heard in
 9 this module is further justification for the pre-emptive
 10 consideration of impact, inequality and vulnerability in
 11 the context of planning and response. We will explore
 12 how anticipating inequality will inform those who are
 13 charged with the duty of planning for future civil
 14 emergencies.

15 Second, while digital expansion is a generally
 16 positive story for this pandemic, many were unable to
 17 engage. We will consider a proactive approach to
 18 innovation which seeks to ensure that no-one is
 19 inadvertently left behind. This will build on the
 20 existing recommendations of the Inquiry on digital
 21 access, inclusion and exclusion.

22 Third, we will consider how evidence on data gaps in
 23 this module, relating to particular vulnerable groups,
 24 provides a strong indication that these gaps must be
 25 addressed in order to fully understand the impact of any

120

1 future civil emergency upon those most affected. This
 2 will build on the evidence that my Lady has heard in
 3 several earlier modules.

4 Fourth, we will consider how evidence on the
 5 approach to guidance and communications, on
 6 collaboration and co-working, as arising in each of the
 7 areas of scope for this module, might be incorporated
 8 into strategic planning and preparation for the next
 9 pandemic in order that lessons might be learned. This
 10 will build on the lessons of Module 2.

11 Fifth, we will consider how lessons might be learned
 12 from the experiences of specific groups impacted in this
 13 pandemic, and such that might be predictably impacted in
 14 the next pandemic, including bereaved people and key
 15 workers.

16 Sixth, the impact of Covid-19 is continuing. We
 17 will consider how learning might continue to be
 18 monitored beyond the pandemic period and beyond the
 19 conclusion of this Inquiry.

20 Finally, we will explore how the general themes and
 21 issues emerging from the impact evidence might build on
 22 your earlier recommendations, such that they might be
 23 embedded in preparation for and in response to the next
 24 pandemic or whole-system civil emergency in a way which
 25 prepares for a stronger, more resilient recovery.

121

1 In concluding, my Lady, we thank everyone who has
 2 supported the work of the Inquiry throughout this
 3 module. The process of reflection as to how Covid 19
 4 has impacted our lives may have been cathartic for some,
 5 but for many it will have involved reliving and sharing
 6 some of the most challenging and painful moments of life
 7 and of loss.

8 To everyone who has shared their story, whether by
 9 participating in Every Story Matters, engaging in the
 10 roundtables, speaking to the Inquiry's videographers,
 11 preparing a witness statement, or in supporting the work
 12 of Core Participants, we thank you.

13 Every personal story shared with the Inquiry informs
 14 your understanding of the impact of Covid-19 and the
 15 challenges which we will face together in the next
 16 inevitable pandemic or whole-systems crisis.

17 Tomorrow, Ms Rahman King's Counsel will introduce
 18 the evidence the Inquiry has drawn from the roundtables.
 19 You will then, during the course of tomorrow's sessions,
 20 hear from each of the Core Participants who wishes to
 21 make an opening statement. Many of these Core
 22 Participants have played a role throughout your work on
 23 this Inquiry. These opening statements, the conclusion
 24 of these hearings and of this final module may for them,
 25 as for the Inquiry, represent the culmination of many

122

1 months and years of work to ensure that the impact of
 2 Covid-19 on our society is not forgotten lost or
 3 underestimated. Your team is grateful to each of them
 4 for their work, focus and dedication during this module
 5 and throughout.

6 **LADY HALLETT:** Thank you very much indeed, Ms Blackwell.
 7 I am very grateful to you. Very well, I think it is
 8 time to adjourn now, and we shall resume at 10 am
 9 tomorrow.

10 **MS BLACKWELL:** Thank you, my Lady.
 11 (3.41 pm)

12 (The hearing adjourned until 10.00 am the following day)

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123

1 **I N D E X**
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 4 Opening Remarks by THE CHAIR 1
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 6 Opening statement by LEAD COUNSEL TO THE 4
 7 INQUIRY for MODULE 10
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124

<p>LADY HALLETT: [11] 1/4 4/4 10/5 32/24 33/4 64/12 64/19 99/1 99/4 99/8 123/6</p> <p>MS BLACKWELL: [8] 4/8 10/6 33/5 64/15 64/20 99/3 99/9 123/10</p> <p>'</p> <p>'COVID [1] 79/21 'COVID-19 [1] 79/21 'disposable' [1] 46/23 'routine' [1] 72/4 'vulnerable' [1] 16/11</p> <p>.</p> <p>... [19] 100/14 100/16 101/3 101/23 102/5 102/17 105/7 106/10 108/7 108/14 108/19 110/23 111/25 112/2 112/18 113/19 117/21 118/20 119/5</p> <p>1</p> <p>1 July 2020 [1] 68/6 1,200 [1] 2/17 1.5 million [1] 45/3 1.50 [1] 64/14 1.50 pm [1] 64/18 10 [4] 1/5 4/7 10/1 124/7 10 am [1] 123/8 10 per cent [1] 98/2 10's [1] 95/1 10.00 [1] 123/12 10.30 [1] 1/2 100,000 [2] 47/13 47/18 11 [1] 23/16 11.45 [1] 33/1 111 [1] 2/21 12 months [2] 91/8 91/10 12.00 pm [1] 33/3 12.49 pm [1] 64/16 138,000 [1] 85/4 15 per cent [1] 53/24 16 February 2026 [1] 1/1 16-25 [1] 77/12 16.9 [1] 47/18 17 per cent [2] 18/21 91/9 18 March 2020 [1] 15/17 18 months [1] 111/20 18-35-year olds [1] 77/3 19 [79] 1/6 1/8 2/8 4/11 4/17 4/21 5/7</p>	<p>26 per cent [1] 77/4 29 March 2020 [1] 80/14</p> <p>3</p> <p>3.04 pm [1] 99/7 3.05 [1] 99/4 3.09 per cent [1] 53/25</p> <p>3.41 pm [1] 123/11 3.7 million [1] 85/3 3.79 per cent [1] 54/1</p> <p>30 [1] 50/13 30 March 2020 [1] 77/18 31 [1] 111/16 31 March 2021 [1] 68/6</p> <p>4</p> <p>40 [1] 84/5 40 per cent [3] 20/5 34/15 78/24</p> <p>43 [1] 9/2</p> <p>46 per cent [1] 18/21</p> <p>48 [1] 2/18</p> <p>5</p> <p>5,700 [1] 12/13 50 [2] 78/24 79/6</p> <p>50 per cent [1] 86/8</p> <p>55,362 [1] 8/24</p> <p>6</p> <p>68 [1] 100/5</p> <p>7</p> <p>70 [3] 50/13 50/18 84/4</p> <p>78.7 Covid-19 [1] 47/13</p> <p>8</p> <p>80,000 [1] 85/4</p> <p>820 per cent [1] 77/24</p> <p>9</p> <p>9.1 per cent [1] 26/16</p> <p>98 [1] 12/16</p> <p>A</p> <p>abandoned [1] 29/16 abandonment [1] 105/12</p> <p>abilities [1] 115/16</p> <p>ability [2] 56/23 79/17</p> <p>able [17] 3/15 17/11 17/13 22/11 26/10</p> <p>according [1] 88/11</p> <p>accordance [1] 11/14</p> <p>According [1] 80/6</p> <p>account [3] 48/2 83/15 107/22</p> <p>accountability [1] 107/4</p> <p>accounts [4] 2/25 8/25 107/18 108/14</p> <p>accounts ... I almost [1] 108/14</p> <p>accused [1] 57/16</p> <p>achieve [1] 55/23</p> <p>achieved [1] 10/12</p> <p>acknowledge [3] 8/8 10/24 13/2</p> <p>acknowledges [1] 30/3</p> <p>acquiring [1] 65/2</p> <p>across [40] 4/16 9/1 13/6 16/20 18/6 18/13 20/7 24/5 27/4 28/12</p> <p>about it [1] 112/6 above [1] 79/6 absence [2] 37/17 38/1 38/7 38/9 38/11 39/18 41/15 44/13</p> <p>absolute [1] 52/12 absorb [1] 74/15 absorbed [1] 72/20 abuse [24] 9/18 52/15 52/21 55/24 56/3 56/14 56/18 66/5 66/6 77/16 77/18 77/20 77/23 77/24 94/8 94/12 94/17 94/20 95/13 96/11 96/23 97/11 97/22 97/24</p> <p>act [6] 26/2 26/15 31/1 60/17 79/15 94/14</p> <p>acted [1] 90/3 acting [1] 49/6</p> <p>action [2] 60/10 83/6</p> <p>actionable [1] 38/4 actions [3] 14/22 51/1 51/2</p> <p>activities [9] 18/18 18/20 22/6 27/10 27/11 41/8 70/15 79/18 85/10</p> <p>activity [4] 41/10 41/13 71/16 79/2</p> <p>acts [1] 6/24</p> <p>actually [4] 101/23 108/13 112/17 117/4</p> <p>acute [4] 24/19 26/6 27/13 34/5</p> <p>acutely [1] 16/11</p> <p>adapt [4] 23/9 40/25 41/1 107/21</p> <p>adaptation [1] 115/22</p> <p>adapted [3] 37/6 40/18 63/22</p> <p>adapting [1] 40/20</p> <p>added [5] 62/25 84/24 109/3 114/25 116/24</p> <p>adding [1] 74/16</p> <p>addition [4] 2/20 7/18 62/3 98/4</p> <p>additional [8] 14/14 55/13 65/22 70/17 72/20 73/3 74/15 88/18</p> <p>Additionally [1] 115/1</p> <p>address [1] 19/20</p> <p>addressed [6] 10/3</p>
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A	after [22] 3/11 3/18 3/22 6/19 15/17 22/20 25/21 25/24 28/10 32/21 49/23 51/15 57/2 68/17 73/24 85/25 91/17 107/16 109/1 113/10 113/23 116/22 after-effects [1] 28/10 afternoon [1] 101/1 again [5] 4/14 41/11 41/14 67/9 98/23 against [5] 6/7 31/17 95/6 97/23 98/2 age [3] 47/12 47/17 73/24 age-standardised [2] 47/12 47/17 aged [4] 77/12 78/24 79/6 84/4 Ageing [1] 78/23 agencies [1] 70/7 Agent [1] 59/1 aggressive [1] 97/14 agoraphobia [2] 19/14 21/17 aid [4] 55/3 95/5 95/12 116/8 air [1] 48/16 akt [1] 77/11 albeit [1] 18/25 alcohol [3] 22/8 23/14 89/3 alerted [1] 98/20 Alexia [1] 58/24 aligned [1] 25/3 alike [1] 29/8 all [43] 3/1 3/3 10/24 14/8 22/21 23/19 24/1 28/5 28/15 30/18 39/18 40/24 45/25 46/14 48/23 49/21 49/22 53/11 55/18 59/7 62/1 62/13 63/5 66/8 68/7 68/21 75/7 84/25 87/6 92/7 101/23 102/5 102/18 103/23 108/3 108/7 108/14 112/23 112/24 113/19 117/21 117/25 118/20 all ... It [1] 113/19 allegations [1] 117/9 alleged [1] 117/7 alleviate [2] 53/4 64/3 Alliance [1] 111/6 allow [5] 34/1 38/24 61/15 101/13 105/20 allowed [9] 44/25 72/1 89/19 96/19 101/3 101/20 102/4 104/7 106/2 allowed ... I have [1] 101/3	allowing [2] 105/23 106/3 almost [3] 20/5 34/15 108/14 alone [3] 15/15 106/2 111/23 along [3] 28/9 108/17 113/24 alongside [1] 31/24 already [32] 1/15 5/10 8/9 10/9 10/12 11/19 16/15 20/3 24/4 32/7 34/2 54/13 57/2 61/5 61/19 65/10 66/25 67/1 69/23 73/22 74/10 74/14 74/17 78/13 81/7 85/6 89/9 94/9 96/21 98/8 103/16 117/11 also [42] 2/16 3/24 5/17 8/25 11/23 22/20 25/7 27/16 30/9 31/23 32/3 33/17 35/25 36/12 40/10 40/12 41/3 41/15 41/17 42/24 43/5 44/8 45/7 53/17 56/9 64/2 67/23 68/10 71/21 73/6 73/12 77/6 77/20 78/6 83/16 91/7 92/18 109/8 111/5 115/18 116/14 119/22 altered [1] 90/21 alternative [1] 28/22 although [11] 3/5 27/3 31/7 34/13 59/22 62/3 62/20 71/1 76/8 114/4 115/4 altogether [1] 90/5 always [2] 51/12 112/15 am [12] 1/2 3/3 28/9 33/1 64/12 98/23 110/23 111/16 111/18 123/7 123/8 123/12 Amazon [1] 40/9 ambulance [2] 63/6 63/16 amended [1] 84/21 American [2] 95/7 95/17 amid [1] 18/21 among [9] 43/17 48/19 53/21 68/24 69/4 69/16 78/22 80/18 119/9 amongst [4] 47/13 100/9 103/18 115/22 amounts [1] 52/10 anaesthesia [1] 68/5 analysis [3] 10/17 33/9 78/22 Andrew [1] 92/3 Andrew Neilson [1] 92/3 anger [8] 49/17 52/15	99/23 102/4 105/19 114/22 117/7 118/8 angry [4] 23/10 101/16 102/14 107/10 announced [1] 30/17 another [15] 23/15 28/4 35/6 37/14 74/17 83/1 98/23 100/11 101/12 107/10 108/9 111/23 112/16 116/6 118/2 answer [1] 107/13 answers [3] 100/10 100/15 100/17 anticipated [1] 62/12 anticipating [1] 120/12 anticipatory [1] 115/7 antidepressant [1] 86/7 antiviral [1] 85/25 anxieties [3] 47/20 80/19 92/2 anxiety [20] 19/12 20/13 21/6 21/16 21/20 22/1 26/19 27/23 28/7 51/3 52/14 53/4 59/23 70/19 82/3 86/16 93/19 94/7 100/20 114/25 anxious [5] 21/22 30/9 46/25 72/4 101/11 any [19] 3/3 3/4 5/25 15/14 23/11 45/24 49/24 51/11 60/10 65/16 67/2 68/20 72/2 80/4 85/19 87/17 99/13 111/19 120/25 anyone [3] 4/1 54/6 80/6 anything [1] 102/21 apart [1] 63/24 apparent [2] 98/8 102/24 appear [1] 5/25 appeared [1] 71/17 appears [1] 58/10 applied [5] 80/24 84/8 84/15 103/12 106/14 apply [1] 38/1 appointments [5] 28/21 30/14 30/18 72/2 72/4 appreciate [1] 7/11 appreciated [2] 7/6 51/21 appreciation [2] 39/19 87/5 approach [10] 11/10 37/22 45/12 45/22 59/19 62/20 65/16 68/21 120/17 121/5 appropriate [6] 9/6	38/13 44/3 60/6 63/12 67/17 appropriately [1] 83/8 approximately [4] 68/2 84/5 86/8 107/8 apps [1] 40/22 April [1] 18/21 April 2020 [1] 18/21 are [37] 1/25 2/1 2/2 3/5 3/6 3/7 3/9 3/12 4/23 5/2 8/21 15/2 16/9 16/15 17/8 28/7 33/20 35/10 36/24 42/24 54/3 55/16 62/23 64/25 66/4 67/2 74/24 77/12 78/15 81/22 98/9 99/17 100/13 113/7 118/9 119/25 120/12 area [5] 6/12 50/14 58/10 63/3 88/14 areas [18] 16/20 33/10 50/9 54/10 58/19 62/1 62/7 63/18 67/20 69/3 73/24 75/7 75/12 87/13 87/21 94/20 115/15 121/7 Arguments [1] 47/2 arising [3] 5/22 69/11 121/6 around [12] 18/20 22/22 33/13 52/11 59/23 68/14 68/16 76/17 80/7 98/15 113/18 118/4 arranged [1] 105/12 arrangements [3] 50/12 63/24 64/2 arrears [1] 75/5 arrests [1] 70/11 arts [2] 41/22 41/23 as [163] Asian [3] 16/17 32/5 68/1 aside [1] 78/11 ask [1] 9/24 asked [1] 119/18 asking [1] 11/17 asks [1] 119/22 aspect [2] 35/21 73/12 aspects [2] 105/9 108/23 assessing [1] 30/1 assessments [1] 47/3 assist [7] 3/17 10/3 11/5 13/8 19/22 55/14 112/11 assistance [1] 66/23 assisted [1] 15/5 Associate [1] 70/22 associated [13] 19/17 32/1 35/9 43/19 86/12 86/15 87/3 92/2
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A	autumn [1] 84/23 availability [3] 33/9 76/18 92/25 available [6] 13/3 33/18 48/16 109/9 109/25 111/14 average [2] 24/7 77/19 avoid [4] 1/17 8/13 85/19 85/20 avoidable [1] 102/14 avoided [2] 26/10 90/4 aware [2] 55/16 64/6 away [8] 17/2 25/5 37/14 42/19 52/2 96/4 101/10 117/22 Azeem [1] 19/25	61/2 61/12 61/13 61/13 62/2 62/12 62/22 62/24 64/6 64/24 66/17 71/10 71/19 72/8 74/8 75/6 77/14 79/10 79/25 80/7 80/11 83/19 83/21 84/2 85/21 88/9 88/23 90/17 92/10 95/23 97/8 98/8 99/24 101/2 101/3 102/12 103/4 104/2 105/8 106/3 109/25 110/8 112/17 112/24 112/25 112/25 115/6 118/14 119/6 119/9 119/10 119/19 119/21 119/23 120/3 120/5 120/24 121/7 121/9 121/11 121/13 121/17 121/22 be learned [1] 74/8 beautiful [1] 119/6 became [9] 23/10 35/17 51/2 56/20 72/13 73/8 78/17 85/11 101/9 because [17] 23/18 27/24 28/2 42/19 44/22 53/13 60/22 61/1 61/8 66/11 89/2 90/5 96/9 96/10 109/18 112/1 118/22 Bail [1] 93/25 balance [2] 17/16 97/4 Bambra [1] 74/20 Bangladeshi [1] 69/4 bank [1] 107/17 banks [2] 45/10 108/3 barely [1] 101/22 barrier [1] 90/3 barriers [4] 29/21 69/13 85/17 94/25 base [1] 57/4 based [3] 28/25 33/23 57/10 baseline [1] 16/21 basically [3] 52/3 101/25 109/14 basics [1] 109/19 basis [1] 13/4 be [115] 1/16 1/18 2/4 2/18 3/8 3/15 3/22 4/19 5/8 6/5 6/22 7/6 7/23 7/25 9/8 10/2 10/5 11/3 11/25 13/3 13/13 14/10 14/20 15/5 15/9 15/14 16/10 26/17 27/24 32/5 33/8 35/2 35/8 35/10 35/11 38/18 40/16 42/7 42/7 43/2 44/2 48/3 49/6 49/16 50/12 52/21 54/7 54/12 59/13 59/19 60/14 60/19	begun [1] 7/4 behalf [10] 20/2 58/24 83/17 85/12 90/13 92/3 92/5 92/6 96/12 118/10 behaviour [4] 40/20 71/14 117/15 118/14 behaviours [3] 37/6 37/13 78/21 behind [3] 4/23 118/16 120/19 being [29] 11/2 16/8 17/13 17/13 22/5 30/4 39/5 39/9 45/8 51/11 60/12 65/24 68/11 69/12 70/3 70/3 77/7 79/25 81/3 91/21 94/1 98/18 99/20 109/24 112/11 112/17 113/23 114/17 116/25 Belfast [1] 20/17 believe [1] 29/14 believed [3] 43/18 43/20 113/10 belongings [1] 113/9 benefit [2] 2/25 8/19 benefits [2] 80/8 111/19 bereaved [35] 1/13 8/17 16/12 62/18 101/15 103/3 103/19 103/21 104/5 104/14 105/2 105/15 106/24 107/6 107/24 108/24 110/16 111/22 111/23 112/12 113/7 113/10 113/15 114/5 114/7 114/13 116/24 117/6 117/14 117/16 118/11 118/16 118/18 118/24 121/14 bereavement [37] 8/3 8/24 9/18 14/9 14/13 14/17 35/5 98/25 99/11 99/16 99/19 104/6 104/12 104/22 104/24 106/16 106/21 107/15 108/6 109/5 109/21 110/1 110/2 110/11 110/17 110/24 111/5 111/6 111/11 111/13 111/14 111/20 112/7 112/9 113/12 115/24 116/21 best [3] 17/17 52/1 110/8 better [11] 6/22 7/9 56/13 57/17 66/17 67/1 83/13 98/12 98/20 113/1 115/3 between [10] 15/2 20/9 30/5 39/8 45/6 49/19 53/24 71/6 75/11 93/1 beyond [16] 7/8 10/18 17/6 17/21 22/4	56/16 58/13 65/22 79/9 85/7 91/6 105/22 110/18 118/17 121/18 121/18 big [1] 40/9 binary [1] 33/25 biological [1] 71/10 bipolar [1] 28/19 bit [2] 40/8 118/22 black [15] 16/17 30/24 31/3 31/11 31/13 31/14 32/2 32/2 32/4 32/12 68/1 68/9 69/4 95/2 95/3 Blackwell [7] 3/19 4/5 33/4 64/19 99/2 99/8 123/6 blame [1] 51/12 blamed [1] 116/21 blood [1] 86/2 BMI [1] 84/4 board [1] 66/1 boat [1] 64/25 Bobby [1] 103/19 Bobby Storey [1] 103/19 bodies [4] 1/20 63/10 68/17 93/8 borders [2] 38/9 38/11 bore [2] 55/1 74/18 both [15] 2/4 5/11 11/21 14/11 16/7 22/20 42/16 51/6 51/14 55/6 60/23 66/18 73/18 94/18 102/17 both clinically [1] 51/6 boundaries [1] 49/19 break [7] 32/21 33/2 50/18 64/10 64/13 98/23 99/6 breaking [2] 117/7 117/12 breathing [1] 96/3 brief [2] 65/22 101/13 briefing [1] 21/19 briefly [1] 116/11 brilliant [1] 106/9 bring [3] 12/5 46/24 104/19 bringing [2] 9/10 47/1 brings [1] 63/5 British [3] 39/4 42/3 83/12 broad [1] 38/3 broke [1] 103/23 brother [3] 73/4 73/9 101/4 brought [5] 17/5 50/10 53/5 60/9 72/21 Brown [1] 18/8 Buddhist [1] 44/24 budget [1] 88/22
----------	---	---	--	---

B	15/9 100/15 103/24 110/8 112/20 112/20 118/5 119/5 119/22 can't [4] 28/2 100/14 100/18 105/5 cancer [1] 86/2 cancers [1] 84/11 cannon [1] 48/10 cannot [6] 5/8 7/6 61/13 65/18 115/12 118/7 capabilities [1] 40/19 capacity [5] 40/25 62/7 62/12 64/3 115/21 captured [1] 3/7 Cardiff [1] 114/3 cardiopulmonary [1] 80/20 cardiovascular [1] 71/13 care [52] 1/11 16/2 16/14 17/3 19/25 25/11 25/13 26/22 26/23 27/16 28/12 29/2 29/23 30/6 30/11 46/5 48/5 48/11 53/15 59/24 60/4 68/11 68/12 68/16 71/4 72/18 72/21 72/22 72/24 73/3 73/7 73/14 76/14 78/3 78/19 79/21 80/1 80/5 80/8 80/11 81/1 82/17 86/2 88/15 93/2 110/20 111/18 113/6 113/9 114/17 115/4 115/7 cared [3] 29/15 60/24 73/6 careful [2] 13/2 120/4 carefully [2] 6/22 7/18 Caregivers [1] 73/15 caregiving [1] 72/14 carer [1] 73/9 carers [4] 19/3 73/19 97/7 97/8 Caribbean [5] 31/11 31/13 32/2 105/4 105/6 caring [2] 72/23 73/17 carried [3] 14/13 43/10 81/1 carry [2] 51/12 79/17 carrying [1] 46/7 case [4] 21/21 59/4 82/14 90/23 caseloads [1] 27/6 cases [10] 56/3 56/9 57/14 61/7 61/13 61/17 69/19 76/1 88/25 112/21 casket [1] 105/13 catching [3] 48/19 101/11 102/20	categorisation [1] 45/23 category [2] 84/6 84/16 cathartic [1] 122/4 caught [2] 51/7 102/12 cause [5] 60/15 72/13 80/5 80/17 103/14 caused [14] 18/4 21/7 21/19 36/13 38/8 54/15 55/17 56/7 60/23 61/12 64/6 104/8 104/13 117/13 causes [2] 24/1 24/6 causing [2] 44/9 51/12 caution [1] 58/12 cautious [2] 33/17 77/14 celebration [2] 104/1 105/10 cells [4] 55/15 91/12 91/14 92/14 cent [24] 18/21 18/21 20/5 24/24 24/25 26/16 34/15 53/24 53/25 54/1 68/2 75/12 77/4 77/6 77/19 77/23 77/24 78/24 84/5 86/8 91/9 98/1 98/2 98/3 central [2] 11/13 24/23 centralised [1] 6/5 centre [4] 3/16 12/11 81/21 114/3 centres [3] 24/23 38/6 73/8 century [1] 4/22 certain [5] 32/19 59/8 65/1 84/10 87/14 Certainly [1] 32/24 certificate [2] 4/18 60/15 certification [1] 63/3 certified [1] 61/2 cetera [1] 63/7 CHAIR [3] 1/3 81/20 124/4 challenge [3] 13/16 35/4 88/13 challenges [12] 6/10 19/7 32/20 56/1 56/11 69/7 70/20 76/1 85/15 88/18 110/4 122/15 challenging [3] 38/1 74/14 122/6 chamber [1] 63/21 chance [1] 118/1 change [7] 37/4 37/14 58/13 60/24 62/19 79/12 102/3 changed [6] 37/6 37/13 59/5 59/22 84/21 112/25	changes [10] 18/25 25/8 25/9 38/14 40/20 54/20 59/6 61/10 66/25 73/10 changing [1] 49/9 chapter [1] 45/18 characterised [1] 92/19 characteristics [3] 33/8 33/15 65/21 charged [2] 88/19 120/13 charging [1] 90/6 charities [1] 82/6 charity [4] 66/6 77/11 77/12 93/25 Charlie [1] 92/5 Charlie Taylor [1] 92/5 chased [1] 52/3 chatting [1] 22/24 chefs [1] 40/8 chief [8] 55/2 58/23 59/1 60/11 60/21 61/22 62/17 91/16 Chief Coroner [2] 58/23 60/21 childcare [3] 54/2 54/6 72/13 children [6] 5/4 11/20 48/5 49/25 72/24 73/18 children's [1] 38/5 choice [1] 105/9 choices [1] 104/2 choose [1] 105/13 choosing [1] 104/7 chose [1] 59/18 Christopher [2] 55/2 56/24 chronic [1] 86/3 chronology [1] 11/6 circumstances [12] 57/24 60/19 69/11 74/15 96/19 101/14 101/17 107/1 107/7 107/22 114/11 116/18 cited [3] 4/14 38/14 106/4 cities [1] 9/3 civil [6] 14/24 15/10 64/4 120/13 121/1 121/24 Clare [3] 19/23 70/22 74/20 clarity [6] 39/3 54/14 54/23 98/14 106/13 113/5 classed [1] 62/4 classes [2] 23/8 41/5 cleaner [1] 51/4 cleaning [2] 46/6 52/11 clear [6] 10/9 15/25 18/5 39/9 89/23 94/5 clients [1] 55/11	clinical [8] 19/13 24/20 42/14 78/12 79/19 79/23 80/15 84/18 clinically [26] 18/13 19/15 19/16 20/2 42/11 50/3 50/4 50/24 51/6 81/5 81/5 83/23 83/24 84/1 84/7 85/2 85/7 85/12 85/15 85/24 86/7 86/9 86/13 86/20 86/23 86/23 clinicians [1] 113/8 close [11] 5/3 9/11 26/8 37/12 39/10 48/2 50/8 102/7 108/18 112/23 119/23 close-knit [1] 5/3 closed [2] 26/21 73/8 closely [1] 83/14 closing [3] 42/8 43/12 107/17 closure [7] 36/1 42/2 42/25 43/6 44/12 78/14 105/11 closures [1] 72/21 clothes [1] 105/14 clubs [2] 39/14 41/5 co [1] 121/6 co-working [1] 121/6 coach [2] 38/10 38/11 codes [1] 40/22 coercive [1] 97/3 coffin [1] 100/8 cohesion [2] 68/23 69/2 cohorting [1] 84/20 collaboration [2] 45/6 121/6 collaborative [1] 39/1 collapse [1] 72/12 colleagues [5] 46/22 46/25 48/20 50/17 96/8 collected [1] 47/14 College [6] 17/23 19/24 20/1 24/21 67/12 74/23 combat [1] 6/2 combination [1] 89/6 combined [2] 93/18 97/3 come [7] 3/5 19/20 32/21 42/22 101/2 101/3 113/17 comfort [2] 99/24 101/5 coming [4] 77/14 87/24 105/3 105/7 commemoration [1] 119/1 commencing [1] 77/17 Commission [1] 81/2
----------	---	--	---	--

C				
commissioned [1] 12/7	compliance [1] 117/17	confines [1] 44/4 confirm [1] 115/12	consultation [3] 29/5 82/19 83/9	23/10 30/7 35/16 95/20 96/25 97/3
commitment [1] 53/18	complicated [4] 99/20 107/20 114/8 116/21	confirmed [2] 60/12 95/25	consultations [1] 29/25	controlled [1] 101/14
commitments [1] 17/7	complications [3] 67/25 68/5 84/9	confirming [1] 104/6	consulted [1] 83/8	convened [1] 9/10
common [2] 37/19 104/13	complicit [1] 108/15	confirms [2] 69/18 86/14	consumer [2] 37/13 40/20	conversations [2] 9/13 30/8
communicating [1] 49/23	compounded [4] 85/16 91/3 97/6 108/11	conform [1] 48/24 confused [1] 101/16	consumers [3] 37/5 39/11 42/17	converted [1] 26/21
communication [2] 94/5 114/16	compounding [2] 65/25 76/15	confusion [7] 38/8 38/12 45/23 49/4 54/15 98/15 103/14	contact [18] 17/20 27/9 28/15 29/12 40/23 41/21 50/8	cope [6] 21/17 21/25 22/3 23/14 92/2 114/5
communications [4] 37/20 82/4 113/5 121/5	comprehensive [2] 66/12 76/6	connect [2] 44/25 88/4	59/18 88/12 91/2 92/21 95/24 96/15 96/19 99/21 103/3 103/8 109/7	coping [4] 22/5 23/11 91/24 114/24
communities [21] 5/4 7/3 12/3 16/18 21/2 35/21 36/13 36/19 41/21 42/1 54/18 67/13 69/8 69/13 70/18 74/17 104/25 105/4 106/15 106/18 115/19	compromised [1] 76/17	connected [1] 41/25	contacted [2] 51/16 109/14	cords [1] 12/4
communities' [1] 104/9	compulsive [1] 20/19	connection [3] 23/18 30/12 87/5	contacts [1] 25/11	Core [10] 1/19 1/23 8/15 10/24 11/7 66/24
community [29] 7/15 9/15 13/14 13/21 28/12 28/24 35/14 35/15 35/24 36/5 36/16 36/18 37/9 40/13 41/4 43/14 44/5 45/2 45/5 45/7 45/12 45/13 68/24 69/25 82/6 85/20 113/18 115/20 117/2	compulsory [5] 31/9 31/11 31/12 31/15 32/1	conscious [1] 101/22	contained [2] 21/21 98/6	95/1 122/12 122/20 122/21
community-level [1] 115/20	concentration [1] 18/17	consequence [1] 5/7	context [3] 10/16 65/12 120/11	Coronavirus [2] 60/17 89/17
companies [2] 107/21 108/8	concern [7] 24/5 24/9 33/6 39/7 42/12 42/13 54/5	consequences [6] 5/22 15/6 15/22 65/5 81/9 90/6	continue [9] 32/22 36/6 46/23 50/1 56/8 59/9 116/16 118/14 121/17	coroner [20] 58/23 58/25 59/14 59/18 60/11 60/12 60/16
company [1] 47/4	concerned [4] 29/24 42/11 59/17 96/9	consider [25] 10/16 10/19 11/3 14/9 14/17 15/11 35/10 35/20	continued [14] 6/18 8/14 17/21 24/7 26/3	60/20 60/21 60/22
Comparable [1] 93/16	concerning [2] 9/14 91/7	36/23 43/19 54/7 54/19 60/9 66/22 81/17 119/9 119/19	40/17 48/9 80/17 88/9	61/3 61/4 61/7 61/18
compared [9] 18/15 31/14 68/8 68/13 69/5 70/20 79/8 99/19 115/4	concerns [7] 29/19 29/22 38/12 47/23 47/24 51/18 90/5	120/6 120/7 120/8 120/17 120/22 121/4 121/11 121/17	88/9 92/13 93/2 105/22 106/6	61/22 62/1 62/7 62/15 62/17 63/12
comparison [1] 66/9	concession [3] 89/17 89/17 89/18	considerable [3] 80/17 90/22 104/3	continues [2] 98/18 115/25	coroner's [1] 62/3
compassion [3] 53/14 108/1 113/5	concluded [2] 65/10 94/12	considerably [1] 82/9	continuing [6] 34/8 35/5 53/3 101/16	coroners [8] 58/16 61/1 61/23 62/3 63/1
competing [1] 15/3	concludes [3] 32/14 34/12 79/6	consideration [8] 5/21 6/1 9/8 10/4 11/9	117/18 121/16	63/3 63/14 63/22
compilation [1] 4/9	concluding [1] 122/1	65/15 120/4 120/10	continuum [1] 12/18	coronial [1] 59/3
complain [1] 107/10	conclusion [3] 78/10 121/19 122/23	considerations [1] 15/20	contraception [1] 97/20	cost [1] 2/14
complaint [1] 107/3	conclusions [6] 3/2 6/24 10/19 10/25 12/16 78/15	considered [16] 6/9 6/21 11/19 12/13 13/4 26/23 40/16 49/6	contracted [1] 59/24	cost-effective [1] 2/14
complaints [2] 51/18 107/8	condition [1] 12/22	57/20 65/12 79/25 80/11 84/2 87/3 103/16 117/11	contracting [3] 42/12 46/1 52/12	costs [1] 75/3
complete [1] 89/4	conditions [26] 5/1 12/19 16/17 18/22 19/5 20/15 24/10	considering [3] 1/18 12/9 103/18	contributors [1] 7/21 70/18	could [19] 15/15
completed [1] 12/11	25/13 25/14 25/19 69/10 71/12 80/10 81/25 84/3 84/8 84/13 85/16 86/3 87/19	considers [2] 15/5 35/23	contributing [1] 70/18	21/24 22/22 26/10
completely [7] 77/7 80/4 102/11 102/13 102/15 104/21 116/4	88/16 89/12 91/3 92/18 95/10 115/11	consistency [1] 103/11	contribution [3] 45/18 53/7 82/8	31/17 36/6 42/6 44/2
complex [6] 30/1 40/4 61/13 61/23 86/24 88/15	conducted [6] 2/23 55/11 58/18 61/14 62/22 77/2	consistent [3] 21/12 35/6 59/20	contributions [6] 8/20 17/8 36/9 45/8 66/23 116/14	48/12 52/3 62/6 66/17
complexity [1] 42/4	conferencing [1] 62/2	consistently [3] 86/14 86/19 86/21	contributor [26] 19/8 20/16 21/3 22/9 22/17	93/14 95/24 99/23
	confidence [3] 30/13 37/6 55/23	console [1] 50/20	23/6 23/15 26/7 28/4 28/18 29/9 71/25	100/21 102/6 105/8 111/2
	confined [2] 91/14 94/4	consolidates [1] 20/7	100/3 100/11 100/23	couldn't [5] 41/1 45/1
	confinement [4] 91/2 92/2 94/2 94/7	Consortium [5] 39/4 42/4 56/19 69/6 90/14	101/8 101/19 108/2 108/9 109/12 110/19	89/3 105/1 106/19
		constant [1] 85/11	112/22 113/15 113/21	council [5] 41/23
		constantly [2] 112/19 117/22	117/19 119/1	49/7 51/16 51/23 90/7
		constructive [1] 45/6	contributors [3] 17/4 21/13 103/1	Counsel [9] 3/19 3/24 4/6 9/20 36/25
			control [7] 22/11	43/2 98/5 122/17 124/6

C	99/16 99/19 106/23 111/22 121/16 122/14 123/2 Covid-19 impacted [1] 45/19 Covid-19-related [2] 24/11 75/16 Covid-positive [1] 48/7 Covid-secure [1] 88/11 crafts [1] 17/14 create [1] 89/11 created [6] 45/23 56/4 70/16 85/17 95/10 105/18 creative [1] 40/2 credit [2] 75/14 95/22 cremate [1] 100/9 crime [1] 55/20 criminal [5] 56/16 57/6 57/14 64/3 70/10 crises [2] 16/4 88/24 crisis [13] 5/12 6/12 6/23 7/11 14/11 15/15 15/15 26/1 34/5 67/3 87/17 120/3 122/16 criteria [2] 84/15 84/16 critical [6] 10/17 45/21 76/19 79/21 80/1 80/8 criticism [2] 10/12 109/6 cross [2] 54/13 119/24 cross-cutting [2] 54/13 119/24 Crown [2] 58/25 59/1 Cruse [2] 110/1 110/5 cry [1] 52/12 culminated [1] 9/13 culmination [1] 122/25 cultural [13] 9/14 35/25 36/15 39/21 39/23 40/13 41/17 41/23 43/12 65/5 105/1 106/19 106/21 culture [1] 104/18 cumulative [1] 13/12 Curie [1] 114/2 curtailed [1] 93/3 custodial [1] 70/11 custody [1] 91/4 customers [1] 37/5 cuts [2] 57/3 117/21 cutting [3] 54/13 89/7 119/24 cycling [1] 41/8 Cymru [2] 88/5 118/11 cynical [1] 90/11	D	deaths [29] 4/16 24/8 24/11 47/13 47/18 50/17 59/15 59/23 60/2 60/2 60/9 60/13 60/19 60/24 61/1 61/2 61/11 62/10 62/14 63/13 75/16 91/4 91/6 91/8 107/1 108/16 110/14 114/14 114/19 debating [1] 63/20 debt [1] 75/4 decade [1] 57/3 deceased [2] 62/13 114/6 December [2] 53/25 91/8 December 2021 [2] 53/25 91/8 decision [9] 1/18 1/19 5/23 10/11 11/4 13/22 15/1 65/17 117/12 decision makers [1] 5/23 decisions [11] 1/22 5/18 6/2 6/13 7/8 10/18 14/15 15/4 30/3 79/24 83/4 declared [1] 15/18 decline [6] 20/25 71/19 73/19 73/21 79/4 91/19 declined [2] 40/14 69/2 declining [2] 15/21 57/4 decrease [2] 24/18 25/18 decreased [1] 86/16 decreasing [1] 41/10 dedicated [1] 82/24 dedication [1] 123/4 deemed [1] 85/15 deepened [1] 23/24 deepening [1] 76/10 deeply [2] 3/3 117/21 defendant [1] 57/7 defined [4] 79/15 83/23 84/1 85/2 dealing [4] 89/1 107/18 110/15 110/21 dealt [3] 51/17 60/14 112/15 dearth [1] 33/12 death [36] 4/18 8/3 21/20 24/6 51/13 51/15 59/12 59/18 60/15 62/8 62/8 62/11 63/3 68/17 71/8 84/9 101/18 105/5 105/5 105/11 107/7 108/10 108/11 108/15 108/23 109/2 113/10 114/16 114/23 115/1 115/3 115/7 116/11 116/18 116/19 119/3	delivered [3] 21/15 41/5 110/5 delivery [1] 27/15 demand [1] 77/21 demands [1] 63/2 dementia [1] 24/10 demographic [3] 41/15 65/22 115/9 denial [1] 117/21 denial ... it [1] 117/21 denied [2] 22/5 92/20 department [3] 16/2 25/1 97/12 departments [2] 24/19 25/6 dependent [1] 80/5 depleted [1] 91/21 depression [9] 19/12 19/14 20/9 23/17 28/8 82/3 113/25 116/3 116/20 depressive [1] 86/16 deprivation [4] 66/5 74/3 81/25 87/7 deprived [6] 69/3 73/24 75/7 75/12 87/13 87/21 depth [1] 7/2 descending [1] 11/11 describe [2] 74/16 98/7 described [15] 28/11 28/22 46/11 49/8 51/1 51/7 53/1 58/7 83/23 91/17 91/21 92/18 93/25 104/5 106/24 descriptions [1] 43/3 deserved [2] 53/13 105/17 designate [1] 1/19 designated [1] 86/10 desperate [2] 21/9 62/23 despite [4] 44/15 46/24 75/17 80/16 destroying [1] 100/17 detail [4] 1/16 3/22 11/11 38/24 details [1] 9/21 detained [2] 26/14 93/24 detainees [2] 93/25 94/1 detainees' [1] 94/6 detention [8] 26/2 90/19 90/20 92/8 93/9 93/17 93/18 94/3 detentions [4] 26/16 31/10 31/13 31/15 deterioration [8] 18/5 18/12 23/3 32/16 73/15 76/14 98/17 103/6 determinants [1] 75/1
----------	--	----------	--	--

D	41/19 44/17 45/14 45/15 45/16 57/10 57/25 78/14 84/20 93/5 94/21 98/13 120/15 120/20 dignity [4] 53/14 113/11 119/3 119/4 diminished [3] 5/8 29/25 82/5 diminution [1] 113/11 direct [5] 7/9 40/22 81/13 92/7 96/15 directly [2] 20/24 103/21 director [4] 50/15 53/10 53/16 81/21 disabilities [4] 19/5 73/5 80/10 81/8 disability [10] 66/11 79/14 80/13 81/18 81/20 81/21 82/18 83/6 85/1 94/24 disabled [19] 42/10 79/14 80/18 80/21 81/4 81/9 81/11 81/14 81/23 82/1 82/2 82/8 82/14 83/13 83/17 83/18 96/21 96/23 97/5 disadvantage [3] 72/12 74/18 87/4 disadvantaged [3] 65/8 87/22 115/15 disadvantages [1] 87/25 disaggregated [1] 66/13 discharges [2] 27/1 27/6 discourage [1] 92/22 discouraged [1] 90/10 discretion [1] 44/24 discrimination [1] 95/9 discussed [2] 37/8 48/15 discussions [1] 3/25 disease [4] 4/22 59/11 59/21 71/13 disorder [10] 12/22 19/12 20/19 20/22 23/13 28/20 29/11 114/10 114/13 115/2 disorders [1] 24/11 disparities [2] 41/15 76/11 disproportionate [1] 70/14 disproportionately [4] 72/20 74/2 87/21 104/23 disquiet [1] 80/18 disregarded [1] 68/21	disrespect [1] 43/23 disrupted [1] 85/18 disruption [6] 34/20 35/15 35/18 36/13 85/9 114/24 distancing [8] 15/23 48/1 48/4 48/12 61/16 85/22 92/16 113/2 distinct [1] 58/4 distinction [1] 39/8 distractions [1] 23/8 distress [14] 12/21 18/14 20/6 20/12 34/16 43/5 71/22 73/19 79/8 87/11 93/19 104/13 117/10 117/12 distressed [1] 55/14 distressing [2] 3/9 69/11 disturbing [1] 91/19 divergent [1] 88/10 diverse [2] 33/20 37/25 divisions [1] 58/19 DIY [1] 17/14 DNACPRs [1] 81/3 DNCPR [1] 81/1 do [15] 1/17 2/5 3/12 4/2 4/15 22/13 36/11 36/22 48/13 62/21 78/4 80/20 96/5 105/5 111/2 doctor [1] 60/16 doctors [2] 60/24 61/3 document [1] 79/22 documented [1] 78/2 documents [3] 2/16 2/17 80/17 does [3] 5/25 10/14 35/20 doesn't [1] 117/21 doing [4] 15/1 28/1 49/14 73/20 domestic [20] 9/17 30/20 55/24 56/2 56/14 56/18 66/5 77/16 77/18 77/20 77/23 77/24 88/17 94/8 94/11 94/17 94/19 95/13 96/22 97/24 don't [7] 20/21 42/21 64/13 95/21 109/15 112/5 113/1 done [4] 13/11 39/4 42/1 50/7 Dorland [2] 3/12 7/20 Dorland House [1] 7/20 double [5] 20/10 24/6 28/1 74/1 101/23 doubts [1] 114/20 down [17] 19/10 20/21 26/11 39/14	70/13 71/22 72/1 72/6 73/11 74/4 74/7 75/1 75/20 75/24 76/15 77/2 77/17 78/11 downtime [1] 50/19 downturns [1] 16/15 dozen [1] 100/9 Dr [5] 70/22 72/10 96/18 97/7 97/11 97/15 97/18 103/13 106/5 107/2 107/15 111/5 111/7 111/10 113/12 113/18 115/24 122/19 123/4 during the [1] 24/1 Durran [1] 58/24 duty [4] 53/13 60/13 63/12 120/13 dying [3] 65/3 101/25 118/4 dynamic [1] 12/20
E	each [15] 6/20 7/4 8/11 14/2 15/11 28/6 36/17 59/3 63/3 94/4 113/3 119/20 121/6 122/20 123/3 earlier [15] 6/20 6/24 8/9 10/11 10/18 10/25 10/25 13/10 14/2 20/8 31/22 64/10 120/1 121/3 121/22 early [13] 20/10 21/11 25/11 26/4 37/2 46/12 46/14 62/8 71/2 73/7 80/22 100/5 109/23 eased [3] 37/3 40/21 96/17 easements [2] 60/18 60/25 easier [2] 38/21 42/8 easily [1] 109/2 eating [3] 22/23 23/13 24/10 economic [18] 15/6 16/7 16/14 31/23 32/19 36/19 36/20 65/5 67/23 73/22 74/2 74/25 75/19 79/11 81/25 87/4 111/8 115/10 economically [2] 65/8 87/22 Economics [1] 70/23 economy [1] 37/15 edge [1] 74/14 education [5] 6/17 48/15 53/22 53/23 71/5 educational [1] 47/16 effect [6] 4/11 60/18 66/3 79/17 91/19 116/3 effective [4] 2/14	each [15] 6/20 7/4 8/11 14/2 15/11 28/6 36/17 59/3 63/3 94/4 113/3 119/20 121/6 122/20 123/3 earlier [15] 6/20 6/24 8/9 10/11 10/18 10/25 10/25 13/10 14/2 20/8 31/22 64/10 120/1 121/3 121/22 early [13] 20/10 21/11 25/11 26/4 37/2 46/12 46/14 62/8 71/2 73/7 80/22 100/5 109/23 eased [3] 37/3 40/21 96/17 easements [2] 60/18 60/25 easier [2] 38/21 42/8 easily [1] 109/2 eating [3] 22/23 23/13 24/10 economic [18] 15/6 16/7 16/14 31/23 32/19 36/19 36/20 65/5 67/23 73/22 74/2 74/25 75/19 79/11 81/25 87/4 111/8 115/10 economically [2] 65/8 87/22 Economics [1] 70/23 economy [1] 37/15 edge [1] 74/14 education [5] 6/17 48/15 53/22 53/23 71/5 educational [1] 47/16 effect [6] 4/11 60/18 66/3 79/17 91/19 116/3 effective [4] 2/14	

E	<p>effective... [3] 34/1 38/24 56/19</p> <p>effectively [2] 38/1 119/10</p> <p>effectiveness [2] 47/24 109/9</p> <p>effects [6] 28/10 35/3 71/11 71/13 75/17 98/21</p> <p>efficiency [1] 57/22</p> <p>effort [1] 94/2</p> <p>eight [1] 99/14</p> <p>either [4] 13/22 72/15 77/4 84/19</p> <p>Elder [1] 82/21</p> <p>Elder-Woodward [1] 82/21</p> <p>elements [1] 36/17</p> <p>elevated [6] 20/6 20/13 27/18 31/13 83/21 86/15</p> <p>eligible [2] 80/1 80/11</p> <p>else [1] 52/24</p> <p>elsewhere [1] 59/16</p> <p>elsewhere in [1] 59/16</p> <p>embedded [1] 121/23</p> <p>emerge [1] 80/22</p> <p>emerged [1] 84/22</p> <p>emergencies [2] 15/10 120/14</p> <p>emergency [14] 14/24 15/3 24/18 25/1 25/5 46/7 50/6 52/18 56/4 93/2 97/12 99/14 121/1 121/24</p> <p>emerging [4] 54/14 98/9 119/25 121/21</p> <p>Emeritus [2] 18/8 67/9</p> <p>Emily [1] 114/1</p> <p>emotional [6] 62/22 74/18 85/18 91/20 104/4 117/3</p> <p>emotionally [2] 27/22 49/18</p> <p>emotions [2] 23/12 112/3</p> <p>emphasise [1] 2/1</p> <p>emphasised [1] 38/22</p> <p>employees [1] 49/2</p> <p>employer [2] 51/14 51/20</p> <p>emptive [1] 120/9</p> <p>enable [2] 61/24 63/19</p> <p>enabled [1] 45/3</p> <p>enabling [3] 57/23 59/8 63/25</p> <p>encountered [1] 69/13</p>	<p>encouraging [1] 25/5</p> <p>end [10] 12/19 27/25 34/25 38/18 99/24 100/21 101/14 108/21 113/6 113/9</p> <p>endeavour [2] 9/5 13/10</p> <p>ended [2] 6/19 101/23</p> <p>ending [2] 26/8 88/7</p> <p>endless [1] 50/19</p> <p>enduring [2] 34/19 106/25</p> <p>energy [1] 49/24</p> <p>enforce [1] 49/16</p> <p>enforced [1] 52/24</p> <p>enforcement [2] 70/6 70/15</p> <p>enforcing [2] 52/17 52/23</p> <p>engage [7] 29/20 30/10 30/13 57/17 96/18 115/16 120/17</p> <p>engage with [1] 115/16</p> <p>engaged [2] 41/21 70/1</p> <p>engaging [3] 43/25 79/1 122/9</p> <p>England [17] 9/3 22/18 30/25 41/12 41/23 46/20 49/13 58/23 59/10 60/11 61/22 64/5 68/1 80/13 82/15 84/17 85/3</p> <p>English [1] 78/23</p> <p>enjoy [1] 18/19</p> <p>enjoyed [1] 17/8</p> <p>enjoyment [1] 18/18</p> <p>enormous [1] 47/2</p> <p>enough [2] 63/23 65/12</p> <p>ensure [6] 60/5 60/7 63/10 67/1 120/18 123/1</p> <p>ensuring [1] 36/5</p> <p>entered [4] 6/1 16/23 89/9 98/10</p> <p>entirely [1] 64/12</p> <p>entitled [2] 79/20 111/19</p> <p>entitlement [1] 90/3</p> <p>entrusted [1] 36/7</p> <p>entry [1] 52/22</p> <p>environment [2] 23/11 26/12</p> <p>environments [4] 28/11 30/14 48/15 76/24</p> <p>epidemiology [3] 17/22 24/21 74/22</p> <p>episode [1] 32/4</p> <p>equality [3] 43/13 66/13 79/15</p> <p>equality-disaggregat ed [1] 66/13</p>	<p>equally [3] 14/4 43/20 64/22</p> <p>equipment [2] 30/11 41/6</p> <p>equipped [1] 110/12</p> <p>equivalent [1] 13/19</p> <p>erosion [1] 75/5</p> <p>escalated [1] 97/15</p> <p>especially [3] 43/16 68/8 87/14</p> <p>essence [1] 74/16</p> <p>essential [5] 39/8 39/8 39/10 43/22 45/20</p> <p>established [2] 48/25 79/11</p> <p>estate [3] 63/18 92/4 93/7</p> <p>estimated [1] 85/1</p> <p>et [1] 63/7</p> <p>et cetera [1] 63/7</p> <p>ethnic [26] 16/17 19/6 30/24 31/3 32/13 67/7 67/13 67/15 67/19 67/22 67/24 68/7 68/9 68/11 68/18 68/20 68/22 68/24 69/1 69/4 69/16 70/1 70/7 70/18 87/23 104/23</p> <p>ethnicities [1] 87/15</p> <p>ethnicity [5] 33/7 33/14 66/10 73/25 115/10</p> <p>Evaluation [1] 12/11</p> <p>even [8] 53/18 61/6 96/20 97/5 100/18 102/3 112/1 116/22</p> <p>event [2] 20/17 99/13</p> <p>events [7] 9/1 9/9 11/6 14/14 41/7 41/19 103/18</p> <p>Eventually [1] 51/15</p> <p>every [64] 3/1 6/12 7/15 7/15 7/16 7/18 7/24 8/20 8/22 9/2 9/25 11/24 17/4 19/8 20/16 21/3 21/13 21/22 22/9 22/17 23/6 23/20 26/7 27/20 27/23 28/18 29/9 30/15 35/20 46/21 48/8 49/13 51/4 51/17 51/23 52/12 52/20 52/25 53/10 53/12 58/20 71/25 73/4 95/14 100/3 100/11 100/23 102/6 103/1 108/2 108/9 109/12 110/19 111/15 112/12 113/15 116/14 117/19 117/20 118/18 119/2 119/20 122/9 122/13</p> <p>everyday [2] 18/3 85/10</p> <p>everyone [10] 1/4</p>	<p>29/7 29/16 52/24 75/15 78/17 88/6 113/23 122/1 122/8</p> <p>everything [4] 40/2 52/2 96/2 100/21</p> <p>everywhere [1] 117/22</p> <p>evidence [102] 1/14 2/13 2/24 6/10 7/25 8/1 8/2 8/8 8/10 9/8 9/25 10/4 10/7 10/14 10/20 11/1 11/11 11/13 12/7 12/8 12/13 12/17 13/2 13/17</p> <p>evidence including [1] 81/17</p> <p>evidenced [1] 18/5</p> <p>evident [1] 28/8</p> <p>evolution [1] 37/7</p> <p>evolved [1] 92/25</p> <p>exacerbate [1] 16/10</p> <p>exacerbated [11]</p> <p>exacerbating [1] 113/7</p> <p>exacerbation [1] 24/15</p> <p>exacerbations [1] 31/19</p> <p>examination [3] 5/9 62/22 74/25</p> <p>examine [2] 11/16 70/12</p> <p>examined [1] 12/15</p> <p>examining [2] 1/22 3/22</p> <p>example [26] 5/24 10/19 22/17 25/10 26/15 30/19 33/10 33/18 33/22 38/10</p>	<p>39/3 40/21 44/18 45/2 48/1 54/19 55/24 62/21 63/15 63/19 66/3 71/1 80/22 82/16 84/23 115/25</p> <p>examples [2] 67/5 113/7</p> <p>Excellence [1] 79/20</p> <p>exceptional [3] 57/24 89/18 91/13</p> <p>excess [2] 24/8 62/10</p> <p>excluded [1] 45/14</p> <p>exclusion [4] 78/14 85/10 94/21 120/21</p> <p>exclusively [1] 84/18</p> <p>excuses [1] 108/8</p> <p>executive [3] 55/3 59/1 60/4</p> <p>exercise [5] 3/1 8/21 22/1 23/8 92/20</p> <p>exist [1] 10/14</p> <p>existed [1] 108/19</p> <p>existed ... That [1] 108/19</p> <p>existing [26] 11/23 16/10 16/16 16/24 17/25 19/4 19/4 23/4 24/15 28/17 31/23 32/18 57/1 63/9 65/25</p> <p>exited [1] 72/16</p> <p>expansion [2] 45/13 120/15</p> <p>expect [1] 42/7</p> <p>expectation [1] 110/25</p> <p>expectations [1] 56/5</p> <p>expected [6] 25/17 80/3 94/6 114/4 114/18 115/8</p> <p>experience [32] 7/17 11/23 12/2 12/21 12/23 14/9 16/4 17/24 20/15 35/11 46/3 46/4 46/14 46/21 47/22 66/4 67/12 71/15 72/6 78/9 79/4 82/2 96/22 99/11 100/7 100/19 106/16 111/7 114/8 115/9 116/2 119/20</p> <p>experienced [45] 4/25 7/8 7/12 14/5 16/25 19/1 19/7 19/19 20/5 21/1 23/22 24/11 28/19 31/19 46/17 46/18 54/20 62/18 73/14 75/6 76/5 76/11 76/13 76/23 77/9 77/21 79/9 81/23 87/9 87/10 87/22 88/1 89/5 93/16 94/21 94/22</p>
----------	---	---	--	---	--

E	84/7 85/3 85/24 86/9 86/20 86/24 101/4 101/11	117/2 family's [1] 73/11 far [4] 3/6 44/3 52/9 60/8 fatal [1] 59/4 fatihers [1] 5/4 favourite [1] 105/14 fear [13] 8/2 21/11 46/1 50/23 52/12 57/15 81/11 90/2 94/7 101/6 102/25 111/1 111/8 fearful [1] 21/5 fears [5] 46/20 47/22 48/14 50/21 51/7 feature [2] 35/6 85/11 February [3] 1/1 84/24 91/17 February 2021 [2] 84/24 91/17 Federation [1] 38/16 fee [1] 57/3 feedback [1] 57/13 feel [12] 26/9 42/21 51/21 57/17 72/3 101/4 101/16 102/4 107/10 110/11 111/23 118/22 feeling [7] 13/1 22/24 34/15 49/2 77/6 98/18 114/14 feelings [9] 18/24 20/24 56/10 93/19 99/11 99/23 102/25 105/17 114/21 feels [2] 20/23 102/13 fell [3] 23/12 59/15 86/10 fellow [1] 114/2 felt [37] 14/3 16/10 21/8 21/15 23/10 25/25 29/15 29/16 30/8 32/12 39/20 43/25 46/23 47/5 48/10 50/7 54/18 56/11 58/20 62/20 77/4 81/12 88/9 101/20 102/18 103/10 105/15 107/2 108/15 108/15 108/20 108/22 108/24 109/17 113/19 117/7 118/16 felt so [1] 113/19 female [1] 44/23 festivals [1] 43/8 fewer [5] 24/19 25/23 27/6 27/9 34/10 Fi [2] 95/22 96/6 Fifth [3] 9/8 14/9 121/11 fight [3] 52/5 52/6 108/16 figure [1] 4/19 figures [4] 4/14 4/23	70/8 117/8 fill [2] 2/10 83/11 film [4] 3/7 3/9 3/18 4/3 filtration [1] 48/16 final [8] 1/7 4/8 12/15 83/2 98/24 99/8 100/1 122/24 finally [5] 2/25 9/18 14/19 50/21 121/20 finances [1] 6/18 financial [13] 19/6 39/12 46/17 69/9 72/5 72/12 74/11 75/5 76/2 89/10 111/4 111/9 111/12 financially [1] 111/17 find [3] 2/12 3/8 100/15 finding [3] 18/18 21/25 114/22 findings [4] 10/18 10/25 18/10 31/22 fine [1] 102/15 finished [1] 38/18 fire [1] 53/16 firefighter [1] 50/5 firefighters [1] 48/3 first [28] 8/8 11/16 15/12 15/25 17/16 18/11 19/11 24/17 24/25 25/2 25/16 25/20 25/21 27/3 28/14 30/17 31/7 32/4 36/15 47/23 67/6 72/2 75/10 77/2 79/22 94/13 99/15 120/2 first-hand [1] 99/15 Fiscal [1] 59/2 fit [1] 80/2 fitness [1] 41/9 fits [1] 68/21 fitting [1] 4/8 five [1] 20/8 fixed [1] 70/14 flatmates [1] 76/25 fleeing [1] 95/4 flexibility [1] 56/12 flouting [1] 117/9 flow [1] 2/5 flowers [1] 105/15 fluctuated [1] 41/10 focus [7] 1/9 7/13 11/21 13/20 27/1 32/10 123/4 focusing [1] 8/22 fodder [1] 48/10 followed [3] 34/14 117/8 118/13 following [14] 3/10 17/8 25/2 26/9 27/5 38/13 85/22 95/2 103/24 105/11 114/15 118/12 119/24 123/12 food [5] 45/10 46/8 53/9 75/12 75/21	forced [2] 55/8 97/19 foreseeable [1] 99/13 forget [1] 2/8 forgotten [4] 81/12 118/17 119/7 123/2 form [1] 119/12 formally [1] 72/14 format [1] 44/15 formed [1] 37/17 forms [2] 72/11 109/5 Forum [1] 63/4 forward [5] 14/20 22/14 116/7 117/4 119/22 forward-looking [1] 119/22 found [16] 4/12 5/13 6/4 22/3 39/11 41/1 50/17 56/15 63/18 77/3 81/2 107/7 109/10 111/25 114/3 116/10 Foundation [4] 39/23 45/11 64/23 74/6 Foundation's [1] 77/20 four [6] 54/9 66/9 68/12 75/7 84/14 96/22 four days [1] 68/12 Fourth [4] 8/19 13/23 50/1 121/4 frailty [2] 79/23 80/15 framework [2] 15/5 120/6 Francesca [1] 90/13 Francesca Humi [1] 90/13 frankly [1] 51/25 free [1] 41/6 freedom [1] 21/4 freeing [1] 27/1 freelance [1] 39/22 Friday [1] 38/18 friends [7] 4/24 5/6 12/2 21/2 55/21 105/23 112/10 frightened [1] 110/21 front [1] 50/6 front-line [1] 50/6 frontline [2] 52/15 71/4 frustrating [1] 100/16 frustration [2] 45/23 108/7 full [3] 52/5 60/8 73/9 full-time [1] 73/9 fully [4] 7/6 117/1 118/23 120/25 function [2] 59/9 60/22 functioning [2] 13/1 58/16
----------	---	--	--	--

F	99/1 105/16 given [6] 2/25 5/21 39/3 43/3 50/13 85/13 Glasgow [1] 81/22 global [3] 15/15 19/24 70/22 glory [1] 52/3 glory-chased [1] 52/3 go [7] 52/13 102/6 108/17 112/20 117/22 117/23 118/5 going [9] 40/3 40/8 49/15 53/11 92/12 98/23 100/13 102/18 117/4 good [3] 1/4 13/1 96/10 goodbye [3] 99/21 101/22 114/18 got [7] 21/22 23/9 23/19 96/2 106/9 108/7 109/7 government [17] 1/20 5/14 5/18 13/18 37/24 39/6 44/1 48/22 54/14 66/14 70/4 76/18 82/23 83/20 94/14 98/16 117/9 governments [6] 6/1 59/7 70/24 75/9 82/11 82/12 governments' [1] 66/16 GP [3] 25/16 28/20 84/19 GPs [1] 63/7 grandfather [1] 101/10 grandparents [1] 5/5 grandson [1] 112/12 grassroots [1] 13/15 grateful [4] 3/3 106/1 123/3 123/7 greater [19] 24/12 26/14 32/20 37/9 39/3 48/25 53/5 56/12 61/6 65/1 67/19 70/2 71/5 73/20 74/18 79/10 79/12 84/4 87/10 greatest [1] 34/6 grief [24] 5/6 73/11 74/1 99/11 106/2 109/3 109/19 110/15 111/1 111/7 111/23 112/11 113/13 114/6 114/10 114/12 115/2 115/3 115/7 115/9 116/9 116/15 117/18 117/25 grieve [4] 100/18 113/24 114/23 117/1 grieving [2] 114/9 115/21 grinned [1] 6/11 group [12] 8/17	26/12 44/20 49/23 55/3 56/18 68/9 76/7 82/17 85/19 95/1 96/13 groups [45] 5/16 13/24 14/6 16/11 16/14 16/15 19/2 19/7 28/23 29/4 29/19 30/24 31/4 31/14 32/5 32/12 32/19 41/15 43/17 44/7 44/9 44/24 45/7 48/24 65/1 67/7 68/8 68/18 68/20 68/21 68/24 69/1 69/4 69/16 72/9 76/5 78/18 80/12 82/7 83/21 84/21 95/2 104/23 120/23 121/12 groups' [1] 43/7 growth [1] 17/20 guidance [27] 15/19 37/20 37/24 38/7 38/12 38/14 38/14 38/18 38/21 38/23 39/2 39/5 43/19 44/2 49/4 49/8 49/9 49/11 60/11 61/21 80/15 83/12 89/23 103/11 106/13 109/1 121/5 guideline [1] 79/21 guidelines [2] 80/16 85/22 guilt [8] 99/23 100/20 102/3 102/25 105/17 112/3 114/22 117/17 guilty [2] 101/4 101/17 Gutteridge [1] 88/3	half [1] 18/15 Hamlyn [1] 39/23 hand [4] 52/6 52/11 99/15 102/1 handling [2] 113/6 113/9 hands [2] 2/1 64/12 happen [2] 48/12 102/4 happened [2] 99/25 106/12 happening [2] 63/17 106/22 happiness [1] 18/23 happy [1] 52/5 hard [6] 14/7 23/20 29/11 108/13 114/23 118/4 harder [4] 55/20 56/15 71/19 110/9 hardest [1] 49/14 hardship [2] 19/6 76/2 harm [7] 5/13 8/2 23/13 67/2 91/25 102/21 102/22 harming [1] 23/20 harms [3] 65/13 81/16 87/6 Harrop [3] 114/1 115/6 115/11 harrowing [1] 97/9 has [49] 1/11 1/15 3/18 6/18 7/4 7/14 7/15 7/16 7/16 10/12 11/1 11/7 11/19 12/7 24/22 30/24 43/14 49/20 56/24 57/7 58/12 60/21 63/12 64/21 69/22 73/6 73/22 76/4 79/16 81/7 82/20 82/21 83/6 85/13 103/16 105/22 109/1 112/15 116/2 116/4 116/5 116/7 119/13 119/18 121/2 122/1 122/4 122/8 122/18 have [127] having [13] 6/6 12/22 23/7 28/20 52/13 88/24 89/2 96/8 97/4 98/22 99/21 103/7 108/17 he [8] 30/3 73/9 74/8 97/14 100/5 100/8 101/1 107/13 he acknowledges [1] 30/3 head [4] 38/19 97/13 112/24 118/6 headlines [2] 15/11 65/23 headlining [1] 9/21 headquarters [1] 63/21
----------	---	--	---

H	49/20 49/23 49/25 51/13 52/4 62/7 77/8 85/20 85/23 86/14 87/18 96/5 108/4 115/4 115/7 homeless [2] 88/3 88/8 homelessness [8] 9/17 66/5 77/13 77/15 87/2 88/2 88/11 88/21 homes [3] 59/24 78/3 97/5 honour [2] 7/23 58/23 hope [2] 2/9 119/11 hormone [1] 71/11 horrific [1] 101/9 hospice [1] 110/20 hospital [6] 26/9 27/8 51/9 102/12 107/11 107/12 hospitalisation [1] 71/8 hospitality [6] 9/16 36/2 36/16 37/25 38/4 42/15 hospitals [1] 63/7 host [1] 43/8 hostels [1] 88/19 hosting [1] 41/6 hotel [1] 89/1 hotels [3] 38/5 88/22 88/25 hour [2] 50/18 87/12 hours [7] 53/14 55/15 72/16 73/20 91/15 94/4 108/4 house [4] 3/12 7/20 111/18 111/19 households [3] 48/7 72/18 87/23 houses [1] 87/10 housing [16] 9/17 74/12 75/3 75/14 76/24 77/10 87/2 87/8 87/12 87/15 87/15 87/19 88/1 88/21 89/6 89/8 how [50] 6/2 7/2 7/7 7/11 7/21 10/8 11/17 14/5 14/21 35/21 37/11 41/4 43/6 45/19 48/15 49/8 49/15 49/16 54/11 58/17 59/6 62/18 62/20 66/16 66/24 67/13 70/12 70/23 82/24 86/4 87/9 88/23 95/9 100/14 100/15 106/20 107/13 108/6 108/22 111/6 112/9 113/20 119/10 120/12 120/22 121/4 121/11 121/17 121/20 122/3 Howard [1] 92/4 however [26] 10/14	18/4 22/3 24/8 29/6 32/6 35/23 37/14 40/24 46/5 46/14 53/2 57/25 58/10 61/6 62/1 64/5 75/17 76/8 79/3 82/18 89/22 104/11 106/13 112/7 115/17 hug [1] 112/20 huge [5] 2/11 52/10 63/20 111/17 117/12 human [1] 92/21 humane [1] 102/5 Humi [1] 90/13 husband [3] 22/21 107/11 111/16 husbands [1] 5/5 Hygiene [1] 81/19 I I am [8] 3/3 28/9 64/12 98/23 110/23 111/16 111/18 123/7 I and [1] 54/3 I blamed [1] 116/21 I came [1] 26/8 I can [2] 112/20 118/5 I contacted [2] 51/16 109/14 I could [3] 21/24 22/22 111/2 I definitely [1] 118/22 I developed [2] 21/17 52/10 I did [3] 49/14 52/10 102/21 I didn't [1] 109/17 I do [1] 2/5 I don't [3] 20/21 109/15 113/1 I enforced [1] 52/24 I feel [2] 26/9 102/4 I fell [1] 23/12 I felt [6] 29/15 29/16 50/7 102/18 108/15 109/17 I found [2] 50/17 111/25 I got [2] 21/22 108/7 I had [6] 17/16 21/7 22/19 23/10 96/9 102/3 I have [6] 29/10 96/10 98/4 100/7 111/17 118/7 I have developed [1] 20/18 I hope [1] 2/9 I kind [1] 108/20 I look [1] 117/23 I make [1] 3/3 I must [1] 1/23 I now [2] 9/24 113/24 I really [1] 102/2 I received [1] 100/25 I refer [1] 8/12	I repeat [1] 108/5 I reported [1] 51/13 I saw [1] 29/13 I shall [4] 2/4 32/24 64/14 99/4 I should [1] 2/1 I spent [2] 49/21 108/4 I started [2] 22/13 111/2 I still [2] 113/24 116/22 I struggled [1] 23/9 I suggest [1] 3/10 I think [4] 37/13 112/4 118/21 123/7 I took [1] 51/13 I touch [1] 116/11 I turn [6] 11/10 35/13 45/17 67/4 94/8 119/17 I wanted [1] 101/2 I was [25] 17/11 19/11 21/14 21/21 I came [1] 26/8 I can [2] 112/20 118/5 I contacted [2] 51/16 109/14 I could [3] 21/24 22/22 111/2 I definitely [1] 118/22 I developed [2] 21/17 52/10 I did [3] 49/14 52/10 102/21 I didn't [1] 109/17 I do [1] 2/5 I don't [3] 20/21 109/15 113/1 I enforced [1] 52/24 I feel [2] 26/9 102/4 I fell [1] 23/12 I felt [6] 29/15 29/16 50/7 102/18 108/15 109/17 I found [2] 50/17 111/25 I got [2] 21/22 108/7 I had [6] 17/16 21/7 22/19 23/10 96/9 102/3 I have [6] 29/10 96/10 98/4 100/7 111/17 118/7 I have developed [1] 20/18 I hope [1] 2/9 I kind [1] 108/20 I look [1] 117/23 I make [1] 3/3 I must [1] 1/23 I now [2] 9/24 113/24 I really [1] 102/2 I received [1] 100/25 I refer [1] 8/12	23/25 24/4 28/14 28/18 29/10 29/20 31/16 33/14 65/2 71/7 images [1] 7/19 imaginative [1] 63/18 immediate [4] 6/14 56/21 85/8 91/11 immediately [2] 39/12 114/15 immense [1] 61/20 Immigrants [1] 90/8 immigration [9] 56/17 89/8 89/25 90/6 90/15 93/16 93/17 93/25 94/24 imminently [1] 101/21 immune [1] 71/11 immunocompromised [1] 84/11 immunosuppressed [1] 84/12 impact [119] 1/6 1/8 1/11 1/14 1/21 2/8 2/11 2/22 2/24 3/7 4/3 4/10 5/15 6/5 6/16 7/14 8/9 10/15 11/3 11/16 11/19 12/9 13/5 13/8 13/15 13/20 14/3 14/5 14/7 14/14 15/9 15/16 23/2 28/17 29/4 29/14 32/9 32/11 32/17 34/2 34/19 35/5 35/8 35/14 36/1 36/10 36/12 36/17 36/18 36/23 38/10 42/2 42/25 43/7 43/11 43/15 44/8 54/16 54/17 55/5 56/9 56/22 57/5 58/15 64/9 64/21 64/22 65/15 65/20 65/23 68/18 70/21 73/13 75/22 78/13 82/20 83/8 86/6 87/8 88/8 88/9 90/16 91/11 92/15 93/13 93/23 98/12 99/10 99/16 100/2 103/4 103/10 103/16 104/16 106/16 106/21 108/11 110/21 111/4 112/7 112/22 113/7 115/24 116/1 116/6 116/25 117/2 117/11 117/15 119/15 119/25 120/2 120/7 120/10 120/25 121/16 121/21 122/14 123/1 impacted [30] 6/13 7/3 7/5 7/22 8/4 8/16 10/8 19/3 27/9 27/14 impacted [30] 6/13 7/3 7/5 7/22 8/4 8/16 10/8 19/3 27/9 27/14 104/10 104/22 121/12
----------	--	--	---	---

I	32/8 impacted... [2] 121/13 122/4 impacted significantly [1] 39/15 impactful [1] 98/5 impacting [1] 117/4 impacts [28] 5/7 5/24 7/10 13/14 13/25 16/8 16/9 19/1 27/16 33/13 34/7 35/24 48/23 53/2 58/20 71/15 76/12 81/13 89/7 89/15 90/22 93/16 104/22 112/8 113/21 115/18 116/16 117/3 impairment [1] 79/16 Imperial [1] 20/1 impersonal [1] 109/11 implementation [1] 38/25 implemented [1] 47/4 implementing [2] 38/19 49/11 implications [2] 15/23 44/17 importance [2] 53/17 118/25 important [12] 6/4 8/8 9/12 17/12 25/8 37/11 46/12 63/1 105/6 105/7 112/4 116/12 important ... people [1] 105/7 imposed [3] 36/2 98/16 98/22 imposition [1] 104/14 impossible [4] 7/23 48/4 92/17 105/25 impoverished [1] 92/21 improve [2] 34/13 74/8 improved [4] 16/25 39/2 63/25 106/11 improvements [2] 2/9 34/17 improving [1] 57/22 inability [6] 21/4 21/16 30/10 43/8 62/6 105/13 inaccessible [2] 30/22 109/11 inadequate [1] 5/14 inadvertently [1] 120/19 inappropriate [2] 80/20 81/3 incapable [1] 45/16 incidence [2] 32/4	32/8 incidents [2] 51/14 97/17 include [4] 26/18 54/14 65/15 84/25 included [11] 46/6 59/6 67/19 70/13 77/22 84/2 84/6 84/10 84/20 89/16 114/13 includes [1] 54/18 including [46] 2/18 8/1 14/5 16/11 16/16 19/4 22/2 24/2 24/9 24/19 25/13 28/23 29/23 30/2 41/18 45/9 45/13 50/2 52/16 53/8 54/22 55/23 56/16 58/17 63/6 63/8 66/10 70/10 71/13 75/21 80/12 81/17 87/6 88/2 90/16 91/25 94/6 94/20 94/23 96/25 101/15 106/14 109/22 113/5 114/9 121/14 inclusion [4] 82/21 83/1 84/17 120/21 inclusive [1] 44/23 income [1] 75/13 inconsistency [1] 33/8 inconsistent [2] 39/9 76/20 incorporated [1] 121/7 increase [18] 16/6 26/25 41/7 44/13 44/14 57/8 60/23 64/2 73/13 73/19 77/23 77/24 78/21 79/9 91/6 91/9 96/15 97/10 increased [24] 17/2 20/12 22/24 31/2 44/21 61/18 67/18 67/21 67/23 68/10 70/14 71/20 71/22 72/22 75/4 77/19 83/22 86/15 91/5 94/7 97/18 97/22 114/12 117/10 increases [3] 75/4 79/7 87/10 increasing [4] 44/24 61/17 62/9 99/11 increasingly [1] 83/2 incredible [1] 17/15 incredibly [2] 22/21 102/23 indeed [2] 45/22 123/6 independent [1] 30/25 independently [1] 93/9 indicate [1] 25/9 indicated [3] 30/9 31/5 57/15	32/8 indicates [2] 96/17 104/13 indication [1] 120/24 indicator [1] 74/3 indirect [4] 5/22 7/10 81/13 112/8 individual [10] 4/10 7/3 7/16 9/22 15/24 47/21 60/9 68/25 80/4 111/12 individuals [15] 2/15 4/23 8/18 9/5 9/11 13/24 18/19 19/6 33/20 35/12 63/5 90/4 99/15 114/5 114/8 industries [1] 36/3 industry [3] 39/1 40/2 70/4 individuals [15] 2/15 4/23 8/18 9/5 9/11 13/24 18/19 19/6 33/20 35/12 63/5 90/4 99/15 114/5 114/8 inequalities [29] 16/10 19/4 24/15 29/23 31/24 32/6 32/19 34/21 40/4 41/16 66/1 66/20 67/13 67/16 67/22 67/23 68/10 72/5 72/11 72/18 74/25 75/3 75/10 75/19 76/5 81/23 88/14 92/9 94/23 inequalities including [1] 19/4 inequality [8] 44/17 65/24 73/22 74/17 75/13 80/13 120/10 120/12 inequities [3] 23/22 76/16 115/13 inequity [1] 29/3 inevitable [4] 15/2 35/18 64/6 122/16 inevitably [2] 27/8 99/18 infected [1] 84/9 infection [22] 26/22 30/4 30/7 35/16 42/13 47/7 47/23 50/21 50/22 67/18 67/21 67/24 71/6 71/21 71/24 73/23 76/7 78/2 78/5 81/11 85/8 97/2 infectious [1] 59/21 inflicted [1] 91/7 influence [1] 83/4 influx [1] 88/20 inform [5] 3/2 14/22 15/9 65/16 120/12 information [4] 21/22 84/22 108/22 109/2 informed [3] 9/9 84/18 107/9 informs [1] 122/13 inherent [2] 80/13 93/17 initial [4] 22/11 25/23 46/10 96/18 initially [3] 58/11	71/17 84/16 104/13 injustice [3] 105/19 106/25 114/22 innovate [1] 40/18 innovation [7] 41/3 41/18 41/20 45/12 56/13 58/11 120/18 innovations [1] 105/20 inpatient [2] 26/21 26/22 input [1] 11/9 inquests [8] 58/17 58/17 61/11 61/23 62/2 63/19 63/23 63/25 inquiries [1] 59/5 Inquiry [69] 1/25 2/3 3/19 3/24 4/6 4/15 4/20 5/9 7/14 8/6 8/25 9/10 10/1 10/2 10/13 10/22 11/1 11/21 12/7 17/5 20/8 23/15 34/3 35/7 41/13 49/20 54/2 54/13 55/25 56/25 60/21 62/17 64/21 64/24 65/20 69/22 73/10 74/9 74/24 82/22 83/7 95/9 103/5 103/16 103/20 106/1 107/6 107/21 108/25 109/13 110/20 111/6 111/12 113/22 115/11 116/17 117/6 118/10 119/11 119/13 119/18 120/20 121/19 122/2 122/13 122/18 122/23 122/25 124/7 Inquiry's [6] 3/14 6/20 8/20 9/12 95/12 122/10 insecure [1] 74/12 insecurities [1] 46/17 insecurity [9] 39/18 69/9 75/12 75/22 87/2 87/15 88/1 89/7 89/10 insomnia [1] 21/23 Inspector [1] 91/16 Inspectorate [3] 60/5 92/6 92/11 inspectors [1] 92/18 instability [1] 111/8 installed [1] 48/17 instance [1] 87/9 instead [1] 17/2 Institute [1] 79/19 institutional [1] 54/16 institutions [10] 9/15 35/25 36/14 36/15 39/21 39/24 40/13 41/17 41/24 54/19 instructed [2] 13/8 59/19 instruction [1] 87/18	instrument [1] 95/15 insufficiency [1] 63/16 insufficient [3] 62/13 107/24 108/25 insulting [1] 117/24 integral [1] 106/4 intense [1] 61/5 intensely [1] 15/4 intensification [1] 76/1 intensified [5] 57/1 72/17 89/13 93/19 111/10 intensifying [1] 74/1 intensity [1] 97/10 intensive [1] 73/20 interact [1] 45/1 interaction [1] 23/7 interactions [1] 113/8 interests [1] 15/3 intermingled [1] 50/14 internal [1] 16/1 international [1] 45/2 internet [1] 30/12 interpret [1] 49/15 interpreting [2] 49/11 68/15 interrupt [1] 2/5 intersectional [1] 95/8 intersectionality [1] 66/2 interventions [3] 29/21 31/21 66/17 into [16] 6/1 9/24 11/11 23/12 38/3 40/6 41/14 48/2 51/13 61/11 92/12 97/19 107/22 113/20 118/23 121/8 into hibernation [1] 118/23 introduce [3] 9/6 9/20 122/17 introduced [9] 17/10 40/22 59/7 71/23 72/14 77/22 89/14 90/25 91/18 introducing [2] 37/1 60/18 introduction [4] 25/3 57/10 57/25 91/13 introverted [1] 116/4 investigate [2] 60/1 60/13 investigating [1] 2/11 investigation [9] 8/6 11/14 13/8 14/19 60/2 62/14 62/18 62/24 107/3 investigations [5] 14/8 59/4 60/6 60/7
----------	--	---	--	--	---

I	21/21 21/23 22/13 23/17 23/19 29/6 34/20 35/8 36/6 37/12 38/1 38/19 38/21 40/3 40/9 41/1 43/20 43/25 44/22 46/2 48/18 48/19 53/13 53/15 53/16 55/20 56/7 56/15 56/23 58/8 58/10 61/6 62/20 63/23 64/24 66/11 69/23 72/11 73/2 82/25 85/1 89/12 89/24 90/12 93/12 93/13 94/12 94/21 96/6 98/8 100/6 100/8 101/12 102/5 102/13 102/13 102/23 103/10 104/20 106/11 106/22 108/6 108/18 109/15 109/18 111/1 111/7 112/5 112/6 112/9 113/19 114/4 114/7 114/22 116/6 116/12 117/21 117/21 117/22 118/1 119/5 122/5 123/7	just [10] 3/11 22/19 26/10 42/24 50/19 62/14 69/23 98/4 109/14 112/17 justice [26] 9/17 36/14 46/13 54/17 54/20 56/7 56/15 56/20 56/22 56/24 57/6 57/12 57/13 57/19 58/4 58/6 58/14 58/19 70/10 89/22 90/8 93/10 93/21 103/20 105/2 118/11 justification [1] 120/9	27/10 33/22 54/5 54/14 54/23 66/12 68/15 70/3 83/9 94/5 98/14 98/19 99/21 106/13 106/20 113/4 lacked [1] 107/25 lacking [6] 30/11 30/12 30/13 91/22 98/13 104/21 lacks [1] 76/6 lady [34] 4/8 4/21 5/10 6/9 8/6 9/24 11/3 15/12 16/20 32/21 33/5 36/5 45/17 54/8 55/16 64/5 64/8 64/20 73/22 81/7 94/9 97/9 98/8 98/23 99/9 103/4 109/16 109/17 116/12 117/11 119/13 121/2 122/1 123/10 Lama [1] 45/4 lambs [1] 51/25 language [2] 83/12 94/24 Lara [3] 20/2 85/12 87/1	73/5 80/9 80/12 84/25 121/17 least [6] 24/6 30/25 45/25 74/1 75/12 96/3 leave [6] 3/13 4/1 20/21 28/2 89/19 118/7 leavers [1] 88/15 leaving [4] 4/24 27/24 40/1 97/5 led [26] 11/1 18/1 23/3 32/15 38/12 41/3 41/20 44/6 44/12 49/2 51/19 52/9 56/1 56/6 57/11 66/13 69/11 70/2 75/25 97/23 101/6 103/5 106/22 110/23 113/14 114/21 left [8] 6/25 49/24 57/25 76/21 83/11 97/5 118/16 120/19 leg [1] 99/8 legacy [1] 42/20 legal [10] 1/24 54/21 55/3 55/6 55/7 55/17 57/23 59/9 61/2 89/7 legal requirements [1] 61/2 legislation [1] 59/17 legislative [1] 59/6 leisure [6] 6/17 9/15 35/25 36/17 41/4 43/22 less [11] 26/20 27/9 43/9 61/8 74/15 79/2 79/3 80/3 102/16 111/23 115/8 lessening [1] 118/6 lesser [1] 48/25 lessons [16] 13/13 14/25 35/10 54/7 66/24 74/7 83/18 90/17 92/9 119/9 119/16 119/19 119/22 121/9 121/10 121/11 lest [1] 2/8 let [2] 15/15 47/5 letter [1] 84/18 letters [1] 21/14 level [12] 9/15 13/15 13/21 13/22 14/14 27/17 39/3 45/6 58/2 64/7 69/1 115/20 levels [24] 18/15 20/6 20/13 25/17 25/20 25/21 27/7 30/23 31/15 32/1 34/16 34/23 34/24 39/18 41/9 41/13 69/17 69/18 69/24 71/17 73/17 82/3 91/1 91/4 LGBT [1] 77/20 LGBT Foundation's [1] 77/20 LGBTQ [6] 76/5
investigations... [1] 62/9				
invincible [1] 42/20				
involuntary [1] 30/23				
involve [2] 10/17 113/11				
involved [2] 42/4 122/5				
involvement [1] 111/21				
Ireland [13] 9/4 13/19 58/25 82/13 83/5 83/6 85/5 88/4 100/4 103/19 103/20 103/22 104/15				
is [74] 1/6 1/21 2/7 4/8 4/12 4/17 4/18 5/7 6/6 7/20 8/10 8/11 10/10 10/21 12/4 12/20 13/2 14/7 15/12 16/5 22/15 26/13 28/8 31/1 34/2 34/6 35/14 35/25 37/19 41/20 44/14 45/18 47/9 53/20 58/10 61/6 66/18 69/23 76/10 78/2 79/15 82/6 82/12 93/7 95/2 102/5 103/25 104/20 105/5 105/7 105/20 106/8 110/5 111/19 112/4 114/4 114/7 115/7 115/7 116/6 116/12 117/23 118/5 118/8 118/19 118/22 119/14 120/9 120/15 120/18 121/16 123/2 123/3 123/7				
isolate [2] 50/2 106/2				
isolated [10] 21/1 21/23 22/21 23/10 49/3 95/23 112/10 113/19 113/19 113/23				
isolation [11] 15/21 18/1 20/24 22/15 23/2 78/7 91/2 99/12 102/25 113/12 113/20				
issue [9] 14/7 30/23 32/9 32/10 34/2 38/15 40/1 63/12 69/21				
issued [5] 15/18 37/20 61/22 63/14 80/14				
issues [11] 2/2 3/21 9/22 10/11 23/9 30/2 56/17 63/15 112/16 113/24 121/21				
it [108] 1/8 1/16 4/8 5/7 5/12 5/22 5/25 6/4 6/6 7/12 7/23 10/21 11/3 12/4 12/13 13/4 14/13 15/14 15/18 19/13 20/19 20/23 20/23 21/15 21/21				
James [1] 78/8				
January [1] 53/25				
January 2022 [1] 53/25				
Jim [1] 82/20				
job [4] 39/18 46/17 72/13 96/10				
jobs [3] 48/13 67/20 72/7				
Joint [1] 90/7				
joke [1] 52/25				
Joseph [3] 45/10 64/23 74/6				
journal [1] 116/8				
Judge [1] 58/24				
Judge Alexia [1] 58/24				
July [1] 68/6				
June [2] 16/1 20/10				
June 2020 [1] 20/10				
jurors [1] 63/23				
jury [3] 61/11 61/12 63/19				
just [10] 3/11 22/19 26/10 42/24 50/19 62/14 69/23 98/4 109/14 112/17				
justice [26] 9/17 36/14 46/13 54/17 54/20 56/7 56/15 56/20 56/22 56/24 57/6 57/12 57/13 57/19 58/4 58/6 58/14				
justify [1] 120/9				
K				
Kate [1] 3/19				
KC [2] 3/19 3/24				
keenly [2] 32/12 39/21				
keep [3] 28/6 40/3 52/1				
keeping [2] 13/16 36/8				
kept [2] 34/15 53/11				
key [41] 1/10 5/7 8/23 9/16 11/6 13/16 35/24				
King's [8] 9/20 17/23 19/24 36/25 43/2 67/12 98/5 122/17				
Kingdom [1] 1/9 113/1 119/6				
know [10] 5/2 8/10 9/13 88/23 98/20 108/6 109/15 112/5 113/1 119/6				
know will [1] 8/10				
knowing [4] 100/14 100/15 100/16 100/17				
knowledge [3] 35/12 80/25 81/13				
known [3] 24/5 46/24 86/11				
L				
lack [18] 5/20 23/18				

L				
LGBTQ... [5]	76/13	100/22 108/20 108/21 122/4	looks [1] 7/1 Lord [1] 59/19 lose [2] 4/15 72/7 losing [3] 111/2 111/16 118/5	65/17 117/12 making [7] 1/19 2/7 10/11 11/4 13/22 38/1 40/19
lies [1]	6/8	living [12] 10/20 67/20 74/7 74/10 77/6 77/10 81/24 88/1 94/20 98/11 102/16 115/22	loss [24] 4/13 4/21 4/25 7/16 7/20 14/10 14/16 21/4 35/5 40/6 43/5 43/13 72/13 91/2 98/25 99/20 102/9 105/9 107/18 107/23 110/25 112/14 119/10 122/7	man [3] 73/4 73/6 73/8
life [41]	4/13 6/17 7/20 14/10 14/16 14/16 17/7 17/16 17/19 18/3 18/23 21/18 22/4 26/8 29/1 35/15 35/24 36/5 36/18 36/19 43/24 45/16 78/9 85/11 86/17 86/20 89/2 90/21 100/5 100/14 101/14 102/16 102/22 104/1 104/20 105/10 113/6 113/9 114/6 118/19 122/6	local [15] 13/18 13/22 27/5 37/9 41/25 45/7 48/22 51/16 60/4 63/4 63/5 63/7 83/13 83/15 110/6	losses [2] 5/3 102/7 lost [12] 5/6 22/20 39/20 54/4 58/21 81/12 96/10 98/18 100/5 103/7 118/20 123/2	managed [1] 58/3 management [6] 28/24 52/2 62/11 85/11 88/7 91/13
life such [1]	35/24	locations [1] 115/23	managing [5] 14/16 63/2 73/10 88/20 107/14	
lifted [1]	116/9	lock [1] 50/11	Manchester [1] 67/10	
light [2]	59/23 60/9	lockdown [39] 5/25 6/14 6/19 15/24 15/25 17/10 18/11 18/16 18/22 22/12 23/2 23/17 25/2 25/24 25/25 27/5 27/7 30/17 31/7 31/12 35/17 37/2 37/3 46/12 49/21 75/10 76/23 77/2 77/22 78/22 94/11 94/14 95/10 96/2 96/16 96/18 97/8 97/15 97/18	mandatory [1] 61/10 manner [1] 105/24 many [53] 9/5 9/5	
like [14]	20/23 29/15 38/5 48/10 51/3 63/24 96/6 102/13 102/19 107/17 108/18 112/18 112/20 112/23	lockdowns [4] 20/7 29/11 34/17 86/5	11/24 14/14 22/4 28/15 34/18 37/3 40/14 41/25 42/2 42/23 46/6 47/5 48/23 49/1 50/25 51/21 54/18 55/8 60/25 62/2 68/19 70/9 72/15 76/9 76/21 80/9 81/9 81/11 89/9 91/11 92/12 96/17 99/20 100/2	
likelihood [2]	67/19 87/11	locked [3] 19/10 55/14 91/12	100/21 101/17 102/1 102/12 104/8 105/11 105/14 105/16 107/1	
likely [19]	16/5 16/9 24/1 26/20 66/4 68/2 71/1 71/15 71/21 72/7 72/8 75/6 78/6 79/3 82/2 82/13 92/22 96/22 111/10	logical [1] 102/5 logical ... if [1] 102/5	107/16 108/11 116/10 119/1 119/3	
limit [2]	81/10 90/25	London [9] 17/23 19/24 20/1 24/22 24/23 67/12 70/23 74/23 81/19	lovely [1] 109/17 lower [3] 27/7 31/17 97/2	
limitations [2]	33/21 66/20	lowest [1] 47/17 lunch [1] 64/11	100/19 102/7 103/10 105/9 105/10 107/20 109/6 110/13 110/14	
limited [12]	5/21 5/23 29/11 32/12 52/18 56/3 76/9 89/10 108/4 108/22 109/4 115/21	Luncheon [1] 64/17	113/15 115/25 116/15 117/24 120/16 122/5 122/21 122/25	
line [2]	50/6 103/25	M	March [11] 15/17 made [32] 1/22 5/18	
linked [4]	17/2 43/14 79/10 86/19	loneliness [7] 15/21 18/24 20/24 22/15 22/25 78/7 82/3	16/1 18/11 22/12 25/21 60/17 68/6 77/18 79/19 80/14 83/20	
links [1]	3/14	lonely [1] 72/3	March 2020 [2] 22/12 79/19	
list [6]	12/15 83/21 84/17 84/20 84/24 109/15	long [19] 6/18 15/7 27/16 35/3 35/8 39/12 52/3 53/1 53/21 53/23 54/4 65/3 79/17 80/10 88/23 90/11 112/20 113/21 116/23	Marie [1] 114/2 marital [1] 97/17 marked [1] 18/24	
listened [1]	9/4	long term [1] 15/7	Marmot [1] 74/22 mask [2] 52/22	
listeners [1]	12/1	long-lasting [1] 53/1	101/23	
listening [4]	3/1 8/21 9/1 20/17	long-term [7] 27/16 35/8 39/12 65/3 79/17 80/10 113/21	masked [1] 102/6 massive [1] 21/16	
listing [1]	57/8	longer [10] 19/12 56/4 71/18 71/18 93/4 99/1 101/24 111/2	matching [1] 101/12 Matejic [2] 64/23	
literally [1]	46/22	114/24 117/5	74/5	
literature [1]	115/13	longer-term [3] 71/18 114/24 117/5	material [2] 3/2 8/12 materialised [1] 62/16	
little [6]	50/7 50/13 64/10 82/24 99/1 118/1	Longitudinal [1] 78/23	maternal [1] 68/3 matters [48] 3/1 8/20	
live [5]	3/10 37/12 42/14 100/14 106/10	look [5] 13/23 19/18 22/14 117/23 119/5	8/22 9/2 9/25 11/25 17/4 19/8 20/16 21/3	
lived [4]	17/15 46/15 52/11 81/11	looked [1] 42/24	21/13 22/9 22/17 23/6 26/7 27/21 28/18 29/9	
lives [9]	6/13 7/3 98/22 99/25 100/1	looking [6] 14/20 28/22 53/19 116/22 118/24 119/22	make it [1] 38/21 makers [4] 5/23 15/1	
			30/15 46/21 48/8 49/13 51/4 51/17	

M				
member... [1] 101/12	26/19 54/15 76/18	1/21 2/2 2/7 2/16 3/22	mortality: [1] 47/18	Muslim [1] 44/21
members [20] 37/5	met [3] 13/16 61/4	4/7 6/8 7/1 7/13 8/5	mortality: 16.9 [1]	must [9] 1/23 2/2 2/3
50/22 50/25 52/16	82/17	8/21 10/1 10/14 11/19	47/18	5/6 14/10 14/20
54/3 55/10 55/13	metal [1] 12/18	11/21 12/4 12/24 14/2	mortem [1] 62/22	109/15 119/4 120/24
56/23 62/5 68/15	methods [2] 47/25	14/8 14/16 14/20	mortuaries [1] 63/8	my [85] 1/19 2/10 3/2
76/24 80/23 93/14	49/1	14/25 32/11 35/20	mortuary [1] 62/12	4/8 4/21 5/10 6/9 8/6
93/15 101/7 104/7	metres [1] 63/24	35/23 36/22 46/3 46/4	mosaic [1] 51/5	9/24 11/3 15/12 16/20
107/16 112/10 114/18	Michael [1] 74/21	65/23 69/23 74/24	most [31] 1/12 4/11	17/12 17/14 17/15
117/13	mid [3] 2/5 34/25	78/4 86/11 95/1	8/4 8/15 16/14 19/20	17/16 19/10 21/16
	41/14	103/18 117/15 120/5	24/5 36/20 46/16	21/18 22/11 22/20
members' [1] 105/12	mid-2023 [1] 34/25	120/9 120/23 121/7	53/15 57/5 62/11 65/7	22/20 22/22 22/24
memorial [2] 7/18	mid-flow [1] 2/5	121/10 122/3 122/24	66/15 67/2 69/3 72/9	23/8 23/11 23/12
103/24	mid-November 2021	123/4 124/7	72/12 75/6 75/7 75/11	23/16 23/17 23/19
	[1] 41/14	Module 1 [1] 74/24	75/18 91/11 91/14	26/8 29/15 32/21 33/5
memorialised [1]	midday [1] 32/25	Module 10 [4] 1/5 4/7	91/18 96/14 100/6	36/5 45/17 49/24
119/11	might [16] 6/22 14/22	10/1 124/7	114/4 118/8 121/1	49/25 50/17 51/11
memories [1] 104/19	66/24 71/10 74/7	Module 10's [1] 95/1	122/6	51/14 51/15 51/18
memory [1] 116/5	75/18 101/7 115/18	Module 2 [5] 14/25	mostly [2] 31/10	51/19 51/20 52/13
men [3] 70/25 71/6	119/19 121/7 121/9	86/11 103/18 120/5	48/20	54/8 55/16 64/5 64/8
71/7	121/11 121/13 121/17	121/10	mother [3] 72/2	64/20 72/1 73/22 81/7
Mencap [2] 80/12	121/21 121/22	Module 3 [1] 46/3	103/7 112/13	94/9 96/5 96/9 97/9
80/22	migrant [10] 56/19	Module 4 [1] 69/23	mother's [1] 107/7	98/8 98/23 99/9 101/4
mental [123] 1/10	69/8 69/13 88/17 89/5	Module 6 [1] 78/4	mothers [3] 5/4	101/9 101/10 102/15
2/24 8/1 8/22 11/17	89/16 90/4 90/15 95/4	Module 8 [1] 11/19	72/13 72/15	102/19 102/22 103/4
11/20 11/24 11/25	95/8	Module 9 [1] 36/22	mourning [4] 103/9	110/22 110/22 110/25
12/10 12/14 12/18	migrants [3] 90/1	modules [12] 1/12	103/15 105/9 105/24	111/2 111/16 111/18
12/20 12/23 13/6	90/10 93/24	1/16 2/18 6/9 6/20 8/9	move [3] 64/8 116/7	111/18 111/19 112/15
15/12 15/16 15/19	Migrants' [2] 69/6	13/10 13/11 20/4	118/17	116/11 116/18 116/19
15/21 15/24 16/6	90/14	85/14 120/1 121/3	moved [3] 41/5 44/22	117/11 119/13 121/2
16/16 16/16 16/19	mile [1] 50/14	moment [3] 3/13	88/10	122/1 123/10
16/21 16/24 17/1	million [2] 45/3 85/3	17/5 27/23	movements [1]	my Lady [1] 4/21
17/15 17/17 17/25	Mind [2] 104/23	moments [1] 122/6	113/2	myself [1] 116/21
18/5 18/12 19/5 19/10	106/17	Monday [2] 1/1 42/7	moving [3] 4/9 99/14	N
19/18 20/14 20/25	Mind's [1] 66/6	monitor [1] 93/9	118/1	
21/16 23/4 23/4 23/8	Miners [1] 63/21	monitored [1] 121/18	Mr [3] 58/24 59/2	
23/16 23/23 23/25	minimal [1] 83/3	monitoring [1] 67/17	74/5	
24/4 24/19 25/13	Minister [1] 82/16	month [2] 25/2	Mr Patrick [1] 58/24	
25/19 26/2 26/3 26/15	Minnoch [2] 55/2	102/17	Mr Peter [1] 74/5	
27/17 27/18 27/20	56/24	months [7] 80/4	Mr Stephen [1] 59/2	
28/2 28/14 28/17	minoritised [1] 95/3	80/23 91/8 91/10	Ms [13] 3/19 3/23 4/5	
29/10 29/13 29/15	minority [22] 16/17	91/15 111/20 123/1	9/20 33/4 36/25 43/2	
29/20 30/2 30/11	19/6 30/24 31/4 32/13	morbidity [1] 83/22	64/19 98/5 99/2 99/8	
30/16 31/1 31/8 31/11	67/7 67/13 67/20	more [62] 1/16 3/22	122/17 123/6	
31/16 31/19 31/21	67/24 68/7 68/11	4/22 16/10 18/14 19/1	Ms Blackwell [5] 33/4 64/19 99/2 99/8	
32/11 32/16 32/22	68/18 68/20 68/22	21/22 23/25 26/6	123/6	
33/5 33/14 34/5 34/7	68/24 69/16 70/1 70/7	26/16 32/12 37/15	Ms Kate [1] 3/19	
34/13 34/21 34/23	70/18 87/23 104/23	39/1 42/2 42/18 42/21	Ms Rahman [5] 9/20	
35/9 47/21 53/2 55/5	114/7	44/23 55/8 55/9 56/20	36/25 43/2 98/5	
66/4 66/6 69/7 69/14	minute [3] 38/23	57/2 60/25 61/13 66/4	122/17	
69/15 69/18 70/19	102/15 102/16	68/2 69/19 71/1 71/15	Ms Shaheen [1] 3/23	
71/16 71/22 72/25	minutes [1] 3/11	71/17 72/3 72/7 72/8	much [12] 6/18 32/24	
73/15 73/17 73/19	misinformation [1]	72/8 73/16 73/20 78/5	42/8 72/3 85/23 96/2	
74/11 75/22 76/1 76/3	76/17	78/6 78/6 78/18 78/25	103/7 109/18 109/18	
76/11 77/9 79/5 79/7	missed [1] 104/21	79/1 81/9 82/1 82/13	112/19 117/5 123/6	
79/16 86/19 86/21	mitigate [6] 5/24 63/9	82/19 87/13 87/20	multifaith [1] 44/20	
87/16 87/20 88/16	75/9 75/15 81/15	96/22 97/6 100/9	multiple [4] 5/2 20/7	
88/24 90/17 90/22	89/15	101/11 104/10 107/15	23/20 102/7	
93/23 98/17 101/9	mitigating [1] 75/17	107/20 109/19 110/13	mum [5] 100/14	
110/16 112/15 113/14	mitigation [1] 120/7	110/14 111/8 114/8	112/15 112/18 118/4	
113/21 115/20 116/16	mix [1] 21/5	115/8 115/21 121/25	118/5	
116/19	mixed [1] 44/8	Moreover [1] 25/25	mum's [1] 103/6	
mentioned [2] 4/18	mixing [1] 85/20	morning [2] 1/4 3/23	mundane [1] 92/1	
48/18	mobile [1] 47/10	mortality [11] 24/3	Munshi [7] 17/21	
merely [1] 34/20	moderate [1] 84/2	47/8 47/9 47/12 67/8	23/1 23/24 24/14 25/7	
merited [1] 60/10	modify [1] 80/15	67/19 67/25 73/25	31/5 33/10	
messaging [4] 25/4	module [47] 1/5 1/7	75/11 76/7 83/22		

N	non [7] 24/6 39/8 39/10 43/22 45/8 82/2 96/23 non-Covid [1] 24/6 non-disabled [2] 82/2 96/23 non-essential [3] 39/8 39/10 43/22 non-profit [1] 45/8 none [1] 6/6 nonsense [1] 118/22 nor [1] 34/25 normal [3] 79/18 105/5 118/21 normally [4] 44/6 45/1 64/10 104/18 norms [2] 105/2 106/19 Northern [13] 9/4 13/19 58/25 82/13 83/5 83/6 85/5 88/4 100/3 103/19 103/20 103/22 104/15 Northern Ireland [1] 85/5 not [113] 1/10 1/18 1/19 1/21 2/5 4/15 5/8 5/13 5/17 5/25 10/10 10/14 10/17 13/11 13/21 14/3 21/10 21/21 25/25 29/6 30/1 31/20 32/12 34/19 34/24 35/2 35/19 35/20 36/22 37/21 37/24 38/13 39/16 40/24 41/14 41/21 43/10 45/25 46/14 46/16 47/4 47/9 48/1 48/16 51/21 52/10 52/18 52/25 54/25 55/17 58/2 59/13 61/4 61/8 62/1 62/6 62/14 62/21 64/22 64/25 65/11 70/1 72/1 72/10 72/14 73/2 76/25 77/7 78/4 79/24 80/11 80/19 80/20 83/7 83/10 86/23 89/11 92/17 94/12 95/24 99/23 100/14 100/16 100/17 101/3 101/3 101/5 101/20 102/5 102/5 102/6 103/25 105/5 105/8 106/11 107/9 107/13 107/21 109/2 109/25 110/11 111/19 112/17 112/24 112/25 115/5 116/21 116/25 118/15 118/20 119/7 119/14 123/2 not ... I lost [1] 118/20 notable [1] 68/25 notably [2] 33/21 72/12 noted [4] 42/4 44/25	offices [2] 38/19 108/3 offs [1] 15/2 often [13] 37/4 38/23 49/9 50/18 53/12 79/7 81/24 85/16 92/14 92/20 97/7 97/8 115/8 old [1] 2/1 older [16] 29/24 42/10 43/16 73/18 78/1 78/2 78/5 78/11 78/14 78/18 78/22 78/24 79/3 79/6 79/12 97/5 olds [1] 77/3 omissions [1] 6/25 on [211] on ... I ended [1] 101/23 on behalf [1] 58/24 once [5] 35/17 67/9 70/2 93/14 101/21 one [69] 1/16 3/9 5/6 12/19 19/8 20/8 20/16 22/9 22/17 23/6 26/7 28/18 29/9 29/15 31/5 34/3 35/4 37/10 46/20 48/11 49/20 51/4 51/17 51/23 52/7 53/18 54/2 54/19 58/21 61/10 68/21 71/25 73/4 73/12 73/16 79/1 95/1 95/19 97/11 100/1 100/3 100/21 101/8 101/19 102/1 102/9 102/12 102/15 103/3 105/11 105/14 107/6 107/8 107/16 108/2 109/12 110/19 111/14 112/12 112/16 112/22 113/15 113/21 116/1 116/16 117/19 118/18 119/1 120/18 one died [1] 107/16 one's [3] 104/8 108/11 116/11 one-third [1] 79/1 ones [10] 17/15 21/6 46/25 49/22 50/23 68/17 99/24 105/16 119/1 119/3 ones' [2] 101/17 107/1 ongoing [4] 35/4 99/18 100/20 111/13 online [19] 3/10 17/19 28/23 29/1 29/2 30/18 40/19 41/5 44/13 44/22 44/25 45/3 49/22 56/6 57/15 58/8 77/2 106/3 109/10 only [21] 5/13 5/17 12/1 22/10 22/13 23/17 29/13 59/15	72/10 73/2 83/3 95/21 96/19 97/8 107/6 108/5 111/20 112/19 116/6 116/11 119/14 ONS [1] 53/22 onto [1] 50/10 open [1] 32/22 opening [17] 1/3 3/20 4/6 8/13 9/7 10/10 19/21 42/6 42/8 65/18 98/24 118/10 119/23 122/21 122/23 124/4 124/6 operated [1] 38/11 operating [1] 38/9 operation [1] 57/6 operational [3] 13/17 36/8 42/4 operatives [2] 46/6 47/11 operators [1] 38/11 opportunities [3] 17/6 17/20 96/24 opportunity [7] 10/10 27/11 40/25 41/3 96/20 109/4 116/12 or [118] 1/22 4/2 5/3 6/23 7/10 9/11 10/11 10/18 12/2 12/22 13/3 13/22 14/23 15/14 19/5 20/5 20/13 20/13 21/14 21/15 23/2 24/16 26/1 26/11 26/12 26/19 26/21 28/7 28/8 28/25 30/8 30/12 30/13 30/18 30/20 34/16 35/2 35/2 35/3 37/5 37/25 38/9 39/9 40/25 45/15 46/1 46/17 47/4 48/25 49/3 50/2 50/25 51/3 53/12 54/5 56/6 59/4 59/7 59/17 61/3 62/5 62/23 65/3 65/21 65/22 66/10 67/3 71/11 72/16 76/24 76/25 77/5 77/6 77/13 78/24 79/8 79/11 79/16 79/24 80/10 83/7 83/22 84/9 84/11 84/19 86/2 86/14 86/18 87/12 89/3 90/4 90/6 92/20 93/3 94/24 95/22 95/22 97/20 99/13 99/24 100/15 101/7 101/12 101/15 105/10 105/13 105/14 107/3 108/25 112/1 112/11 112/16 115/15 120/3 121/24 122/11 122/16 123/2 or other [1] 94/24 oral [1] 83/16 order [8] 7/9 8/3 10/15 11/5 59/7 60/1 120/25 121/9
----------	--	---	---

O	ordinarily [1] 112/12 ordinary [1] 22/5 organ [1] 84/12 organisation [6] 15/18 77/16 82/23 83/7 93/8 95/3 organisations [19] 2/15 2/21 3/15 9/10 38/9 39/2 39/14 40/24 41/25 45/9 55/21 63/6 80/18 82/14 82/18 83/17 96/13 96/14 107/21 organise [1] 50/20 original [1] 80/17 Osborn [5] 24/20 25/15 26/25 29/17 32/3 other [29] 12/20 13/10 19/5 23/2 28/6 30/24 31/3 33/7 33/15 35/3 40/6 50/9 58/19 60/19 65/21 68/20 84/19 90/19 90/20 92/8 94/24 99/19 101/7 103/18 107/17 111/1 113/3 113/24 115/4 others [17] 28/7 28/9 44/10 45/1 46/2 46/15 53/18 54/24 62/23 70/3 73/14 91/25 97/17 97/19 104/11 109/10 111/21 otherwise [2] 45/15 64/1 ought [2] 61/7 65/16 our [39] 1/6 1/17 3/1 6/12 7/3 7/21 11/10 13/5 14/8 14/21 30/18 35/13 35/14 35/14 35/21 36/13 36/17 36/19 40/5 44/20 46/9 48/11 48/13 49/16 50/10 51/13 53/13 53/17 53/17 54/17 54/18 64/8 64/20 100/5 100/14 104/18 119/3 122/4 123/2 ourselves [2] 50/17 113/3 out [19] 3/5 17/13 27/22 43/10 46/7 47/1 59/16 67/4 77/14 79/18 80/13 81/1 96/6 98/4 100/15 106/10 107/7 109/18 118/23 outbreaks [1] 59/21 outcome [3] 55/24 71/20 99/12 outcomes [14] 19/18 57/11 68/3 73/1 73/23 74/4 76/3 76/7 76/14 82/8 83/13 87/16	113/14 115/3 outdoor [1] 41/19 outdoors [1] 41/7 outlining [1] 82/24 outraged [1] 118/14 outreach [1] 41/20 outset [2] 4/20 46/23 outside [4] 10/21 27/12 40/19 86/10 outweighed [1] 3/6 over [36] 2/15 2/17 2/19 3/11 4/18 6/9 10/7 12/13 23/10 33/6 34/14 39/7 42/13 43/21 44/1 45/3 45/21 48/14 49/4 49/9 50/21 53/24 54/23 55/11 70/9 84/4 91/5 93/1 94/4 100/7 101/9 101/17 106/7 116/23 117/7 117/17 over-represented [1] 70/9 overall [8] 18/4 18/23 31/8 31/17 34/13 69/1 71/5 112/3 overcrowded [3] 87/10 87/12 92/14 overcrowding [3] 87/14 91/3 92/12 overlap [1] 34/6 overlapping [3] 81/23 88/14 94/23 overload [1] 18/1 overnight [1] 30/19 oversight [1] 6/5 overview [1] 11/10 overwhelm [1] 102/17 overwhelmed [2] 63/10 112/10 own [15] 7/15 7/16 7/16 12/3 15/19 28/2 46/19 49/12 49/24 49/25 89/2 101/25 102/16 110/22 117/17 owned [1] 111/19 P	68/11 68/13 110/22 Patrick [1] 58/24 patterns [2] 23/12 98/9 paucity [1] 34/1 Paul [1] 39/23 Pauline [1] 83/16 Pauline Nolan [1] 83/16 pause [5] 3/10 4/1 4/2 59/7 98/23 payments [1] 111/14 peace [1] 108/7 peer [2] 111/21 111/25 peers [1] 82/2 Penal [1] 92/4 penalty [1] 70/14 people [162] people contributed [1] 81/14 people's [6] 75/21 82/14 83/17 87/8 93/13 111/1 peoples' [1] 111/11 per [28] 18/21 18/21 20/5 24/24 24/25 26/16 34/15 47/13 47/18 53/24 53/25 54/1 68/2 75/12 77/4 77/6 77/19 77/23 77/24 78/24 84/5 86/8 91/9 98/1 98/2 98/3 105/1 106/19 perceived [3] 23/23 83/21 114/18 perfect [1] 95/10 perhaps [4] 69/23 87/17 108/21 109/24 perinatal [1] 68/4 period [28] 6/19 6/25 12/15 14/10 14/18 17/1 24/8 25/10 25/24 25/25 29/12 29/14 34/8 34/25 37/18 40/15 58/21 61/9 68/5 69/15 75/2 78/17 91/5 96/18 98/11 101/10 105/23 121/18 periods [6] 12/24 31/14 34/5 34/6 34/9 94/1 permanent [1] 2/7 permissible [1] 76/19 permission [1] 9/24 perpetrator [2] 95/23 96/5 perpetrators [5] 95/16 95/20 96/25 97/7 97/22 Perpetrators' [1] 97/3 persisted [1] 91/15 persisting [1] 69/19 person [15] 28/15	43/10 44/5 47/13 47/19 56/6 57/16 58/20 73/16 99/22 100/9 102/9 107/6 112/18 116/17 person-years [2] 47/13 47/19 personal [9] 4/10 6/18 14/11 51/22 80/5 103/8 108/19 116/2 122/13 persons [1] 62/13 perspective [2] 2/22 44/23 Peter [2] 64/23 74/5 PGD [1] 114/10 pharmaceutical [1] 70/4 phase [1] 28/14 phone [4] 29/12 95/22 100/25 108/14 phoning [1] 112/18 physical [16] 17/17 29/21 41/10 44/12 48/14 52/16 77/9 79/2 79/16 90/22 91/20 97/10 98/17 103/3 116/3 117/3 physically [2] 27/22 97/14 Pia [1] 92/4 Pia Sinha [1] 92/4 picking [1] 108/13 pilot [1] 57/14 Pitman's [1] 63/20 place [15] 9/1 19/13 42/7 56/4 56/6 59/25 67/1 67/17 70/24 75/8 89/21 107/5 107/19 115/1 118/3 placed [2] 63/2 84/8 places [10] 36/3 42/23 43/1 43/4 43/11 78/15 90/19 90/20 92/8 93/9 plan [3] 5/24 7/9 91/13 planning [8] 5/21 66/21 87/6 103/15 120/4 120/11 120/13 121/8 plans [2] 83/3 105/13 platforms [1] 41/19 play [1] 38/5 played [6] 3/18 4/3 21/12 63/1 82/7 122/22 please [1] 3/12 plus [1] 77/8 pm [6] 33/3 64/16 64/18 99/5 99/7 123/11 point [3] 72/15 101/1 111/1 pointed [1] 80/13 points [1] 65/23
----------	---	--	---	---

P	102/3 police [12] 26/1 46/13 48/6 48/17 48/18 52/18 54/21 55/9 60/5 63/6 70/6 96/9 policies [8] 1/22 10/18 10/23 44/1 68/14 75/14 81/1 83/2 policing [1] 70/13 policy [2] 1/18 70/23 political [1] 117/21 politicians [1] 1/20 poor [10] 30/20 69/18 73/23 74/11 76/3 87/12 87/15 87/16 91/3 113/14 poorer [8] 16/15 74/3 82/4 86/19 86/21 87/20 115/14 115/19 poorly [1] 92/14 population [20] 1/9 6/3 11/17 11/22 12/10 12/14 16/23 18/6 18/13 24/7 24/12 31/18 32/17 33/23 33/24 34/24 70/12 70/20 76/2 84/5 population-based [1] 33/23 populations [1] 69/5 portrayed [1] 52/8 posed [1] 81/8 posing [1] 92/23 position [3] 65/11 78/3 115/12 positions [1] 118/15 positive [17] 3/5 12/19 12/25 17/23 21/25 22/6 27/24 29/2 45/8 45/14 48/7 57/11 57/13 71/2 86/1 105/20 120/16 positively [1] 29/18 positives [2] 57/22 104/20 positivity [1] 17/6 possible [9] 24/13 25/6 26/17 44/4 60/8 61/6 62/24 85/21 85/23 possibly [1] 65/18 post [3] 20/22 62/22 69/15 post-mortem [1] 62/22 post-pandemic [1] 69/15 potential [2] 15/23 79/25 potentially [1] 115/19 poverty [7] 10/20 10/23 66/7 74/2 74/7 74/10 75/13 power [3] 4/15 88/4	102/3 powerful [1] 7/25 powerfully [2] 104/15 116/15 powerlessness [2] 93/20 114/22 powers [1] 26/2 PPE [6] 47/25 51/8 52/5 63/16 97/1 101/15 practical [1] 38/3 practically [1] 61/13 practice [2] 43/9 91/15 practices [9] 27/5 43/8 43/9 44/3 49/1 68/22 70/13 70/16 76/20 practitioners [4] 55/3 55/8 57/2 89/25 pre [28] 11/23 16/24 17/25 18/15 19/4 23/4 25/17 25/21 27/7 28/17 31/1 31/14 31/23 32/18 34/24 41/13 66/19 68/7 69/10 69/17 70/8 76/11 76/15 79/9 84/3 85/16 105/12 120/9 pre-arranged [1] 105/12 pre-emptive [1] 120/9 pre-existing [14] 11/23 16/24 17/25 19/4 23/4 28/17 31/23 32/18 66/19 69/10 76/11 76/15 84/3 85/16 pre-lockdown [1] 27/7 pre-pandemic [11] 18/15 25/17 25/21 31/1 31/14 34/24 41/13 68/7 69/17 70/8 79/9 precarious [1] 16/22 predictable [4] 15/14 24/14 65/24 87/17 predictably [1] 121/13 predominantly [1] 13/15 preferred [1] 30/7 pregnancies [1] 97/21 pregnancy [4] 71/20 71/21 72/1 97/19 pregnant [2] 51/5 84/3 prematurely [1] 4/24 premises [1] 50/11 preparation [3] 14/22 121/8 121/23 prepare [2] 6/22 50/20	102/3 prepared [1] 49/16 preparedness [1] 5/11 prepares [1] 121/25 preparing [1] 122/11 preplanned [1] 105/18 prescribing [1] 76/20 prescriptions [2] 25/18 86/8 presence [1] 98/19 present [3] 26/5 26/5 75/20 presentation [1] 16/2 presentations [5] 24/18 24/20 24/24 25/1 25/15 presented [3] 26/6 83/2 96/24 Presiding [1] 58/25 press [1] 4/2 pressure [8] 50/1 50/16 61/4 61/20 62/10 64/3 104/3 110/13 pressures [3] 28/11 40/5 63/8 pretence [1] 118/21 Pretending [1] 118/19 process [8] 57/18 60/15 62/19 107/8 107/14 111/22 119/12 122/3 processes [8] 38/20 56/4 57/23 107/17 107/25 108/10 114/9 114/24 Procurator [1] 59/2 product [1] 9/9 profession [2] 28/9 47/9 professional [2] 29/13 68/15 professionals [3] 47/16 114/15 115/17 professor [36] 17/21 17/22 18/7 18/8 19/23 19/23 19/25 19/25 23/1 23/24 24/14 24/20 24/20 25/7 previous [8] 1/12 1/15 2/17 16/4 20/3 59/21 85/14 91/9 previously [1] 105/25 70/22 74/20 74/20 74/21 74/22 76/4 78/8 78/15 78/20 81/17 81/18 81/20 Professor Clare [1] 19/23 Professor Das-Munshi [1] 24/14 Professor James [1] 78/8 Professor Osborn [5] 24/20 25/15 26/25 29/17 32/3 Professor Sarah [1] 18/7 Professors [2] 69/21 86/4 Professors Shakespeare [1] 86/4 profile [1] 103/17 profit [1] 45/8 profound [4] 43/4	87/8 99/10 99/22 programme [3] 77/20 88/6 88/7 progressed [3] 19/13 59/22 61/21 progression [1] 90/23 90/23 progressively [1] 23/9 prolonged [8] 19/17 85/9 86/18 91/12 113/12 114/10 114/12 115/2 prominent [2] 22/16 103/22 prompting [1] 44/10 promptly [1] 63/11 pronounced [4] 18/17 69/3 69/20 88/15 properly [3] 83/7 100/18 117/1 proportion [6] 16/23 18/19 26/14 31/9 34/10 76/22 proportionality [1] 8/5 proportionate [1] 2/13 proposing [1] 65/14 prosecution [1] 57/3 prospects [1] 90/11 protect [3] 16/9 50/7 51/1 protected [4] 33/7 33/15 65/21 67/2 protecting [1] 75/18 Protection [1] 59/12 protections [2] 75/8 89/14 protective [1] 75/14 provide [6] 2/22 3/21 3/24 26/22 30/5 67/5 provided [11] 8/25 11/7 17/19 52/4 53/3 53/14 69/6 76/4 82/22 105/22 118/10 provider [3] 57/4 84/19 95/5 providers [2] 83/14 114/17 provides [3] 3/14 13/4 120/24 providing [6] 41/5 44/7 48/5 55/7 73/14 95/21 provision [4] 29/23 63/9 92/25 115/14 proximity [1] 48/2 psychiatric [4] 17/22 24/18 24/21 24/24 psychological [11] 12/21 16/8 18/14 18/25 20/6 20/12 70/17 73/18 86/12 87/11 91/20
----------	---	---	--	---

P	rapid [5] 27/1 29/5 79/21 80/16 110/4 rate [3] 24/12 32/7 54/5 rates [13] 26/1 27/18 47/12 47/17 57/3 68/4 68/7 70/19 71/6 73/25 75/11 86/7 87/14 rather [2] 34/20 50/2 rationale [1] 39/9 re [2] 80/14 116/10 re-issued [1] 80/14 re-visiting [1] 116/10 reach [1] 3/2 reached [1] 21/8 reaching [1] 12/16 reactions [1] 89/2 readjust [1] 114/6 ready [2] 3/16 108/21 reaffirmed [1] 53/17 real [4] 50/23 52/25 108/19 110/4 reality [1] 52/9 really [16] 20/18 20/19 23/19 23/19 40/4 49/17 93/12 93/13 96/10 101/3 102/2 109/18 112/4 112/16 112/16 112/23 rears [1] 118/6 reason [1] 65/21 reasons [3] 54/25 62/23 115/5 reassemble [1] 3/18 rebounded [1] 25/24 receive [1] 60/1 received [4] 17/9 58/22 100/25 114/1 recently [2] 22/19 116/7 recipients [1] 84/12 recoding [1] 33/24 recoding/recording [1] 33/24 recognise [2] 94/14 101/22 recognised [17] 5/10 5/15 7/5 14/2 14/6 15/2 30/25 34/2 46/11 66/8 73/23 81/7 85/6 86/11 87/19 94/9 114/7 recognition [6] 6/7 12/4 37/11 53/6 53/12 65/15 recommendations [4] 3/3 87/5 120/20 121/22 recommended [2] 79/23 120/5 recommending [1] 2/9 record [3] 2/7 11/25 94/18 recorded [2] 16/3 57/19	recording [1] 33/24 records [5] 8/22 8/24 9/25 53/22 119/21 recount [1] 54/10 recover [1] 71/18 recoveries [1] 32/20 recovering [1] 16/13 recovery [3] 34/9 41/13 121/25 recurring [2] 74/13 83/1 redeployed [1] 27/15 reduce [5] 5/19 26/24 40/22 75/10 94/2 reduced [8] 18/1 20/13 25/15 28/12 56/7 62/7 72/16 74/12 reduction [6] 18/2 24/24 25/1 25/25 27/2 69/2 reductions [1] 25/12 refer [3] 8/12 12/8 12/25 reference [2] 2/10 11/15 referenced [1] 117/22 referral [2] 59/13 61/3 referrals [4] 25/23 26/1 62/8 109/23 referred [6] 24/22 59/15 60/20 61/1 61/7 68/12 refers [1] 25/7 reflect [6] 12/1 54/12 94/16 104/19 115/14 119/24 reflected [7] 6/21 8/11 42/24 45/10 47/5 72/5 118/9 reflecting [1] 69/24 reflection [2] 105/20 122/3 Reform [2] 92/4 92/5 Refuge [2] 77/16 97/24 refusing [1] 52/22 regard [2] 11/5 18/10 regarding [3] 33/22 76/18 101/11 Regime [1] 91/13 regimes [1] 92/21 regional [1] 82/10 registered [2] 60/16 61/3 regular [2] 43/15 61/21 regularly [3] 50/8 50/14 82/17 regulations [2] 59/12 98/16 relapse [1] 28/19 relapses [1] 31/21 relate [1] 115/18 related [4] 18/3 24/11	60/2 75/16 relating [3] 32/22 63/15 120/23 relation [10] 33/7 33/17 33/18 59/20 70/10 81/4 82/22 83/5 90/2 109/8 relationship [1] 39/1 relationships [6] 29/25 45/13 47/3 68/24 104/3 112/22 relatively [1] 71/6 relax [1] 59/8 relaxed [1] 101/13 released [1] 63/11 relentless [1] 50/16 relevant [2] 59/17 63/5 reliability [1] 55/12 reliable [1] 76/21 reliance [1] 22/7 reliant [1] 78/19 religion [2] 66/10 73/25 religions [3] 43/20 44/14 106/15 religions' [1] 104/9 religious [10] 43/6 43/8 43/9 43/13 43/14 44/3 44/6 44/17 62/23 68/18 religiously [1] 43/10 reliving [1] 122/5 reluctance [2] 37/16 58/7 reluctant [1] 40/15 relying [1] 23/14 remain [1] 89/19 remained [7] 27/7 42/11 69/16 73/24 75/20 76/2 107/4 remains [6] 7/17 16/19 35/5 42/13 64/7 86/24 remand [2] 55/9 55/14 remarked [1] 4/20 remarks [4] 1/3 8/13 10/10 124/4 remember [1] 1/24 remembered [1] 119/6 remembering [1] 119/5 remembering ... we [1] 119/5 remembrance [1] 118/25 reminder [1] 117/23 remote [13] 29/1 29/5 29/18 29/20 29/24 30/9 30/11 30/14 55/19 57/14 57/20 88/12 105/21 remotely [2] 61/14 95/21	remove [1] 61/10 removed [1] 57/15 rendering [1] 51/6 rent [1] 75/4 renting [1] 87/13 reopen [1] 42/9 reopened [2] 39/16 42/18 reopening [4] 36/2 40/15 42/3 43/21 reopening while [1] 40/15 repeat [5] 13/11 36/22 66/11 78/4 108/5 repeated [3] 19/17 85/9 86/18 repeatedly [3] 20/6 106/3 119/13 repetition [4] 1/17 4/15 8/13 66/12 replicate [1] 65/19 report [8] 24/22 29/17 63/13 66/7 69/22 76/4 94/18 97/24 reported [34] 18/2 18/16 20/9 21/25 22/5 22/7 27/14 29/7 30/5 44/21 51/13 54/23 55/11 55/13 68/19 70/16 77/6 77/17 78/25 79/1 80/22 85/25 86/1 86/21 92/1 93/22 94/3 96/1 97/11 97/17 101/16 102/24 109/23 112/9 reportedly [1] 27/6 reporting [2] 53/23 92/23 reports [14] 8/12 9/14 9/21 10/1 14/3 26/25 37/1 60/1 63/14 71/22 94/13 98/6 119/12 119/21 represent [2] 8/15 122/25 representative [4] 90/7 93/10 104/4 106/17 representatives [4] 1/24 2/21 56/11 58/6 represented [4] 70/9 72/9 83/10 91/9 representing [2] 9/11 54/9 require [1] 59/13 required [7] 36/11 37/4 40/18 48/3 55/10 61/14 107/25 requirement [1] 61/11 requirements [6] 48/1 49/5 61/2 61/15 73/3 106/1 research [7] 24/22
----------	---	--	--	---

R				
research... [6] 33/13 74/13 81/18 81/21 114/2 114/2	result [16] 16/6 17/11 20/15 21/9 59/5 65/4 66/19 66/20 71/22 74/19 75/13 81/10 94/23 101/8 107/19 113/13	94/10 rituals [4] 103/9 104/10 105/10 105/24	50/15 51/10 51/21 52/7 52/15 53/5 56/2 58/8 71/25 80/7 89/23	70/15
resentment [2] 43/17 103/14	robbed [1] 105/10	91/24 97/14 100/4	searched [1] 109/1	
residents [1] 78/3	role [8] 21/12 43/23	100/12 100/24 103/13	seat [1] 63/23	
resignation [1] 51/19	49/7 63/1 82/7 105/3	107/11 108/2 108/10	second [8] 8/14 13/7	
resigned [1] 91/22	110/25 122/22	116/9 117/19 118/2	31/12 35/13 35/14	
resilience [5] 39/13 43/24 45/18 63/4 115/20	roles [2] 46/12 71/4	119/2	49/4 49/21 120/15	
resilient [2] 71/17 121/25	room [4] 3/13 4/2	same [13] 5/3 5/3	secondary [1] 112/8	
resource [1] 39/20	101/25 118/7	46/17 52/23 58/1	section [1] 98/24	
resources [2] 41/1 79/11	resume [1] 123/8	59/19 64/24 64/25	sector [13] 2/23	
respect [1] 54/6	resurgence [1] 75/25	102/8 103/25 108/17	28/13 37/21 38/2	
respecting [1] 8/5	resuscitation [1]	112/2 118/19	39/25 40/5 46/5 53/22	
respectively [1] 56/19	80/21	samples [1] 33/24	54/6 82/6 82/11 83/9	
respiratory [1] 84/13	retail [12] 9/16 36/3 36/15 37/9 37/12 39/4 42/3 43/22 46/13 49/7 53/9 71/4	sanitiser [1] 52/6	83/15	
respite [1] 50/19	return [13] 3/11 9/22 32/9 32/25 34/3 36/25 37/6 37/17 39/16 40/15 64/14 75/24 99/4	Sarah [1] 18/7	sector-specific [1]	
respondents [2] 77/4 78/25	returned [2] 25/20 34/24	satisfaction [1] 18/23	37/21	
responding [1] 26/18	returning [3] 25/17 74/24 81/22	satisfied [1] 60/12	sectors [9] 6/3 36/24	
response [33] 5/12 5/14 5/22 7/12 10/9 14/1 14/15 14/23 15/10 23/3 24/16 25/4 35/3 35/16 35/23 36/21 37/8 37/20 43/18 52/17 53/8 58/3 65/6 65/25 66/21 71/11 82/24 87/18 99/10 113/14 119/16 120/11 121/23	reusing [1] 51/8	save [1] 99/2	39/19 40/6 45/25	
responsibilities [2] 72/21 72/23	revealed [1] 34/20	savings [1] 75/5	46/13 46/15 53/9	
responsibility [2] 16/19 88/20	revelation [1] 117/20	saw [3] 29/13 73/18 76/10	69/25	
responsible [4] 4/17 15/4 49/10 113/8	revelations [1] 118/3	say [10] 20/22 52/3 67/15 78/20 99/21	secure [1] 88/11	
responsive [1] 30/6	revenue [1] 46/24	route [1] 107/3	see [2] 93/14 112/9	
restaurants [2] 38/5 40/21	reverse [1] 71/19	routine [4] 23/7 53/4	seeing [2] 57/16	
rested [1] 36/6	review [16] 2/24 12/8 12/8 12/17 13/2 18/10 31/1 32/13 33/12 33/17 34/12 69/17 79/5 81/1 86/13 94/17	roundtables [3] 3/25 122/10 122/18	101/24	
restrain [1] 48/6	revision [1] 80/16	route [1] 107/3	seek [4] 13/12 14/4	
restricted [1] 89/9	revisit [2] 10/11	routine [4] 23/7 53/4	26/20 78/4	
restricting [1] 96/25	riffs [1] 104/8	says [1] 33/10	seeking [4] 25/12	
restriction [1] 34/6	right [2] 38/3 100/9	scale [8] 4/21 6/12	55/6 71/14 90/5	
restrictions [38] 17/10 19/13 19/17 21/10 34/10 36/2 37/3 40/17 40/21 44/5 44/18 56/1 56/21 68/14 68/16 69/10 75/24 89/21 89/24 90/25 91/18 91/19 92/15 92/19 93/18 95/14 96/16 101/13 103/9 103/17 104/11 104/14 104/16 106/14 106/23 107/4 107/19 116/8	Rights [5] 56/19 69/6 90/14 95/7 95/17	Rowntree [3] 45/11 64/23 74/6	seeks [2] 119/21	
rising [2] 18/14 41/10	rising [2] 18/14 41/10	rule [2] 117/7 117/12	120/18	
risk [39] 6/14 14/16 16/15 22/16 24/5 26/22 26/24 30/2 30/4 37/4 40/16 42/11 47/3 62/16 63/9 65/1 67/18 67/25 71/7 71/20 71/24 72/9 72/25 74/11 77/9 77/15 81/7 84/2 84/9 85/6 85/10 86/15 87/16 88/16 89/6 92/23 94/11 97/2 120/6	routines [1] 92/1	rule-breaking [1]	seemed [2] 34/13	
risks [18] 24/3 46/19 46/24 47/8 47/23 51/22 66/18 67/8 70/17 81/15 86/12 87/3 87/25 90/16 94/10 94/15 94/19 97/4	Safekeeping [3] 55/25 94/18 95/13	117/7	48/11	
risks associated [1]	safely [1] 96/18	rules [13] 38/13	seen [2] 4/22 29/5	
	safer [1] 57/17	49/15 52/23 59/8	self [11] 8/2 17/3	
	safety [6] 39/5 51/16 56/10 60/4 77/9 96/9	98/15 102/3 103/11	23/13 23/20 28/24	
	said [33] 20/20 21/3 22/9 22/18 23/6 28/4 29/9 38/16 48/17	103/23 103/24 117/8 117/10 117/18 118/13	50/2 53/23 91/7 91/25	
		rules in [1] 117/18	102/21 102/22	
		run [2] 105/1 106/19	self-care [1] 17/3	
		running [4] 41/8 45/9 52/2 88/19	self-harm [5] 8/2	
		runs [1] 14/7	23/13 91/25 102/21	
		rural [2] 35/21 94/20	102/22	
		Ruth [1] 88/4	self-harming [1]	
		S	23/20	
		sack [1] 51/20	self-inflicted [1] 91/7	
		sacrifices [2] 36/10 51/22	self-isolate [1] 50/2	
		sad [1] 104/20	self-management [1]	
		sadness [2] 99/23 105/19	28/24	
		safe [7] 21/15 28/6 30/21 42/21 47/25 52/4 102/13	self-reporting [1]	
		Safeguarding [3] 55/25 94/18 95/13	53/23	
		safely [1] 96/18	send [1] 105/16	
		safer [1] 57/17	send-off [1] 105/16	
		safety [6] 39/5 51/16 56/10 60/4 77/9 96/9	senior [1] 114/2	
		said [33] 20/20 21/3 22/9 22/18 23/6 28/4 29/9 38/16 48/17	sense [8] 18/2 43/4	
		Scot [1] 19/8 82/23 104/4	46/10 53/6 102/17	
		scream [1] 96/7	105/11 105/19 106/25	
		screening [1] 86/3	sensitivity [1] 43/13	
		scrutinise [1] 10/22	sensory [1] 18/1	
		scrutiny [1] 61/8	sentencing [1] 70/11	
		search [2] 70/11	sentiments [1] 118/9	

S	series [1] 14/25 serious [2] 29/10 29/20 seriously [2] 51/17 62/13 served [1] 32/18 service [30] 25/8 27/14 30/7 30/10 30/17 30/22 31/12 37/5 48/9 52/4 52/19 58/16 59/2 60/22 61/5 61/18 61/19 63/6 82/20 83/14 95/5 95/7 95/17 95/25 97/25 105/15 106/5 106/6 109/25 115/14 services [36] 12/12 25/16 26/6 28/13 28/25 30/9 35/9 37/12 42/9 44/5 44/7 44/13 44/22 44/23 44/25 45/3 46/7 46/20 50/6 50/19 68/15 68/19 72/22 74/12 90/24 93/2 95/21 95/24 98/14 105/21 106/3 106/8 109/8 109/10 110/11 110/17 serving [1] 53/18 sessions [3] 2/20 109/16 122/19 set [6] 3/20 59/16 60/3 67/4 82/17 98/4 setting [4] 45/9 49/22 63/8 64/4 settings [2] 38/5 115/4 several [2] 34/16 121/3 severe [23] 8/1 11/23 12/18 12/23 16/13 17/25 21/20 23/4 23/23 23/25 24/4 25/13 28/14 28/17 31/16 31/19 33/14 65/2 71/7 75/5 81/9 84/13 89/2 sex [1] 73/24 sexual [1] 97/11 sexuality [1] 76/25 Shaheen [1] 3/23 Shakespeare [2] 81/18 86/4 shall [12] 1/14 1/17 1/18 2/4 2/18 3/18 3/22 32/24 64/14 70/12 99/4 123/8 shape [1] 7/1 share [3] 92/13 104/19 116/1 shared [12] 4/12 5/6 8/25 13/13 36/24 46/14 47/22 64/22 98/9 103/2 122/8	122/13 sharing [2] 90/6 122/5 sharp [1] 18/12 sharply [1] 72/17 she [18] 3/20 51/7 51/9 62/25 76/5 97/13 100/16 101/20 101/22 101/24 101/25 102/1 107/11 109/17 109/19 116/2 116/4 116/7 she's [1] 112/19 Shelter [3] 88/3 88/4 88/21 shelves [1] 46/9 shield [3] 19/16 50/2 103/7 shielding [9] 84/17 85/8 86/12 86/14 86/18 102/19 102/24 103/1 103/5 shift [7] 17/19 27/23 37/9 37/14 55/19 57/20 110/4 shifts [1] 28/1 shock [1] 114/19 shocks [2] 74/16 111/12 shopping [1] 21/15 short [9] 7/24 15/6 27/25 33/2 39/10 46/15 65/18 79/20 99/6 short-lived [1] 46/15 shortages [2] 27/14 50/1 shortfalls [2] 50/9 50/12 shortly [1] 22/20 should [5] 2/1 79/25 80/11 94/12 119/23 showed [5] 34/15 43/22 53/11 70/8 79/7 showers [1] 92/20 showing [1] 24/23 shows [1] 78/24 shut [5] 20/21 39/14 40/2 56/3 108/18 shutting [1] 108/14 sick [1] 107/12 sickness [1] 28/1 Sign [1] 83/12 signed [1] 60/15 significant [29] 15/22 18/14 28/19 31/18 32/20 34/10 43/7 45/18 55/5 55/12 57/5 58/15 59/21 59/23 66/8 69/7 70/19 76/13 78/18 79/4 79/9 86/6 90/3 92/23 94/10 96/15 111/5 113/6 114/7 significantly [5] 19/2 39/15 45/24 68/23 74/10	signposting [1] 108/25 signs [1] 34/9 similar [3] 64/2 71/7 112/1 similarly [4] 12/22 38/22 43/20 83/5 simmering [1] 118/8 simply [1] 22/24 since [3] 23/16 77/21 103/17 single [1] 7/24 Singleton [2] 43/6 44/19 Sinha [1] 92/4 Sir [1] 74/21 Sisters [1] 95/3 sit [2] 26/11 61/11 sites [1] 44/12 sitting [2] 55/17 78/25 situation [4] 21/7 28/3 91/23 112/2 situations [3] 30/21 77/11 87/8 six [1] 80/4 six months [1] 80/4 Sixth [1] 121/16 size [1] 68/21 skeleton [1] 88/25 skilled [1] 26/11 skills [4] 22/2 23/12 29/22 30/12 slaughter [1] 52/1 sleep [3] 18/17 21/24 52/10 slower [1] 32/20 slowly [1] 114/6 small [5] 8/17 33/23 35/21 38/16 96/20 smaller [2] 38/17 79/7 so [24] 3/12 4/2 10/1 14/14 15/1 44/2 48/9 60/8 64/13 77/11 83/11 88/25 96/2 102/13 102/19 105/7 110/8 112/19 113/19 117/4 117/21 117/24 119/3 119/22 social [44] 1/11 10/23 15/5 15/21 15/23 16/2 16/7 17/20 17/22 18/1 18/3 22/10 23/2 23/7 23/18 28/24 31/23 32/18 38/23 41/7 48/1 48/4 48/11 61/16 65/5 66/5 67/11 67/22 68/23 69/1 69/9 71/4 71/13 72/22 75/1 79/11 82/17 85/17 85/19 85/22 92/16 93/5 103/2 113/12 socialise [1] 21/5 socialising [1] 37/15 socially [2] 65/7	115/15 societal [3] 36/1 36/23 66/19 societies [1] 108/3 society [14] 1/6 2/12 6/6 7/1 7/22 11/4 19/21 65/1 65/4 75/19 98/10 117/4 118/17 123/2 socio [8] 73/22 74/2 74/25 75/19 81/25 87/4 87/22 115/10 socio-economic [7] 73/22 74/2 74/25 75/19 81/25 87/4 115/10 socio-economically [1] 87/22 Sociology [1] 67/10 Solace [2] 95/5 95/12 solid [1] 84/12 solidarity [1] 18/2 solitary [1] 94/2 solutions [3] 57/11 57/25 63/18 some [100] 1/14 2/1 3/5 3/7 3/21 7/25 8/12 8/15 9/6 9/21 13/9 13/24 14/6 16/25 17/5 17/19 17/24 17/24 17/25 19/2 19/19 20/14 21/25 22/7 25/9 25/24 26/13 26/21 26/23 26/25 27/4 27/15 28/6 28/22 29/3 29/4 29/19 30/8 30/19 31/2 32/12 35/15 35/24 37/11 39/16 41/20 43/9 43/17 43/25 44/6 44/9 45/6 45/23 49/2 51/1 51/2 52/16 53/2 53/5 55/20 56/7 57/11 57/22 58/1 62/15 62/21 63/18 67/5 67/7 68/22 69/19 74/25 75/18 75/25 78/18 79/12 88/25 90/4 91/24 94/4 96/3 97/18 101/6 104/9 104/25 105/25 106/7 106/18 106/24 108/22 109/9 110/4 111/11 111/22 112/21 113/10 116/9 118/24 122/4 122/6 someone [3] 20/20 59/17 79/15 something [4] 22/14 106/10 112/1 116/23 sometimes [5] 79/8 85/24 88/18 91/22 112/2 sometimes ... there's [1] 112/2 son [5] 51/5 51/9 51/11 73/6 73/9	son's [1] 51/15 sore [1] 20/20 sorted [1] 42/8 soul [2] 100/6 100/17 sources [3] 12/13 28/23 85/18 South [1] 68/1 Southall [1] 95/2 space [2] 30/21 96/3 spaces [5] 40/20 43/7 43/14 61/15 92/14 spat [1] 52/22 speak [2] 18/9 92/7 speakers [1] 2/5 speaking [3] 4/10 96/12 122/10 specialising [1] 110/24 specialist [1] 27/20 specific [10] 10/17 33/22 37/21 37/25 44/7 47/10 81/7 85/6 114/11 121/12 specifically [1] 2/16 spectrum [1] 65/19 speed [1] 110/9 speedily [2] 65/12 81/15 spend [3] 17/11 52/13 55/8 spending [3] 17/14 78/25 87/11 spent [4] 17/2 49/21 91/12 108/4 spike [1] 91/7 spiral [1] 66/7 spiralled [2] 19/11 116/20 spoke [2] 39/18 104/15 sport [3] 35/24 36/16 41/12 sports [3] 9/15 40/13 41/4 sports and [1] 40/13 spread [2] 81/10 94/2 spreading [2] 48/19 50/23 spring [1] 18/16 stability [1] 79/10 stable [1] 80/10 stacking [1] 46/8 staff [27] 27/14 27/15 27/25 28/1 28/5 29/8 29/24 30/5 30/9 38/20 39/11 39/15 42/7 50/1 50/8 50/8 50/13 51/8 52/1 53/23 54/5 54/22 62/4 88/25 89/1 106/4 106/5 staffed [1] 27/25 staffing [1] 50/10 stages [7] 21/12 31/22 37/2 46/12 62/8 70/9 71/2
----------	---	--	---	---	--

S	100/23 103/1 108/2 108/9 109/12 110/19 111/15 112/13 113/16 116/14 117/19 118/18 119/2 119/20 120/16 122/8 122/9 122/13 straightforward [1] 42/3 strain [2] 47/2 55/13 strains [1] 57/1 strangle [1] 97/13 strangled [1] 98/3 strategic [1] 121/8 strategies [1] 91/25 strategy [2] 12/11 65/17 stream [2] 3/11 50/19 streaming [1] 106/7 street [1] 88/11 stress [11] 18/3 20/22 21/17 34/16 52/8 52/10 53/4 74/11 100/13 109/3 111/17 stressful [1] 73/11 strict [2] 2/4 18/22 strike [1] 12/3 stringent [2] 61/8 85/21 strong [1] 120/24 stronger [1] 121/25 strongly [4] 30/7 85/19 86/18 115/1 struck [2] 10/21 59/10 structural [5] 31/24 32/6 66/19 74/18 87/19 structures [2] 66/25 69/9 struggle [2] 102/2 108/19 struggled [6] 23/9 23/16 38/2 103/2 104/25 106/18 struggling [5] 34/11 34/18 57/2 111/16 117/17 studies [5] 12/16 33/24 34/14 76/9 81/20 study [6] 25/10 31/5 77/2 78/23 115/5 115/12 subject [2] 52/21 60/12 subjected [1] 94/1 submissions [1] 3/20 suboptimal [1] 114/16 subsectors [1] 37/25 subset [1] 31/18 substance [2] 66/6 97/22 substantial [7] 16/23 37/4 42/13 46/19 60/23 79/16 93/23	substantially [1] 75/21 substituted [1] 98/14 success [1] 29/6 succession [1] 102/8 such [30] 4/9 10/3 24/10 35/24 36/14 39/4 39/5 41/8 59/14 61/17 61/23 63/14 71/10 71/12 75/15 76/19 80/11 80/14 83/12 86/2 92/16 92/21 93/6 102/9 114/14 115/10 115/13 117/16 121/13 121/22 sudden [4] 102/11 112/24 114/19 115/8 suddenly [1] 90/12 suffer [3] 100/8 113/25 116/22 suffered [10] 23/22 28/7 65/4 65/7 81/9 92/12 99/15 102/9 108/5 116/2 suffering [10] 8/3 28/7 54/4 65/2 65/3 95/15 98/12 114/19 114/21 117/25 sufficient [3] 30/12 38/24 62/1 sufficiently [1] 37/21 suffocated [1] 77/7 suggest [3] 3/10 31/18 31/23 suggested [2] 25/12 80/4 suggesting [4] 26/3 44/14 80/9 113/4 suggestions [1] 71/9 suggests [4] 16/5 41/9 115/6 115/13 suicidal [2] 21/8 21/9 suicide [2] 26/9 102/21 suitable [1] 30/1 suitably [1] 30/14 summarise [1] 98/5 summary [2] 3/24 10/1 summed [1] 46/20 summer [1] 85/1 supermarket [1] 52/19 support [44] 3/16 9/19 22/15 27/15 28/23 28/23 28/24 37/9 53/12 55/21 56/13 57/12 58/2 69/14 77/21 78/16 81/12 85/18 88/13 88/22 89/11 97/20 103/3 104/6 104/12 104/25 107/24 108/25 109/5 109/7 109/9 109/21 110/1 110/3 110/12 110/16 110/17	111/4 111/14 111/20 111/21 111/25 112/11 114/24 support ... people [1] 111/25 supported [3] 22/6 117/1 122/2 supporting [7] 73/16 77/12 95/3 95/8 111/21 112/13 122/11 supportive [1] 76/25 supports [1] 78/10 supposed [1] 39/24 sure [3] 106/11 119/4 119/7 surge [1] 50/16 surreal [3] 100/6 102/14 102/15 surround [1] 7/19 surrounding [2] 116/19 117/16 surveys [1] 33/23 survive [1] 41/2 survivors [7] 56/8 56/11 56/14 95/6 96/16 97/4 97/18 susceptible [1] 5/17 suspected [1] 61/12 suspended [2] 93/3 93/6 suspension [1] 72/22 suspicious [1] 30/8 sustain [1] 68/3 sustained [1] 35/8 switch [1] 30/18 symptoms [13] 12/21 16/13 25/9 26/7 51/3 53/24 54/4 65/3 69/16 86/16 92/22 114/13 115/2 syndrome [2] 51/6 84/24 system [29] 5/12 6/23 7/10 14/23 36/14 54/17 54/20 54/24 56/2 56/7 56/13 56/22 57/6 57/12 57/13 57/19 58/6 58/14 62/11 63/3 67/3 70/10 89/22 90/8 93/10 93/22 109/22 115/17 121/24 systematic [3] 2/23 6/1 12/7 systemic [1] 34/21 systems [10] 48/16 58/5 58/20 59/9 66/25 67/17 89/8 90/16 120/3 122/16	107/22 111/18 115/25 115/25 116/23 taken [21] 2/14 6/13 6/22 7/8 9/1 10/9 14/1 14/15 14/22 16/8 30/4 51/1 59/20 59/20 65/6 65/25 80/8 81/10 94/12 96/4 119/16 Taking [1] 54/19 talent [4] 39/20 40/6 40/10 40/11 talk [5] 26/11 30/21 81/22 93/14 102/2 talking [2] 23/19 64/13 targeted [1] 37/22 task [4] 2/11 7/23 10/12 12/4 Taylor [1] 92/5 teacher [2] 49/20 52/7 teachers [2] 46/7 52/8 teaching [3] 45/4 47/16 49/22 team [9] 3/16 8/6 9/2 10/24 26/1 27/25 54/3 60/2 123/3 teams [1] 24/23 tears [1] 112/19 technological [2] 29/21 44/16 technologies [1] 45/15 technology [7] 29/18 44/18 45/14 55/12 57/10 61/24 110/6 technology-based [1] 57/10 tele [1] 30/13 tele-health [1] 30/13 telephone [1] 30/19 telephoned [1] 107/12 television [1] 48/18 tell [10] 7/23 20/21 42/6 52/25 54/13 74/8 74/24 76/6 84/14 116/13 temporary [2] 34/20 63/8 tend [1] 61/13 tendency [1] 38/17 tension [1] 30/5 tensions [1] 47/20 term [13] 15/7 27/16 35/8 39/12 65/3 71/18 79/14 79/17 80/10 84/7 113/21 114/24 117/5 terminally [1] 80/3 terms [6] 2/10 11/14 40/9 40/10 41/4 101/3 terrible [2] 4/11 88/24 terrified [3] 21/21
----------	--	--	--	---

T					
terrified... [2]	46/22	44/14 45/6 45/7 47/1 47/22 48/14 50/18 53/20 54/22 55/16 60/13 61/6 62/24 65/10 66/12 66/18 67/16 69/24 71/9 75/8 76/10 78/21 80/7 81/2 82/10 82/12 82/19 82/23 88/10 88/18 88/23 88/25 89/1 89/14 91/7 98/9 101/5 102/1 103/10 103/22 105/8 106/20 106/25 107/2 107/23 108/22 108/24 109/4 110/4 110/25 112/8 112/18 112/19 112/24 112/25 113/18 120/5 there in [1] 112/18 there's [4] 112/2 112/19 113/2 118/22 thereby [3] 2/10 59/8 62/9 therefore [6] 22/21 61/5 61/18 83/3 98/15 117/8 these [55] 4/8 7/13 7/24 8/12 8/24 9/6 9/7 9/12 9/21 11/8 11/12 13/9 19/1 25/20 28/11 31/22 32/22 34/4 36/17 36/24 36/24 44/2 49/1 54/8 56/11 56/17 58/20 60/7 65/14 66/22 67/22 70/16 73/10 73/25 75/17 80/19 80/24 84/21 89/11 89/16 89/18 89/24 94/15 95/25 96/14 99/16 102/18 108/8 114/13 118/9 119/14 120/24 122/21 122/23 122/24 they [93] 2/1 2/3 3/6 4/15 6/2 9/4 10/2 10/5 12/1 17/7 17/18 20/20 26/6 28/19 36/10 42/19 42/20 45/1 46/19 49/2 49/6 51/21 51/22 51/22 52/3 52/3 52/4 52/4 52/15 53/6 53/7 54/12 55/23 59/15 62/20 67/15 68/19 69/25 70/9 74/16 76/10 77/5 78/6 79/8 80/23 83/10 83/11 84/20 86/1 87/9 88/23 89/3 89/3 91/21 91/24 93/14 94/3 94/5 95/9 96/7 96/9 97/16 99/23 100/20 100/21 101/7 101/20 101/24 103/2 103/7 104/10 105/1 105/15 105/16 106/1 106/18 107/2 107/6 107/9 108/18	109/10 110/11 111/9 112/12 115/17 116/10 116/12 117/7 117/8 118/16 119/4 119/7 121/22 they'd [2] 42/1 88/23 they're [2] 102/17 119/7 they've [1] 112/1 thing [5] 22/13 49/14 108/13 109/20 112/4 things [4] 6/21 42/7 96/6 105/6 think [6] 37/13 42/19 112/4 112/5 118/21 123/7 thinking [1] 118/5 third [11] 8/17 13/14 49/19 64/8 64/20 79/1 82/6 82/11 83/9 83/15 120/22 this [160] those [105] 1/25 3/4 3/8 3/9 4/23 5/2 6/16 7/2 7/5 8/4 8/15 10/20 11/1 11/23 12/5 12/5 15/3 15/11 16/12 16/16 19/4 19/5 19/15 111/8 116/23 118/4 118/8 123/8 time-critical [1] 76/19 timely [2] 31/20 55/24 times [7] 23/20 49/2 56/5 93/4 96/22 103/13 110/8 timing [1] 38/13 timings [1] 2/3 today [3] 1/5 116/16 116/22 together [9] 9/10 12/5 22/23 60/3 63/5 97/16 105/3 105/7 122/15 told [61] 17/4 19/9 21/13 23/15 26/7 27/20 28/18 30/15 30/18 37/22 39/23 40/7 41/23 42/15 44/19 48/8 48/22 49/13 49/20 51/4 51/23 52/19 53/10 54/2 56/25 57/12 60/21 62/17 73/4 73/10 82/21 83/6 88/21 95/9 95/12 95/17 101/2 101/8 thoughts [3] 21/9 102/21 102/22 thousands [1] 110/7 threat [1] 85/8 threats [1] 98/1 three [9] 2/19 8/21 9/25 10/7 24/23 96/13 96/22 100/7 102/1 throat [1] 20/20	8/20 24/7 26/4 41/18 44/9 45/13 51/16 53/11 70/9 71/3 84/19 89/6 95/19 98/19 100/14 101/15 107/8 110/12 112/1 112/14 117/25 118/20 119/8 through ... I can't [1] 100/14 throughout [16] 7/5 14/7 14/19 19/20 34/8 36/8 37/19 50/11 55/7 66/22 82/7 84/21 119/13 122/2 122/22 123/5 thus [2] 26/20 38/1 Tim [1] 88/2 time [34] 4/14 10/21 17/2 17/6 17/12 17/14 17/16 29/12 34/14 49/24 59/10 61/14 61/19 64/9 72/2 73/9 76/19 78/25 90/11 91/12 92/1 93/1 104/3 104/19 104/20 106/2 107/10 108/6 108/17 111/8 116/23 118/4 118/8 123/8 time-critical [1] 76/19 timely [2] 31/20 55/24 times [7] 23/20 49/2 56/5 93/4 96/22 103/13 110/8 timing [1] 38/13 timings [1] 2/3 today [3] 1/5 116/16 116/22 together [9] 9/10 12/5 22/23 60/3 63/5 97/16 105/3 105/7 122/15 told [61] 17/4 19/9 21/13 23/15 26/7 27/20 28/18 30/15 30/18 37/22 39/23 40/7 41/23 42/15 44/19 48/8 48/22 49/13 49/20 51/4 51/23 52/19 53/10 54/2 56/25 57/12 60/21 62/17 73/4 73/10 82/21 83/6 88/21 95/9 95/12 95/17 101/2 101/8 thoughts [3] 21/9 102/21 102/22 thousands [1] 110/7 threat [1] 85/8 threats [1] 98/1 three [9] 2/19 8/21 9/25 10/7 24/23 96/13 96/22 100/7 102/1 throat [1] 20/20	110/15 115/25 Toman [1] 83/6 tomorrow [6] 3/23 9/20 37/1 98/4 122/17 123/9 tomorrow's [1] 122/19 too [1] 21/21 took [11] 6/2 6/16 51/13 51/17 51/23 60/18 71/17 83/15 102/8 110/15 118/3 tool [1] 79/24 tools [2] 65/14 65/15 top [1] 52/8 topic [5] 19/22 35/13 35/14 64/9 64/20 topics [1] 61/23 Tory [1] 118/3 total [3] 37/3 54/1 85/2 touch [1] 116/11 touched [2] 36/21 78/13 tourism [2] 36/3 36/16 tours [1] 38/11 towards [2] 57/20 70/7 towns [1] 9/3 trace [1] 6/15 trade [2] 15/2 39/11 trade-offs [1] 15/2 tragedy [2] 4/12 14/12 Tragically [1] 51/9 trained [1] 110/24 trans [1] 76/23 transferred [1] 26/24 transgender [2] 33/19 33/20 transition [4] 29/1 29/5 58/8 88/12 translate [1] 38/21 translated [1] 113/20 translating [1] 38/3 transmission [3] 5/19 50/22 90/25 transpired [1] 82/9 transplant [1] 84/12 transport [3] 47/10 53/9 85/21 trauma [8] 28/10 69/10 70/17 74/2 93/21 99/12 116/10 117/24 traumatic [5] 20/22 94/13 110/15 114/19 117/2 travel [7] 9/16 36/3 36/16 38/22 69/9 76/19 89/21 travelled [1] 9/2 treasured [1] 5/6 treating [1] 68/19 treatment [2] 70/6

T	ultimately [1] 70/18 unable [10] 18/19 28/20 29/20 96/17 97/19 99/21 105/16 112/11 114/17 120/16 unacceptable [1] 81/3 unanswered [1] 114/20 unavoidable [1] 35/17 uncertainty [10] 21/4 21/7 21/11 49/9 80/7 89/7 90/2 93/17 99/25 106/25 unclear [3] 56/5 76/18 83/12 uncles [1] 5/5 uncomfortable [3] 49/3 77/5 77/5 under [5] 26/2 26/14 59/11 61/19 62/14 underestimated [1] 123/3 underexamined [1] 33/21 underline [2] 4/14 116/15 underlines [1] 117/15 underlying [3] 10/22 71/12 81/24 underlying medical [1] 81/24 undermine [1] 66/9 undermined [1] 55/22 undermining [1] 57/4 underrepresentation [1] 76/9 understand [10] 10/15 38/21 49/8 66/15 104/25 106/18 111/25 116/25 119/15 120/25 understanding [13] 5/23 7/7 7/21 13/5 14/4 14/21 19/22 34/2 86/25 106/20 106/22 112/3 122/14 understood [2] 14/11 35/10 undertaken [1] 60/6 unequal [10] 5/15 14/5 14/7 32/9 65/20 70/6 70/12 98/12 115/18 120/2 uneven [3] 19/1 32/17 76/8 unevenness [1] 32/18 unexpected [5] 4/25 17/6 102/11 110/13 114/14 unfamiliar [2] 49/2 69/8	54/21 58/1 58/13 using [5] 26/1 61/24 91/24 92/1 110/6 usual [1] 55/1 usually [2] 96/3 113/17 utilities [1] 107/17 utmost [1] 1/17 utterly [2] 21/23 29/16	visiting [3] 48/7 68/14 116/10 visits [4] 27/8 93/5 101/14 101/15 vital [2] 21/22 98/13 voice [2] 99/2 111/3 voices [4] 4/10 7/4 8/4 83/10 volume [1] 110/13 voluntary [1] 28/13 volunteer [1] 110/5 volunteering [3] 40/14 44/9 44/11 volunteers [4] 39/15 40/12 54/22 110/7 vulnerabilities [5] 44/10 66/2 67/4 87/25 98/11 vulnerability [9] 32/10 42/14 64/9 64/21 67/24 78/1 78/12 91/4 120/10 vulnerable [49] 1/12 5/16 6/3 13/24 19/15 19/16 19/21 20/2 29/4 42/11 42/18 42/21 44/8 50/3 50/4 50/25 50/25 51/6 55/11 56/15 58/1 62/5 62/5 65/11 66/16 67/2 75/18 78/5 78/7 81/5 81/6 83/24 83/25 84/1 84/7 85/3 85/7 85/13 85/15 85/24 86/7 86/9 86/13 86/20 86/23 86/24 97/6 98/7 120/23 vulnerable and [1] 19/16
U	ugly [1] 118/6 UK [49] 4/16 5/18 7/12 7/21 9/2 10/8 11/4 11/17 12/10 12/14 13/6 14/24 15/13 16/6 16/20 16/21 25/10 31/7 32/16 33/10 34/22 34/23 38/10 44/1 45/19 54/10 58/5 58/19 66/14 68/25 69/12 70/24 72/19 75/7 76/6 77/17 81/15 83/20 84/5 84/15 89/20 93/7 93/9 94/14 95/7 103/12 105/2 106/10 115/19 UK ... That's [1] 106/10 UK administrations [1] 84/15 UKHospitality [1] 37/22 Ulster [1] 42/15	urban [1] 35/22 urge [1] 1/23 urgent [2] 26/3 93/2 us [18] 7/19 19/9 44/19 48/22 50/8 101/8 101/19 102/10 103/2 110/7 111/24 112/22 112/25 113/1 116/2 117/24 117/25 119/6 USDAW [1] 39/5 use [11] 25/8 40/19 40/22 41/6 41/19 44/18 63/22 70/14 79/23 80/15 80/20 used [7] 2/17 15/9 47/6 51/25 82/25 95/15 98/2 user [1] 95/25 users [8] 30/7 30/10 31/12 37/5 54/16	victim-survivors [4] 95/6 96/16 97/4 97/18 victims [8] 55/20 56/8 56/10 56/13 57/7 95/11 95/20 95/23 victims' [1] 55/22 video [2] 55/11 62/2 video-conferencing [1] 62/2 videographers [1] 122/10 view [2] 12/17 38/25 viewed [3] 29/18 58/12 106/3 views [1] 77/25 violence [6] 30/20 52/16 88/17 95/5 95/6 95/8 virtual [1] 110/6 virus [6] 4/16 5/17 6/2 16/9 81/11 101/7 visit [4] 101/20 101/21 113/17 114/17 VisitBritain [2] 38/10 40/7

W	
wasn't... [1] 113/18	week [8] 13/20 15/17 18/7 20/2 20/4 24/25 77/17 116/2
watch [4] 3/8 21/21 45/3 118/8	Week 2 [1] 13/20
watching [2] 79/1 101/10	weeks [5] 2/19 10/7 50/18 87/24 102/1
Watson [2] 81/20 86/4	welcome [1] 8/14
wave [6] 24/17 25/16 25/20 25/21 26/4 27/3	welcomed [3] 29/3 88/6 93/5
waves [1] 27/13	welfare [3] 10/23
way [16] 2/12 2/14 3/4 20/22 42/1 50/9 60/24 66/3 82/11 112/16 112/20 117/1 117/5 118/12 119/6 121/24	48/11 90/8
ways [5] 21/25 22/3 95/19 106/21 119/5	well [12] 13/1 24/5 29/22 45/2 48/25 64/6 68/16 75/13 78/2 99/1 102/19 123/7
we [116] 1/5 1/14 1/16 1/18 2/12 2/14 2/16 2/18 2/23 2/25 3/16 3/18 3/21 4/14 5/2 7/11 7/13 7/19 7/24 8/8 8/10 8/14 9/22 11/5 11/12 11/16 12/17 12/25 13/7 13/10 13/11 13/14 13/23 14/4 14/9 14/20 15/8 15/11 17/9 19/18 19/20 24/13 27/22 30/17 32/9 32/21 34/3 34/25 35/10 36/22 36/22 40/10 40/11 42/18 42/20 42/24 45/11 46/23 47/5 48/10 48/10 48/12 51/25 52/5 52/5 52/6 52/21 53/11 53/11 53/12 53/14 54/4 54/7 54/19 64/10 64/13 64/20 64/24 64/25 65/18 66/11 66/22 70/12 78/4 78/7 78/13 79/13 81/17 86/24 99/1 100/5 100/8 100/10 100/13 100/15 100/17 100/18 104/18 109/21 112/23 118/20 119/3 119/5 119/11 119/24 120/11 120/17 120/22 121/4 121/11 121/16 121/20 122/1 122/12 122/15 123/8	
we're [3] 3/8 42/6 118/21	were [229]
we've [1] 2/20	were reflected [1] 72/5
weaknesses [2] 13/3 39/25	weren't [1] 108/21
weaponisation [1] 95/14	Western [1] 106/22
weapons [1] 98/2	what [16] 7/13 11/3
wearing [1] 101/15	35/10 36/10 44/2 47/1 48/12 54/12 60/10 82/25 98/4 99/25 107/25 119/7 119/19 119/22
web [2] 40/4 77/25	whatever [1] 80/5
website [2] 3/14 10/2	whatsoever [1] 88/23
	when [35] 6/4 19/10 19/20 21/24 22/19 26/5 30/17 32/21 39/16 43/10 44/22 47/1 48/17 49/6 51/7 52/17 53/15 53/18 58/17 61/19 80/19 84/20 93/12 96/3 96/4 96/16 96/19 104/20 106/6 109/7 109/14 111/1 115/3 116/8 118/24
	where [22] 6/21 6/23
	7/8 9/4 9/5 25/6 28/5 37/12 42/21 58/10 63/12 76/24 77/5 83/13 85/21 88/14 92/13 105/17 106/25 107/2 108/20 112/20
	whether [11] 4/17 24/14 26/18 40/25 55/23 56/5 56/8 65/20 79/24 100/20 122/8
	which [100] 1/15 2/21 3/7 3/15 4/13 4/16 5/8 6/5 7/17 7/19 7/21 7/25 8/9 8/10 8/11 9/1 9/22 10/15 11/1 11/7 12/3 12/8 13/2 13/4 13/23 14/7 14/24 15/4 15/8 15/12 21/17 22/6 25/9 27/14 31/5 31/10 31/25 32/5 34/3 35/1 36/25 38/11 38/18 42/24 48/2 49/5 51/18 51/19 54/15 57/16 58/8 58/16 60/3 60/19 61/5 61/12 61/25 63/4 65/14 66/9 69/11 69/22 71/17 72/15 75/9 75/15 76/21 78/23 79/16 80/2 85/17 87/17 89/15 91/8 92/18 94/18 95/19 96/10 97/22 98/6 98/13 98/17 98/19 98/25 99/17 103/12 104/7 105/22 111/14 113/10 114/11 116/19 118/3 119/5 119/9 119/24 120/2 120/18 121/24 122/15
	while [35] 6/11 8/5 10/19 18/24 20/12 25/23 26/5 29/1 32/15 34/5 34/8 34/14 40/15 44/10 47/21 48/13 52/2 52/4 52/21 65/4 69/1 78/5 78/16 82/18 88/8 89/20 93/1 97/19 107/4 107/11 107/18 112/11 115/12 118/5 120/15
	whilst [4] 58/11 79/6 91/25 96/7
	white [6] 68/2 68/8 68/13 69/5 70/20 106/22
	who [81] 1/25 2/1 3/4 3/8 4/1 4/23 4/24 5/16 8/15 13/16 16/12 16/15 18/9 19/15 23/22 24/11 30/21 36/7 41/1 41/21 42/10 42/14 43/15 43/17 44/21 48/5 49/10 50/24 50/25 51/17 54/24 55/14 56/22
	58/20 59/24 62/5 65/7 65/7 65/11 66/15 73/2 73/5 73/14 77/12 78/18 81/22 81/24 83/21 83/23 84/11 85/13 86/9 86/23 88/10 89/1 90/10 92/6 92/22 94/16 94/21 94/22 96/1 98/10 98/20 99/15 99/22 102/9 103/1 106/9 108/5 109/22 111/22 111/25 116/1 117/16 118/13 118/15 120/12 122/1 122/8 122/20
	whole [13] 5/12 6/23 7/10 11/22 14/23 40/8 63/17 65/4 67/3 112/4 120/3 121/24 122/16
	whole-system [6] 5/12 6/23 7/10 14/23 67/3 121/24
	whole-systems [2] 120/3 122/16
	whom [5] 20/3 39/16 74/23 103/4 110/1
	whose [6] 11/13 45/17 62/14 65/11 89/19 114/3
	why [6] 64/13 71/9 100/16 102/6 105/1 106/18
	Wi [2] 95/22 96/6
	Wi-Fi [2] 95/22 96/6
	wide [1] 8/19
	widened [1] 29/3
	widening [1] 29/23
	wider [8] 21/2 38/4 63/3 78/8 86/22 92/8 112/21 115/13
	widespread [4] 32/15 55/16 76/17 112/7
	widow [2] 111/15 111/24
	widowed [1] 22/19
	wife [1] 116/24
	will [146]
	will explain [1] 85/14
	window [2] 96/20 101/15
	windowless [1] 48/21
	winter [1] 75/25
	wish [3] 2/5 3/12 119/9
	wishes [2] 4/1 122/20
	within [20] 2/2 5/2 12/3 24/12 44/4 54/24 56/23 59/15 61/17 69/13 70/11 72/18 72/23 92/24 94/3 102/8 104/2 104/8 109/22 117/9
	without [18] 7/7 12/21 38/24 39/9

W

working... [15] 50/2
50/17 53/15 54/22
54/24 54/25 63/10
67/20 96/5 108/4
109/22 110/10 110/16
110/19 121/6
workplace [4] 39/5
51/8 51/14 51/19
workplaces [1] 62/6
works [1] 118/17
world [2] 6/11 15/17
worried [2] 21/14
46/25
worries [2] 110/22
111/9
worry [2] 22/1 107/12
worse [5] 23/9 23/17
28/8 82/9 96/2
worsened [4] 19/18
23/18 72/10 116/9
worsening [1] 86/3
worship [9] 36/4
42/23 43/1 43/4 43/7
43/11 44/12 44/13
78/15
worst [2] 5/24 115/22
worth [1] 69/23
would [33] 6/3 7/23
20/21 38/20 48/3
49/16 52/12 52/21
52/24 55/23 56/6 61/1
61/4 61/5 61/18 63/9
64/1 64/10 82/9 89/19
95/23 96/3 96/5 96/7
97/1 97/8 98/20 101/3
102/12 105/25 106/11
109/25 112/12
wounds [1] 7/2
written [2] 58/22
118/9
wrong [1] 6/21

10/10 10/18 10/24
10/24 11/7 11/13
11/14 13/8 14/2 14/19
19/22 27/25 28/2 43/2
64/12 95/22 95/22
99/2 102/12 104/20
117/1 117/2 117/3
119/11 121/22 122/14
122/22 123/3

Z

Zoom [1] 109/16

Y

year [7] 29/12 75/3
77/3 91/17 103/24
107/8 109/16
years [6] 17/18 47/13
47/19 100/7 113/23
123/1
yes [2] 50/11 112/5
yet [5] 4/19 5/20
35/10 47/16 53/11
you [129]
You have [1] 6/4
you'd [2] 27/24 27/25
you're [3] 95/21
102/14 112/5
young [9] 11/20
16/12 19/3 48/5 73/4
73/6 73/8 76/23 77/13
younger [5] 37/16
42/19 79/3 79/8 79/13
your [36] 6/24 7/4 8/5
8/6 8/11 9/8 9/24 10/3