Monday, 16 February 2026

(10.30 am)

Opening Remarks by THE CHAIR

LADY HALLETT: Good morning, everyone.

Today we begin the public hearings in Module 10, the impact of the Covid-19 pandemic on society. This is our final module.

It will explore the impact of Covid-19 on the population of United Kingdom with a particular focus on mental health and wellbeing, key workers -- but not health and social care workers, the impact on them has been covered in previous modules -- the most vulnerable and the bereaved.

We shall hear some evidence about the impact of the pandemic which has already been explored in previous modules but it will be in more detail in this one and we shall do our utmost to avoid unnecessary repetition.

We shall not be considering decision and policy making, hence my decision not to designate as Core Participants government bodies and politicians.

This module is about the impact of the pandemic, not examining the particular decisions made or policies adopted, and I must urge Core Participants and their legal representatives to remember that.

For those who are new to the Inquiry hearings and

for some who are old hands, I should emphasise that they must stick to issues that are within this module and of the Inquiry and they must stick to their timings. I shall be strict on both.

I do not wish to interrupt speakers mid-flow but I will if necessary.

This module is about making a permanent record of the impact of Covid-19 lest people forget, and about recommending improvements for the future. I hope thereby to fill my terms of reference.

Faced with the huge task of investigating the impact of the pandemic on society, we had to find a way to gather the evidence in a proportionate and cost-effective way. We have taken statements from individuals and organisations and obtained over 2,600 documents specifically for this module. We have also used over 1,200 documents obtained from previous modules. We shall be calling 48 witnesses, including expert witnesses, over the next three weeks.

In addition, we've held nine roundtable sessions at which representatives from 111 organisations gathered to provide their perspective on the impact of the pandemic on their sector and we have conducted a systematic Evidence Review of the impact on mental health.

Finally, we have the benefit of accounts given to

our listening exercise Every Story Matters. All this material will help me reach my conclusions and inform any recommendations I make. I am deeply grateful to all those who have contributed in any way.

Although there are some positive stories to come out of the pandemic, they are far outweighed by the negative stories, some of which are captured in the impact film that we're about to watch. There may be those who find parts of the film distressing. If you are one of those and following online, may I suggest you pause the live stream and return after just over 24 minutes. If you are here at Dorland House and you wish to do so, please leave the hearing room in a moment.

The Inquiry's website provides links to organisations which may be able to help and at the hearing centre we have the Hestia support team ready to assist.

After the film has been played we shall reassemble and Ms Kate Blackwell KC, Counsel to the Inquiry, will begin her opening submissions. She will set the scene and provide some background and explain the issues we shall be examining in the module in more detail. After her, and probably tomorrow morning, Ms Shaheen Rahman KC, also Counsel to the Inquiry, will provide a summary of the discussions at the nine roundtables.

I will now pause for anyone who wishes to leave the hearing room or press "pause" on their device to do so.

(Impact film was played)

LADY HALLETT: Thank you.

Ms Blackwell.

Opening statement by LEAD COUNSEL TO THE INQUIRY for MODULE 10

MS BLACKWELL: My Lady, it is fitting that these final hearings begin with such a moving compilation of individual voices speaking to the personal impact of Covid-19. The most stark and terrible effect of the pandemic is found in that shared tragedy, in the devastating loss of life which resulted.

We underline the figures cited time and again by the Inquiry. They do not lose their power for repetition. The number of deaths across the UK for which the virus was responsible, calculated by whether Covid-19 is mentioned on the death certificate, is now over 230,000. The figure may yet be higher still.

As you remarked at the outset of this Inquiry, my Lady, before Covid-19, nothing on this scale of loss from disease had been seen in more than a century. Behind those figures are individuals who died prematurely, leaving friends and families who experienced an unexpected and heartbreaking loss in

pandemic conditions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: They may be published.

MS BLACKWELL: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

feeling good and functioning well.

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

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

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

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

taken in response.

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

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

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

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

In Module 2, you identified a series of lessons for

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

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

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

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

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

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

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

Mental health remains a devolved responsibility across areas of the UK. My Lady, you will hear that the baseline for wellbeing and mental health in the UK before Covid-19 hit was in fact precarious.

A substantial proportion of the population entered the pandemic with pre-existing mental health difficulties.

Some people experienced improved wellbeing and

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

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

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

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

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

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

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

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

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

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

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

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

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

As one Scottish contributor to Every Story Matters told us:

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

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

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

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

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

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

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

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

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

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

Fear and uncertainty, particularly in the early stages of the pandemic played a consistent role. Contributors told Every Story Matters:

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

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

Some people reported finding positive ways to cope,

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

One contributor to Every Story Matters said:

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

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

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

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

One contributor to Every Story Matters said:

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

Another contributor from Scotland told the Inquiry:

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

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

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

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

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

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

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

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

Professor Das-Munshi also refers to:

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

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

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

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

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

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

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

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

Professor Osborn notes some reports of an increase

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

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

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

A specialist mental health nurse told Every Story Matters:

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

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

Another contributor said:

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

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

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

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

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

As one contributor to Every Story Matters said:

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

As Professor Osborn explains in his report:

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

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

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

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

A psychotherapist told Every Story Matters:

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

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

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

Professor Das-Munshi notes one study which indicated that:

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

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

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

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

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

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

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

(11.45 am)

(A short break)

(12.00 pm)

LADY HALLETT: Ms Blackwell.

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

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

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

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

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

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

The Evidence Review concludes:

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

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

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

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

I turn now to our second topic.

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

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

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

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

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

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

tomorrow in introducing the roundtable reports.

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

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

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

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

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

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

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

The Federation of Small Businesses said:

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

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

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

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

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

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

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

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

Loss of talent extended into other sectors. VisitBritain told the Business Leaders Roundtable:

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

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

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

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

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

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

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

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

The Arts Council England told the Cultural Institutions Roundtable that:

"many organisations connected with their local

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

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

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

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

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

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

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

of places of worship.

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

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

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

Some faith leaders felt it was difficult to engaging

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A prison officer told Every Story Matters:

"I work in the prison service so continued, as I was a key worker ... we felt like we were cannon fodder as no-one seemed to care about our welfare, no social distancing in work, we were scared of what could happen while trying to do our jobs."

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

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

The Welsh Local Government Association have told us:

"Impacts on key workers were many and various; all workforce groups needed to conform with adjustments -- to a lesser or greater extent -- to well-established

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

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

A priest in England told Every Story Matters:

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

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

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

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

A firefighter explained:

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

A funeral director said:

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

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

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

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

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

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

"Quite frankly, we were used as lambs to the

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

One teacher said:

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

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

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

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

A funeral director told Every Story Matters:

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

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

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

3.79 per cent of the total workforce."

One childcare worker told the Inquiry:

"I and the members of the team I work with are suffering with symptoms of Long Covid. We have lost staff at a dramatic rate due to the lack of concern or respect by anyone in authority of the childcare sector."

We will consider lessons that may be learned from these experiences. My Lady, you will hear evidence from experts and from the TUC -- four witnesses representing different areas of the UK workforce, here to recount their experiences of how the pandemic impacted upon them. You will be able to reflect on what they have to tell the Inquiry but cross-cutting themes already emerging include a lack of clarity in government messaging and the confusion which this caused.

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

bore a heavier than usual burden.

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

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

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

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

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

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

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

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

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

However, the introduction of digital solutions left

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Chief Coroner has told the Inquiry:

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

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

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

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

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

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

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

As the Chief Coroner told the Inquiry:

"How bereaved families experienced the investigation process will have been affected by the change in approach, although how they felt about it will have varied. For example, some families do not want a post-mortem examination to be conducted for emotional and/or religious reasons, but others are desperate for there to be as extensive an investigation as possible."

She added:

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

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

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

proceed that otherwise would have been adjourned.

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

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

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

MS BLACKWELL: Thank you.

(12.49 pm)

(Luncheon Adjournment)

(1.50 pm)

LADY HALLETT: Ms Blackwell.

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

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

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

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

inequalities across the board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

One contributor to Every Story Matters said:

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

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

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

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

health and wellbeing outcomes.

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

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

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

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

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

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

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

the key social determinants of health during the pandemic period.

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

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

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

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

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

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

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

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

their gender identity.

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

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

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

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

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

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

Professor Nazroo will say:

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

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

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

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

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

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

eligible for critical care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

experiences with the experts and with Lara Wong.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

migrants.

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

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

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

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

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

Restrictions introduced to limit the transmission of

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

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

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

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

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

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

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

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

The availability of healthcare provision evolved

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

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

Their representative explained in the Justice System Roundtable:

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

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

The charity Bail for Immigration Detainees described

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

I turn now to domestic abuse.

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

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

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

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

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

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

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

These difficulties were confirmed by a service user

who reported that:

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

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

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

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

access to PPE, testing, and vaccines that would have helped them lower their risk of infection.

Perpetrators' coercive control, combined with victim-survivors having to balance the health risks of leaving their homes, left disabled and older women even more vulnerable. This was compounded by the fact that their perpetrators were often their carers, and during lockdown would often be their only carers.

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

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

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

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

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

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

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

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

MS BLACKWELL: Thank you.

LADY HALLETT: I shall return at 3.05.

(2.46 pm)

(A short break)

(3.04 pm)

LADY HALLETT: Final leg, Ms Blackwell.

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

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

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

One contributor to Every Story Matters from Northern Ireland said:

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

Another contributor to Every Story Matters from Wales said:

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

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

A contributor to Every Story Matters from Scotland said:

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

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

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

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

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

One contributor told us:

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

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

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

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

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

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

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

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

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

celebration of life."

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

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

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

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

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

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

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

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

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

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

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

However, a lack of clarity in the guidance on restrictions, including as applied to different communities and religions, exacerbated the negative impact on their experience of bereavement. A representative from Mind explained that:

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

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

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

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

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

compassion.

One contributor to Every Story Matters said:

"Banks, building societies, offices ... all of them were working from home on limited hours. I spent days on hold. I repeat that only those who suffered a bereavement at the time know how difficult it was ... I wanted peace and all I got was frustration, obstacles, excuses from these companies."

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

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

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

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

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

One contributor to Every Story Matters told the Inquiry:

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

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

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

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

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

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

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

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

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

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

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

"I found peer support ... people who understand

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A bereaved wife and daughter from Scotland added:

"Understand that the impact of not being able to

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

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

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

One contributor to Every Story Matters said:

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

little to no chance of moving on from it."

Another said:

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

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

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

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

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

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

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

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

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

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

I turn now to deal with those.

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

earlier modules.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS BLACKWELL: Thank you, my Lady.

(3.41 pm)

(The hearing adjourned until 10.00 am the following day)

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