COVID-19 INQUIRY
MODULE 10

SUBMISSIONS OF DISABLED PEOPLE'S ORGANISATIONS (DPO): DISABILITY RIGHTS UK, INCLUSION SCOTLAND, DISABILITY ACTION NORTHERN IRELAND

INTRODUCTION

1. OUTLINE: Having reached the Inquiry's tenth and concluding Module, the pandemic's brutal impact on Disabled people has been laid bare. Disabled people and DPO have given accounts in Modules 1, 2, 2A-C, 3, 4, 6, 7, 8 and 9 and now Module 10 of this impact in all its dimensions. This has shown that through structural inequities Disabled people faced a triple jeopardy in terms of the virus itself, their access to other health and care services, and as a consequence of the countermeasures.[1] Disabled people felt the pandemic's impact disproportionately at the expense of their lives, their mental, physical, social, economic and financial health and wellbeing, their independence and their dignity. Entering the pandemic in a precarious position involving grave and systemic violations of their rights,[2] the intersecting inequalities faced by Disabled people were exacerbated and entrenched.

2. SOCIAL MODEL: In all of the Inquiry's Modules, the DPO use the "*social model*" of analysis and policy that deliberately questions notions of disability, vulnerability and resilience in order to deepen the understanding that many of the hardships Disabled people face are determined by social, economic and political choice.[3] Further to Article 1 of the United Nations Convention on the Rights of the Persons with Disabilities ('UNCRPD'), it is the "*interaction*" between an individual's impairment/condition with various barriers and attitudes that may hinder their full and effective participation in society on an equal basis with others.

3. RIGHTS: The tools of Human Rights analysis are a means of understanding what action the State should take to plan for, respond to, and recover from emergency.[4] In this Module the DPO draw particular attention to the UK's obligations under the UNCRPD in respect of living independently and being included in the community (Art. 19), health (Art. 25), an adequate standard of living and social protection (Art. 28), participation in cultural life, recreation, leisure and sport (Art. 30), access to the physical environment (Art. 9) and work and employment (Art. 27).[5] The various provisions of the UNCRPD are designed to give emphasis to "*the importance*

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[1] Watson & Shakespeare [INQ000280067/3 §§2, 16]
[2] Watson & Shakespeare [INQ000280067/6 §16] Optional Protocol Report 06.10.16 [M6/INQ000365997/20 §113] UNCRPD UK Country Report 03.10.17 [M6/INQ000509839/12 §§58-59]
[3] M2 DPO Opening 26.09.23 [§§1.4, 1.7-1.10] DPO [INQ000655852/4 §10]
[4] M2 DPO Opening 26.09.23 [§§2.1-2.12]
[5] UNCRPD and Optional Protocol (2007) (UK ratified 2009)

of mainstreaming disability issues as an integral part of relevant strategies of sustainable development".[6] The revelations of this Inquiry show that the UK has yet to achieve this.

4. OUTLINE: The impact on Disabled people is outlined by reference to [I] Disability and Intersections [II] Death, Bereavement and Accountability [III] Mental Health and Wellbeing [IV] Sport, Leisure and Culture [V] Housing, Justice and Security [VI] Key Workers and [VII] Innovations and Adaptation.

[I] DISABILITY AND INTERSECTIONS

5. DISABILITY AND DISABLEMENT: Disabled people have a wide range of impairments and/or long-term health conditions. Disabled people can include autistic people, people with learning disabilities, those with sensory, cognitive, mobility and energy-limiting impairments and people with mental distress and severe mental illness.[7] The latest Department for Work and Pensions ('DWP') Family Resources Survey estimates that there are 16.8 million Disabled people in the UK, making up 25% of the population. Approximately 45% of adults over state pension age, 24% of working-age adults and 12% of children are disabled. The figures are higher in Wales (30%) and the North-East of England (38%). In terms of impairments, pension age adults predominantly report mobility (69%), stamina, breathing or fatigue (45%) and dexterity (34%) impairments with memory impairment (19%) a lower but significant category. Working age adults particularly report mental health (48%), mobility (42%) and stamina, breathing or fatigue impairments (35%). Children report social and behavioural (59%, near to 3 in 5), learning (32%) and mental health (29%) impairments.[8] Many people have been *left disabled* by the pandemic itself, including those living with the severe ongoing symptoms and impact of Long Covid.[9]

6. INEQUALITIES: In Module 1, the evidence of Professors Marmot and Bambra described how Covid-19 "*acted synergistically with existing socio-economic and health inequalities to exacerbate and amplify the impacts of the pandemic but also the impacts of those existing inequalities*".[10] Among those existing inequalities, the Module 2 Inquiry report has found that the effects of socio-economic deprivation, poor housing and poor health were further compounded for Disabled people.[11] As explained by Professors Watson and Shakespeare, structural and systemic inequities and discrimination were faced by Disabled people which as a result of societal and institutional failings put Disabled people in a weakened socio-economic situation compared to their non-disabled peers, with consequences for health and wellbeing,

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[6] UNCRPD Preamble recital (g)
[7] DPO [INQ000655852/4 §11] Mallick [M2/INQ000280035/3 §6] Das-Munshi [INQ000588210/41 §119]
[8] DPO [INQ000655852/4 §11] DWP Family Resources Survey 2023-2024 [INQ000620396/43, 48-50]
[9] M2, 2A, 2B and 2C Report [Vol. I §1.52] Bambra & Marmot [INQ000588215/8 §§39-43, 141-144, 204-212] Bécares & Nazroo [INQ000588214/31 §128] Brightling & Evans [M2/INQ000280198/11 §§1.14, 1.16] Segal & Whittaker [M8/INQ000587960/4 §§5-8]
[10] Bambra & Marmot [INQ000195843/75 §181] [M1/T4/55/6-10] DPO [INQ000655852/5 §14]
[11] M2, 2A, 2B and 2C Report [Vol. II §10.103]

employment, deprivation, digital exclusion, security and social isolation and loneliness, among other matters. The pandemic then exposed and amplified these many pre-existing challenges faced by Disabled people.[12]

7. INTERSECTIONS: Not only were Disabled people disproportionately impacted in all aspects of the pandemic response but negative outcomes were compounded when disability status intersected with other protected characteristics, socio-economic characteristics or other factors.[13] Intersectionality is an analytical framework for understanding how race, gender, class and other systems of oppression and disadvantage 'intersect' with one another to create different modes of discrimination and erasure for groups experiencing multiple oppression, for example Black working class Disabled women.[14] There are two ways to use intersectionality to evolve policy towards Disabled people. First, some Disabled people face multiple discrimination, and therefore multiplied barriers, on the basis of disability together with race, age, sex, gender, being LGBTQ+ and/or other personal and socio-economic characteristics.[15] These intersectional inequalities add to and deepen marginalisation.[16] Second, intersectional characteristics create distinct and unique experiences and distinct risks of marginalisation and harm, when policy responses and interventions fail to understand them.

8. MARGINALISATIONS: The Module 10 evidence reveals the intersecting impact and unique marginalisations experienced by Disabled people in numerous domains.[17] DPO encourage the Inquiry to undertake its examination of adverse impact and inequalities through an intersectional approach. For instance, police forces during lockdown were not necessarily trained to consider that a Disabled woman could be abused by her same-sex partner. When there was a supply side crisis in care workers, providers did not necessarily consider the importance that a care worker carrying out intimate personal assistance should speak the same language or understand the cultural background of the cared for person. An LGBTQ+ Disabled person, like their non-disabled peers, could be estranged from their family because of their views about sexuality, but unlike non-disabled people, it might be far harder to gather friends to act as Next-of-Kin, as other LGBTQ+ people rely on doing. For some time DPO have

[12] Watson & Shakespeare [INQ000280067/3 §§2, 17-21, 25-29, 37, 41] Watson & Shakespeare [INQ000588216/3 §2]
[13] DPO [INQ000655852/52 §144] VODG Spotlight Report Jul 23 [INQ000279963/32] Matejic [INQ000659871/35 §129]
[14] Inclusion London DPO Report Jun 21 [M9/INQ000656192/19]
[15] DPO [INQ000655852/4 §11] Mallick [M2/INQ000280035/3 §6] Bécares [INQ000657973/4 §§4, 30] Das-Munshi [INQ000588210/15 §§36, 56] Wenham [INQ000657974/17 §§46, 105, 107-108, 111]
[16] M2 DPO Opening 26.09.23 [§1.5]
[17] DPO [INQ000655852/16 §§42, 94, 114, 141, 144, 145, 146] VODG Spotlight Report Jul 23 [INQ000279963/17, 21, 28, 29, 32] Bécares [INQ000657973/7 §§21, 76, 97] Das-Munshi [INQ000588210/14 §§36, 56, 84, 93.1] Nazroo [INQ000588213/26 §113] Wenham [INQ000657974/13 §§36, 46, 49, 51, 71, 90] Matejic [INQ000659871/28 §111] DA Group [INQ000652188/16 §§49-50, 66, 70, 283, 287, 294-296] Sisters of Frida Report Apr 20 [INQ000652384/26] Wong [INQ000657970/108 §374]

acknowledged the importance of the intersectional approach to better reflect, understand and represent the full diversity of the Disabled people they serve. However, few DPO have capacity to take specific and comprehensive action. Intersectional specific DPO are limited in number and are chronically under-supported and under-funded; and duly struggled and often disbanded during the pandemic.[18]

9. OMISSION: With Disabled people treated throughout the pandemic as an "*afterthought*" and largely left out of the Government's work on Covid disparities,[19] the intersectional experience and impact on Disabled people was therefore also largely omitted from the siloed approach to equalities, which did not come close to grappling with the lived realities and whole-person needs of Disabled people. With Government failings even to undertake basic equalities analysis on disability,[20] intersectional analysis is yet to be evident, let alone meaningful.[21] For this, it would need not only to include Disabled people and systematic input from DPO, but also to require broader co-production and co-design in decision making and policy (see §§44-47 below).[22]

[II] DEATH, BEREAVEMENT AND ACCOUNTABILITY

[A]. DEATH

10. SEVERE: Disabled people suffered the severest impact of the pandemic in terms of deaths. The mortality rates across the UK were significantly higher among people with a physical impairment or learning disability and people with pre-existing conditions, such as dementia and Alzheimer's disease, heart disease, high blood pressure and diabetes.[23] Disabled people were more likely to die from Covid-19 than non-disabled people.[24] Six out of ten of the Covid dead were Disabled people, despite Disabled people now making up 24% of the population.[25] In Wales, Disabled people made up almost 7 in 10 of all deaths involving Covid-19 between 2 March and 14 July 2020.[26] For some Disabled people, the mortality rates were far higher, for example people with a learning disability, with dementia and with severe mental illness.[27] For people aged 18-34 with learning/intellectual disabilities, the death rate was 30 times higher than their non-disabled peers.[28] Disabled people died more than anyone else in each successive wave of the

[18] Inclusion London DPO Report Jun 21 [M9/INQ000656192/19-20] M9 DPO Closing 22.01.26 [§§27-30]
[19] M2 DPO Closing [INQ000399541/5 §§9, 11, 24]
[20] M9 DPO Closing 22.01.26 [§§46, 54]
[21] Wenham [INQ000657974/40 §§111-112] Watson & Shakespeare [INQ000588216/3 §3]
[22] M9 DPO Closing 22.01.26 [§§50, 53] M2 DPO Closing [INQ000399541/21 §§33] M4 DPO Closing [INQ000474971/13 §32] M6 DPO Closing 19.09.25 [§13]
[23] M1 Report [p.10] M2, 2A, 2B and 2C Report [Vol. II §§10.25-10.26]
[24] M2, 2A, 2B and 2C Report [Vol. II §10.25]
[25] DPO [INQ000655852/5 §13] Mallick [M4/INQ000474256/3 §8]
[26] DPO [INQ000655852/5 §13] WG Report 11.03.21 [INQ000371211/17]
[27] M2, 2A, 2B and 2C Report [Vol. II §10.26] Watson & Shakespeare [INQ000588216/4 §§6, 19-20] DPO [INQ000655852/5 §13] Government Press Release 12.11.20 [INQ000279971] DHSC Report 12.11.20 [INQ000417384]
[28] DPO [INQ000655852/5 §13] Government Press Release 12.11.20 [INQ000279971]

pandemic, and the nationwide higher mortality rate extended to both Disabled men and women, and, among the latter, in particular Disabled women who were "*more-disabled*".[29]

[B]. BEREAVEMENT

11. BEREAVED: There is overwhelming evidence in Module 10 of the isolation, loneliness, guilt, confusion, fear and frustration which has characterised Covid bereavement. Witnesses describe a distinctive, traumatic, tremendous, complicated, complex, difficult, prolonged, haunting and unique form of grief and bereavement.[30] For many of the bereaved, grief has entailed long term emotional consequences, trauma and anxiety, for which there has been inadequate or even non-existent support, and many lack answers and are yet to receive some form of closure.[31]

12. DISABLED BEREAVED: For some Disabled people who were grieving, such as people with learning disabilities, there was "*disenfranchised grief*", including that they were not always told that friends or relatives had died, were not allowed to attend funerals and were excluded from usual grieving processes and practices.[32] Those with a learning disability or who have pre-existing mental or physical health difficulties and already faced barriers to accessing bereavement support prior to the pandemic were among those most at risk of poor bereavement outcomes.[33] Bereaved people who were Disabled or who had additional support needs, such as from hearing or sight loss, were left particularly unsupported.[34]

[C]. ACCOUNTABILITY

13. IMPACT: The lack of accountability for the deaths and potential improper treatment of care recipients in both residential and domiciliary care settings is one of the pandemic's lasting forms of damage. Notwithstanding the numbers of deaths during the pandemic, and the extent to which they occurred in circumstances with Disabled people dependent on others, in 2020 the number of all deaths reported to coroners in England and Wales was the lowest figure since 1995 (when annual data was first collected), due in part to easements to requirements around death registration and reporting by medical practitioners.[35] The reporting level remained low in 2021, followed by a rise in 2022.[36] The Chief Coroner for England and Wales has acknowledged

[29] ONS 09.05.22 [INQ000271341/2 §§2-3] Rourke [INQ000659855/23 §§75-78] Byrne [INQ000661486/4 §§16, 32-34] National Records of Scotland 24.03.21 [INQ000184679/6] Wales [INQ000659760/51 §44 and Table 12]
[30] Among others: Sherwood [INQ000651047/8 §30] Gottlieb [INQ000659978/7 §21] Grundle and Humphries [INQ000657842/54 §230] Waterton [INQ000661494/43 §196] Poole [INQ000660030/6 §§21-23] Llewelyn [INQ000659923/50 §178] Funerals & Bereavement Roundtable [INQ000588201/3]
[31] Sherwood [INQ000651047/10 §§39-40, 53, 57] Poole [INQ000660030/7 §§26-28, 36-44] Grundle and Humphries [INQ000657842/25 §§95-96, 227-229] DPO [INQ000655852/24 §66]
[32] Royston [INQ000657845/35 §§206-207] Funerals & Bereavement Roundtable [INQ000588201/9]
[33] UK CB Bereavement Report 2022 [INQ000349021/208]
[34] Arnott-Barron [INQ000660033/4 §§17, 20]
[35] Teague [M3/INQ000479888/10 §§37-39, 68-69] Durran [INQ000659982/19 §§49-50] DPO [INQ000655852/24 §66] MoJ Coroners statistics 2020 13.05.21 [INQ000652415/4]
[36] Durran [INQ000659982/19 §§49-50]

that "*the majority of deaths by COVID-19 were not reported to coroners*" and that 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, or because of the difficulty of establishing how workers had fallen ill.[37] The bereaved are left with the conclusion that there was a "*fear of opening the floodgates to Covid inquests*"[38] and with the painful reality that many deaths which occurred during Covid remain uninvestigated, that investigation will likely not take place, and that leaves the bereaved without a remedy[39] and unlikely to receive the information or closure they seek through other means such as civil actions.[40] Among the matters left un/under-investigated is whether application of inappropriate DNACPR notices or Clinical Frailty Score assessments or the indirect message they sent to medical practitioners treating Disabled people resulted in preventable deaths.[41]

14. SCOTLAND: In Scotland, by contrast, during the pandemic there was an *increase* in deaths reported.[42] While not without its critics among the Scottish Covid Bereaved,[43] the creation and work of the Covid-19 Deaths Investigation Team ('CDIT') stands in apparent contrast with the localised coronial system in England and Wales.[44] But the requirement for reporting was limited to Covid deaths arising from employment/occupation and among residents in care homes,[45] and the categories of cases considered by the CDIT exclude the deaths of Disabled people who, for example, received domiciliary care.[46]

[III] MENTAL HEALTH AND WELLBEING

15. PRE-PANDEMIC: Prior to the pandemic Disabled people consistently experienced substantially worse mental wellbeing, anxiety, loneliness, depression and more frequent psychological distress compared to those without a chronic illness or impairment.[47] Disabled people are much less likely to participate in community activities, feel part of the community or have trust in the members of their community and as a result are more likely to report loneliness and isolation.[48] People with a learning disability were more likely to be socially isolated pre-pandemic.[49]

16. ADVERSE: The Module 2 Inquiry Report has found that Disabled people who were unable to access their local communities, friends and families experienced significant increases in

[37] Durran [INQ000659982/11 §§27, 35, 37]
[38] Grundle and Humphries [INQ000657842/33 §125(xxv)]
[39] Grundle and Humphries [INQ000657842/53 §225]
[40] Grundle and Humphries [INQ000657842/26 §97]
[41] DPO [INQ000655852/24 §66] Grundle and Humphries [INQ000657842/36 §§141-142]
[42] McGowan [INQ000660055/29 §94]
[43] Waterton [INQ000661494/37 §§170-171]
[44] McGowan [INQ000660055/23 §72, 87, 89] *Cf.* Durran [INQ000659982/24 §63]
[45] McGowan [INQ000660055/20 §63]
[46] McGowan [INQ000660055/22 §§67, 75-77, 85]
[47] Systematic Evidence Review [INQ000659787/51] Wenham [INQ000657974/25 §65]
[48] Watson & Shakespeare [INQ000280067/7 §20]
[49] Uni Glasgow Left out Report Dec 20 [INQ000184683/58] Mencap Feb 21 [INQ000176401/6 §38]

depression and anxiety.[50] This disproportionate impact was felt across the UK, and it persisted: from the outset and throughout the course of the pandemic, Disabled people on average had poorer mental health and wellbeing ratings.[51] Shielding prevented exercise and resulted in long-term isolation from friends and family, with attendant mental health impacts.[52] Other factors reported by Disabled people included financial stressors and poverty, being unable to access vital guidance and advice about the pandemic, the loss or reduction of vital social care support, the loss of health care (including mental health care), having to shield and the reduction in social contact, anxiety around being denied access to life-saving treatment, taking on new or increased caring responsibilities, having to work in high-risk occupations and homeschooling children.[53]

17. ISOLATION: The pandemic amplified the loneliness experienced by Disabled people and those with chronic conditions.[54] This affected Disabled women in particular.[55] Loneliness increased to higher levels, where it has remained with no signs of recovery.[56] Adults with autism were reported to have a larger increase in depression and anxiety and to report feeling more socially isolated and lonely.[57] Disruption in access to care was a major factor that played a role in increasing levels of distress.[58]

18. INTERSECTIONS: Adults with serious mental illness ('SMI') and other impairments or long-term conditions were more likely to experience poor mental health and to have seen their mental health decline, including because they could not access appropriate services.[59] Disabled people were more likely to have tried but been unable to access mental health support and were significantly more likely to face most difficulties in trying to access that support.[60] Fewer patients from ethnic minority groups were referred to mental health services during the first lockdown, and people from minoritised ethnic backgrounds experienced stigma and discrimination due to their mental illness which led to them being treated unfairly by healthcare and other providers which further adversely impacted their mental health.[61] The mental health of Disabled women was particularly impacted, including from the impact of loss of work and the psychological distress caused by social isolation.[62] LGBTQ+ Disabled people experienced an

[50] M2, 2A, 2B and 2C Report [Vol. II §10.77]
[51] DPO [INQ000655852/6 §15] ONS [INQ000417407] Watson & Shakespeare [INQ000588216/6 §8]
[52] Inclusion Scotland 01.07.20 [INQ000142276/5]
[53] DPO [INQ000655852/6 §15]
[54] Watson & Shakespeare [INQ000588216/10 §§22, 24]
[55] Wenham [INQ000657974/27 §71]
[56] Pontefract [INQ000587558/18 §§76, 97]
[57] Das-Munshi [INQ000588210/28 §78] NAS Left stranded Report [INQ000224594/2[
[58] Das-Munshi [INQ000588210/38 §109]
[59] Hughes [INQ000652569/49 §149] Hanif [INQ000659785/16 §37]
[60] MIND Emergency Report Jun 20 [INQ000471282/32]
[61] Das-Munshi [INQ000588210/25 §§65, 93.1]
[62] WBG Report Jun 21 [INQ000228038/8] Women's Resource Centre Crisis Report Jun 20 [INQ000650358/7] Fawcett Society Gendered Report [INQ000650333/10]

increase in levels of poor mental health, difficulties in accessing healthcare and medication and mental health inequalities.[63] Those who experienced consistent poor mental health throughout the pandemic or a sustained decline in mental health over time were more likely to have pre-existing mental or physical ill-health, to live in deprived neighbourhoods, and be of Asian, Black or mixed ethnicity.[64]

19. BARRIERS: Inaccessible information and communications were an issue for Disabled people throughout the pandemic, heightening stress, anxiety and fears about what would happen to them.[65] For those who use BSL, the inability to access key public health guidance and advice was a "*wholly avoidable cause of worry and anxiety amongst Disabled people during the pandemic*".[66] The absence of accessible information left some of the most marginalised Disabled and older people without knowledge of what was happening at a time when other support arrangements were likely to have broken down.[67] Information not provided in BSL, Easy Read or different languages affected BAME people and family members in circumstances where many of the places that Disabled BAME people might normally go for accessible information, such as community centres and places of worship, were closed for much of the pandemic.[68] Several reports noted that d/Deaf people in rural areas and young d/Deaf adults were unable to communicate with anyone during periods of lockdown.[69] The absence of BSL interpretation meant d/Deaf people were left out of conversations about their own lives, including discussions about DNACPR.[70] For Disabled people seeking access to financial support and benefits, failures to provide BSL interpreters at appointments led to delays of months before assessment and entitlement was paid.[71] d/Deaf and Disabled people struggled to access food, medicine and necessities and to use the telephone hotlines set up in order to access GPs and other public services remotely.[72]

[IV] SPORT, LEISURE AND CULTURE

[A]. SPORT AND LEISURE

20. INEQUALITIES: Pre-pandemic, Disabled people were less likely to participate in sport and physical activity and were at greater risk of poorer access to sport and leisure activities.[73] The

[63] DPO [INQ000655852/16 §§42, 146] Bécares [INQ000657973/7 §21]
[64] IPH Wider Impact Report 25.05.21 [INQ000276469/71]
[65] Elder-Woodward [INQ000371664/9 §44] Inclusion London Abandoned Report June 2020 [INQ000182684/19] Watson & Shakespeare [INQ000588216/10 §22]
[66] DPO [INQ000655852/8 §20]
[67] DPO [INQ000655852/40 §114]
[68] VODG Spotlight Report Jul 23 [INQ000279963/18]
[69] WG Locked Out Report 19.04.22 [INQ000650492/88]
[70] DPO [INQ000655852/21 §59] Deaf Action 04.06.21 [INQ000650548]
[71] Advice Services Alliance Londoners Report Jul 20 [INQ000650348/30]
[72] WG Locked Out Report 19.04.22 [INQ000650492/88]
[73] Watson & Shakespeare [INQ000280067/7 §20] Pontefract [INQ000587558/14 §56(d)] Sport Scotland Impact (October 2020) [INQ000661817/2-3] HMG Equality analysis 22.06.20 [INQ000236214/17]

pandemic amplified pre-existing inequalities in sport and physical activity.[74] The impact on physical activity levels was not uniform across demographic groups, with Disabled people and people with pre-existing mental health conditions among those who were less active during the pandemic.[75] These groups faced greater barriers to accessing alternative forms of physical activity, such as not having access to outside spaces or having to shield.[76]

21. DISRUPTION AND CLOSURES: Closures and restrictions, the loss of structured activity and the opportunity for social connection had a detrimental effect on mental wellbeing, particularly for those with mental health conditions.[77] Many adapted, bespoke and inclusive programmes were suspended or unavailable, with impacts on physical and mental well-being and on social connectivity.[78] Disabled people or those with a long-term health condition saw a more prolonged impact on activity levels with much slower recovery to pre-pandemic levels (such levels being lower to start with).[79] The loss of structured exercise opportunities for people with long-term conditions increased risks of physical decline.[80] The closure of sports and leisure facilities severely restricted the ability of many Disabled people to take part in community-level sport and leisure activities.[81] Disabled people experienced interruption to specialised services and accessible facilities, including gyms and swimming pools, reducing opportunities for exercise and community engagement.[82] The closure of facilities such as those providing physiotherapy resulted in hitherto independent Disabled people becoming physically immobilised.[83] Long-term interruptions for indoor sports for Disabled people were particularly problematic, as they could not move outdoors or online. This was compounded by Disabled people being more likely to be clinically vulnerable and to shield, limiting opportunities further.[84] In Northern Ireland, Disabled people were more likely to see their activity levels decline than non-disabled peers.[85] In Scotland, data indicated that groups already less likely to participate in sport, such as Disabled people, were at greater risk of experiencing worsening inequalities.[86]

22. ISOLATED: Isolation during the pandemic reduced mobility for some Disabled people, leading to physical decline.[87] The impacts were greater on those who were digitally excluded and those

[74] Archibald [INQ000661781/17 §3.38]
[75] Sport & Leisure Roundtable [INQ000659775/4]
[76] Sport & Leisure Roundtable [INQ000659775/4, 12]
[77] Sport & Leisure Roundtable [INQ000659775/5]
[78] Dickie [INQ000588234/15 §3.35] Llewelyn [INQ000659923/7 §16]
[79] Pontefract [INQ000587558/18 §§75, 96]
[80] Llewelyn [INQ000659923/13 §42]
[81] Sport & Leisure Roundtable [INQ000659775/4] HMG Equality analysis 30.05.20 [INQ000236212/19]
[82] Llewelyn [INQ000659923/14 §44] Sport Scotland Oct 20 [INQ000661817/3]
[83] OPCW Older People Report May 21 [INQ000184993/12]
[84] Archibald [INQ000661781/15 3.37.1]
[85] Archibald [INQ000661781/15 §§3.37.1-3.37.2]
[86] Dunlop [INQ000659903/8 §§3.11, 5.3]
[87] Matejic [INQ000659871/17 §58]

for whom the sudden change presented extra challenges.[88] Where activity-based support offered to those with mental health conditions was stopped overnight, as face-to-face services were closed and organisations were not set up to deliver services online, this affected those who were already cautious to engage and did not feel comfortable online.[89] This rapid pivoting to online delivery models[90] accordingly posed complex challenges for Disabled people.

23. LASTING: For some Disabled people, movement significantly reduced,[91] and they experienced a decline in strength, decrease in physical capacity and fitness to undertake activities.[92] Activity levels have not recovered.[93] A 2022 survey by the Activity Alliance found that four million Disabled people described themselves as 'inactive' over the past year, taking part in less than 30 minutes of physical activity a week. This reflects a 2.6% increase from before the pandemic.[94]

[B]. CULTURE

24. SUSPENSION: Pre-pandemic, Disabled people were at greater risk of poorer access to cultural activities.[95] Disabled people were among those identified as most vulnerable to the negative health impacts of the loss of cultural engagement.[96] With the suspension of bespoke cultural and leisure activities for Disabled people came an impact on physical and mental well-being, and on social connectivity.[97] The closure of cultural venues and libraries had a significant impact on those who would otherwise be participating in bespoke classes and workshops, such as those designed for clients with special needs and dementia.[98] The loss of in-person cultural activities affected those with existing mental health conditions, who often rely on cultural spaces for social connection and therapeutic engagement.[99] Organisations serving Disabled people faced compounded challenges such as higher health risks, greater economic vulnerability and reduced access to support and continuity of services (as Covid disproportionately affected Disabled people).[100] Organisations supporting underrepresented communities including d/Deaf, Disabled and neurodiverse people and groups faced additional funding challenges, exacerbating existing inequalities within the sector.[101]

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[88] Llewelyn [INQ000659923/14 §44] Sport & Leisure Roundtable [INQ000659775/4]
[89] Sport & Leisure Roundtable [INQ000659775/13-14]
[90] Sport & Leisure Roundtable [INQ000659775/3]
[91] Level Playing Field Fan Survey Summary [INQ000652418/7]
[92] Activity Alliance Mar 21 [INQ000652416/13]
[93] Sport England Active Lives Report 01.10.21 [INQ000653234/19] DCMS Grassroots Report 08.07.22 [INQ000647734/34 §2.17]
[94] DPO [INQ000655852/43 §120] Guardian Article 08.06.22 [INQ000652419/2]
[95] Watson & Shakespeare [INQ000280067/7 §20]
[96] Henley [INQ000659888/36 §130]
[97] Llewelyn [INQ000659923/7 §16]
[98] Llewelyn [INQ000659923/7 §19]
[99] Henley [INQ000659888/9 §34]
[100] Henley [INQ000659888/15 §53]
[101] Henley [INQ000659888/15 §54]

25. ACCESSIBILITY: Organisations serving Disabled, neurodiverse, ethnically diverse and low-income communities struggled with the shift to online platforms due to lack of access to technology and inclusive formats (see further §§37-42 below).[102] Equality and accessibility demands increased at the same time as resources contracted. Organisations serving D/deaf, disabled and neurodivergent artists and audiences faced higher adaptation costs, including provision of BSL/ISL, captioning and specialist equipment, while earned and grant income were constrained, placing additional strain on staff and freelance specialists.[103] Dedicated channels, such as collaboration with University of Atypical, were important but resource-constrained relative to need.[104] Specific accessibility features including BSL interpretation were often absent. Digital barriers included websites that are hard to read and options are usually only offered selectively (for example, with features such as audio description or relaxed performances only available individually, and only for occasional specific events).[105]

26. RE-OPENING AND RE-ENGAGING: For Disabled people, the impact was not only from closure of community venues but also their re-opening. These concerns included that social distancing rules would impact on venue capacity and result in compromised accessibility for Disabled people. Further, there were concerns about the safety of reopened venues for Disabled people, because of uncertainty about the number of people who would comply with social distancing and mask guidelines, or who would be vaccinated.[106] Clinically vulnerable groups at higher risk from Covid-19 were noted as feeling less confident returning to live performances and events.[107] Groups with lower engagement pre-Covid, including Disabled people, were more likely to experience financial hardship and less likely to re-engage post-pandemic.[108] Disabled people more likely to report reduced time and money, limiting their ability to engage with culture.[109]

[C]. SUPPORT TO ACCESS THE COMMUNITY

27. PARTICIPATION: Closures to community support services further reduced the opportunities for Disabled people to be active and participate in their communities,[110] including their participation in cultural, recreation, sport and leisure activities. Community support plays an indispensable role in the lives of Disabled people, profoundly affecting their overall well-being, social inclusion and quality of life.[111] This support encompasses a broad range of services and interactions,

[102] Henley [INQ000659888/16 §54]
[103] McDonough [INQ000661278/9 §38]
[104] McDonough [INQ000661278/6 §28]
[105] Misek et al. Digital Access Report Jun 22 [INQ000653940/60]
[106] DPO [INQ000655852/42 §119]
[107] Cultural Institutions Roundtable [INQ000659832/5]
[108] Henley [INQ000659888/46 §170]
[109] Henley [INQ000659888/46 §171]
[110] DANI Impact Report 01.09.20 [M2C/INQ000396804/23-24]
[111] DPO [INQ000655852/42 §120]

including accessible infrastructure, social networks, healthcare services, educational and employment opportunities, and inclusive cultural activities. As such, the day-to-day reality of living with an impairment can often hinge on the availability of community support. These initiatives can also help to combat loneliness and foster a sense of belonging and community.[112] Local authorities' pause in support for facilitated social contact left people with dementia, learning disabilities and mental ill health isolated or alone for longer periods.[113] The fact that many grassroots DPO, and especially intersectional specific DPO remained under-funded, made it difficult to fill the vacuum, however hard they tried.[114]

[V] HOUSING, JUSTICE AND SECURITY

[A]. HOUSING AND HOMELESSNESS

28. HOUSING: Prior to the pandemic, Disabled people already faced significant challenges in securing suitable, accessible and affordable housing.[115] Disabled people were more likely to live in poor quality or otherwise impairment-inadequate housing and experience lower levels of security.[116] During the pandemic periods of shielding and lockdown, Disabled people were forced to spend extended periods of time in unsuitable conditions, leading many to report feeling trapped in parts of their own homes.[117] Almost a quarter of all respondents stated they did not have a home which met their access needs. Disabled people were over three times more likely than non-disabled people to report that the inaccessibility of their home undermined their wellbeing during lockdown. The DPO received reports of Disabled people becoming entirely housebound because of inaccessibility, exacerbating pre-existing physical and mental ill health. The pandemic also caused considerable delays in the transfers of Disabled people to suitable housing, and the installation of required housing aids. As a consequence, some Disabled people spent lockdown in unsafe and unsanitary housing.[118]

29. HOMELESSNESS: Disabled people are also at a heightened risk of homelessness,[119] which is linked, amongst other things, to higher rates of poverty amongst Disabled people, and the precariousness and unsuitability of their housing options. Shelter report the case of a Disabled wheelchair user who spent around five weeks without accommodation including the first three weeks of lockdown.[120] As with other parts of the pandemic experience, digital exclusion created significant barriers as services provided by homelessness charities and housing advocacy

[112] DPO [INQ000655852/42 §120]
[113] ADASS Winter Surveys Mar 2022 [INQ000514938/5]
[114] M9 DPO Closing 22.01.26 [§§27-30] Inclusion London [INQ000656192/19-20]
[115] Watson & Shakespeare [INQ000280067/7 §20] Elder-Woodward [M2A/INQ000371664/4 §15] WG Locked Out Report 19.04.22 [INQ000650492/16-17, 58] Toman [M2C/INQ000400520/6 §21]
[116] Watson & Shakespeare [INQ000280067/7 §20]
[117] DPO [INQ000655852/46 §130]
[118] DPO [INQ000655852/46 §130-133]
[119] DPO [INQ000655852/48 §134] ONS Dec 23 [INQ000652422]
[120] Shelter Everyone In Report 01.08.21 [INQ000621075/38]

organisations mostly transitioned online, leaving people without phones or internet access unable to get the support they needed, including mental health and advice services.[121]

[B]. DOMESTIC ABUSE

30. ABUSE AND CONTROL: Home is not always a safe space for Disabled people. A higher proportion of Disabled adults experienced domestic abuse.[122] Disabled people are at greater risk of sexual or domestic violence,[123] and Disabled women are three times more likely to be victims of domestic abuse compared with their non-disabled peers.[124] The pandemic, including lockdown and NPIs, provided further ways for perpetrators to abuse and to exert coercive control, such as by restricting access to Personal Protective Equipment ('PPE'), testing, and vaccines, control of communication, medication and access to food and to disability support and equipment, and control of finances and exploiting financial insecurity. Digital exclusion and the need to manage the real health risks of leaving their homes often combined to mean victim-survivors had fewer avenues to seek assistance and were, in effect, trapped and isolated (see §§37-42 below).[125] The impact of domestic abuse on Disabled victim-survivors was compounded by the fact that their perpetrators were often their carers and, during lockdown, would often be *their only carers*, upon which care some victim-survivors were totally dependent.[126] Intimate partner violence was known to increase in frequency during the pandemic.[127]

31. INEQUALITIES: For women, risks were increased at multiple interlocking levels with other protected characteristics.[128] Women with learning disabilities lost access to advocates, faced communication barriers not only due to restricted BSL access but also because of social distancing and the need to communicate by phone.[129] d/Deaf victims of domestic abuse faced barriers to accessing safe accommodation as many refuges could not make their service accessible to d/Deaf victims whilst abiding by restrictions and pandemic measures. For example, having to wear masks in a refuge made lip-reading impossible, which left d/Deaf people who often rely on lip-reading feeling isolated and frustrated.[130] Without BSL interpreters for government messaging, d/Deaf victims and survivors did not receive basic information about the rules and restrictions, allowing perpetrators further to control victims and intensify their

[121] Housing & Homelessness Roundtable [INQ000659913/21]
[122] Watson & Shakespeare [INQ000280067/8 §28]
[123] Watson & Shakespeare [INQ000280067/7 §20]
[124] DPO [INQ000655852/50 §139]
[125] DA Group [INQ000652188/26 §§76, 93] Bécares [INQ000657973/14 §58] Bécares & Nazroo [INQ000588214/42 §184] Wenham [INQ000657974/35 §§93, 100, 102]
[126] DA Group [INQ000652188/25 §71]
[127] Das-Munshi [INQ000588210/38 §106]
[128] Solace Lockdown & Domestic Abuse Report Mar 21 [INQ000280053/10]
[129] Sisters of Frida Impact Report [INQ000652384/26]
[130] Domestic Abuse & Safeguarding Roundtable [INQ000587973/23 §62]

abuse towards d/Deaf people.[131] It was left to organisations to fill in the gaps in government messaging by translating all government guidance, including that about people 'at harm', into BSL so that d/Deaf victims and survivors could understand the situation and their rights.[132]

[C]. PLACES OF DETENTION

32. DIGNITY: For Disabled people in prison, there were failures to meet basic needs for dignity, health and wellbeing. This resulted in some prisoners with mobility difficulties struggling to shower in the time allocated, and at least one prisoner at HMP Northumberland had been unable to shower for more than seven months, as it was no longer possible for him to shower in a neighbouring house block.[133] For Disabled prisoners with mental health conditions, there was over-reliance on medication rather than therapeutic support in the context of delays in access to mental health services, especially for psychologically based therapies.[134] For d/Deaf people in prison, marked isolation coupled with communication deprivation is the general experience. Only a minority of prison staff are trained in BSL and BSL interpreters are not routinely provided. This impedes health and mental health assessments and what can be offered in the way of intervention.[135]

33. INVOLUNTARY: For Disabled people, involuntary detention and institutionalisation *increased* during the pandemic. A higher proportion of people from Black ethnic backgrounds (Black African and Black Caribbean) were detained through involuntary admission, against a background of already elevated levels of such detention[136] and with evidence that patients had experienced difficulty accessing services prior to their sectioning.[137] The withdrawal of mental health and social care services during the pandemic left many autistic people without the support they needed to adapt, against a background that the number of autistic people identified in mental health hospitals in England has increased.[138] Patients contracted Covid-19 during their inpatient admission resulting in subsequent higher mortality[139] in psychiatric units, which experienced delays and limited access to Covid testing kits, PPE and other relevant equipment.[140] In Northern Ireland, barriers in accessing mental health care during the pandemic and changes made to legislation contributed to increased institutionalisation of Disabled people. Similar changes were enacted in the other nations, although they were not brought into

[131] Domestic Abuse & Safeguarding Roundtable [INQ000587973/5 §11, 39-40]
[132] Domestic Abuse & Safeguarding Roundtable [INQ000587973/13 §34]
[133] Taylor [INQ000659848/37 §178]
[134] Taylor [INQ000659848/49 §239]
[135] Centre for Mental Health Report 25.06.21 [INQ000649021/27-28]
[136] Das-Munshi [INQ000588210/30 §§85, 88, 112] Osborn [INQ000588211/4 §§3, 16]
[137] Das-Munshi [INQ000588210/39 §110]
[138] National Autistic Society Left Stranded Report 07.09.20 [INQ000060218/5]
[139] Das-Munshi [INQ000588210/36 §100]
[140] Das-Munshi [INQ000588210/36 §99] Osborn [INQ000588211/4 §§4, 44, 106]

force in Scotland and England – but nonetheless concerns persisted about an increase in mental health detentions and that Disabled people were detained for longer periods.[141]

[D]. IMMIGRATION AND ASYLUM

34. DISABILITY: Many individuals within the asylum seeking and refugee community live with and are more susceptible to mental health conditions, including PTSD, major depression and anxiety.[142] Disabled migrants who experience intersecting inequalities have greater need for publicly funded support services.[143]

[VI] KEY WORKERS

35. EXPOSURE: One of the primary ways to avoid disease exposure at work was to work at home. But despite higher clinical vulnerability and the advent in many occupations of home working, Disabled people in employment in the UK were *more likely* to be going out to work during the pandemic rather than working from home. Disabled people worked in frontline and insecure jobs with often lower salaries and also worked in occupations that were *more exposed* to Covid-19 than the occupations of non-disabled workers, including the wholesale and retail sectors.[144] Disabled people are also an overly represented category of those who suffer in-work poverty, in the context of an entrenched disability employment gap[145] and disability pay gap.[146] Trade unions representing key workers reported Disabled workers having difficulties in receiving full pay and in receiving the reasonable adjustments required by law.[147] These impacts were compounded for Disabled women.[148]

36. CATEGORIES: Categories of key workers did not reflect the needs and risks which Disabled people faced during the pandemic. Notwithstanding the higher and increased risks of domestic abuse faced by Disabled people, domestic abuse and safeguarding staff were not given 'key worker' status.[149] Nor were BSL interpreters, despite their being essential to d/Deaf people including victim-survivors who were disclosing abuse[150] and were told they had to come back another day to report a crime or to arrange their own interpreter.[151] Personal Assistants have a

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[141] DPO [INQ000655852/14 §38] Coronavirus Act 2020 section 10
[142] Humi [INQ000659851/36 §§146-149]
[143] Humi [INQ000659851/70 §242]
[144] Brewer [M9/INQ000588132/13 §§24.4, 42] Mallick [M9/INQ000652758/3 §10] Foyer [M9/INQ000653646/37 §190]
[145] Mallick [M9/INQ000652758/3 §§10, 14] Black [M9/INQ000650934/3 §10] McKillop [M9/INQ000615083/2 §7] Brewer [M9/INQ000588132/10 §21-21.1] TUC Gaps 12.11.20 [M9/INQ000365999/1]
[146] Mallick [M9/INQ000652758/3 §§10, 14] Brewer [M9/INQ000588132/10 §§21, 21.2] [M9/T2/6/15-21] TUC Gaps 12.11.20 [INQ000365999/3] McKillop [M9/INQ000615083/2 §7] JRF Report 01.02.20 [M9/INQ000546942/9]
[147] TUC [INQ000659898/16 §§50-51] Foyer [M9/INQ000653646/37 §193]
[148] TUC [INQ000659898/18 §§55]
[149] Domestic Abuse & Safeguarding Roundtable [INQ000587973/21 §57] DA Group [INQ000652188/102 §§364-366]
[150] Domestic Abuse & Safeguarding Roundtable [INQ000587973/21 §57]
[151] DA Group [INQ000652188/59 §196] EVAW Access Report Aug 20 [INQ000280160/10] Women's Aid Shadow Pandemic Report 09.10.21 [INQ000475125/33, 55]

key role in how some Disabled people manage independent living, but they too, when employed by Disabled people, were not treated as key workers.[152]

[VII] INNOVATION AND ADAPTATION

[A]. DIGITAL

37. EXCLUSION: The Inquiry has already found that Disabled people were disproportionately digitally excluded, that social isolation was exacerbated by digital exclusion, and that Disabled people were more likely to require assistance with accessing information and support which had moved online.[153] The intersection between disability and poverty also deepened digital exclusion and left people without alternatives.[154] Those from lower income families are less likely to have access to digital devices and internet services.[155] Digital exclusion affected communities and those who do not speak English,[156] and more vulnerable, older people including those facing difficulties in using relevant technology because of poor health and poor cognitive function.[157]

38. BARRIERS: Disruptions to routine healthcare and the rapid switch to remote healthcare, while beneficial for some, therefore potentially resulted in delayed care and poorer health outcomes for Disabled people and the clinically vulnerable – including for service users who identified as being of a minoritised ethnic background.[158] Of those who were digitally excluded, people seeking mental health treatment minorities stood out in terms of difficulties in accessing appointments, medication, treatment and the respite of social contact when in crisis.[159] For those who were shielding or following stay-at-home orders, being stuck at home without digital access was also particularly difficult.[160] Overall, there was a considerable risk that Disabled people could be left behind in the migration to telehealth and in many ways, it came to pass.[161]

39. DESIGN: Certain groups of Disabled people faced communication barriers due to the technology used, for example, d/Deaf, visually impaired people, neurodivergent people and some people with learning disabilities. Health services were often slow to make reasonable adjustments to address these barriers despite the direct legal requirements of the NHS Accessible Information Standard.[162]

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[152] M4 DPO Closing [INQ000474971/6 §§17, 22] Mallick [M4/INQ000474256/10 §34]
[153] M2, 2A, 2B and 2C Report [Vol. II §§10.80, 12.99]
[154] Matejic [INQ000659871/13 §34]
[155] DPO [INQ000655852/10 §25]
[156] VODG Spotlight Report Jul 23 [INQ000279963/18, 24-26, 28]
[157] Nazroo [INQ000588213/28 §123]
[158] Das-Munshi [INQ000588210/36 §§100-101 & 111] VODG Spotlight Report Jul 23 [INQ000279963/23 §2.4.1]
[159] Hughes [INQ000652569/6 §20.6] Cumming [INQ000657975/7 §29] Hanif [INQ000659785/10 §27] Institute of Health Visiting [INQ000347049/12, 14] Matejic [INQ000659871/9 §25(i)] JRF [INQ000661595/4]
[160] Matejic [INQ000659871/17 §61]
[161] Watson & Shakespeare [INQ000280067/8 §26]
[162] DPO [INQ000655852/20 §56]

40. SITUATIONS: There was a range of situations in which remote and digital access could compound problems. For victim-survivors of domestic abuse, of which Disabled people make up a significant number (see §30 above), the transition to remote delivery created significant barriers for the digitally excluded, even more for those living with an abusive partner and who were unable to move house while shielding without risks to their health.[163] For the bereaved, grieving Disabled people often experienced limited accessible support from friends and community due to distancing amplified loneliness and trauma, especially among the digitally excluded.[164] Other situations in which exclusion could be aggravated by digitalisation included Disabled residents in supported accommodation without online access or a telephone, whom it then became particularly hard to contact.[165] For prisoners and detainees, including Disabled people in involuntary detention under the Mental Health Act (see §33 above) there was unequal access – or no access – to technology.[166]

[B]. ACCESSIBILITY

41. CHOICE: The time and money saved by remote access can be alluring but it can also be disabling. It remains essential that people have choice in the modes in which support is delivered to them, including that they retain access to face-to-face treatment and care.[167] Face-to-face appointments can be as necessary a reasonable adjustment as accessible information.[168] Too often it was wrongly assumed that if people were not using digital healthcare, it was because they did not have the motivation, despite technical or cognitive barriers to accessibility not having been addressed.[169]

42. SUITABILITY: Remote contact, however, may not be suitable for some types of treatment, or conditions.[170] For some Disabled people, technology simply cannot replace direct human contact.[171] Those with sensory impairments may not want to engage digitally and therefore other accessibility options are needed, while for others digital communication may be essential for overcoming communications barriers.[172] Multiple formats and multiple media as well as alternative access routes are needed.[173] Mental health services generally may be difficult to replicate virtually.[174] Communication is more than speech; it includes body language and eye

[163] DA Group [INQ000652188/47 §§160, 224] Domestic Abuse & Safeguarding Roundtable [INQ000587973/5 §§9, 37] Bécares & Nazroo [INQ000588214/35 §145]
[164] Llewelyn [INQ000659923/53 §190]
[165] Housing & Homelessness Roundtable [INQ000659913/5]
[166] Justice System Roundtable [INQ000656301/18, 25]
[167] Cumming [INQ000657975/9 §39]
[168] VODG Spotlight Report Jul 23 [INQ000279963/26 §2.4.4]
[169] DPO [INQ000655852/53 §148]
[170] Osborn [INQ000588211/18 §45]
[171] WG Locked Out Report 19.04.22 [INQ000650492/87]
[172] Leeds Report [INQ000660061/40]
[173] Das-Munshi [INQ000588210/44 §130] Bécares & Nazroo [INQ000588214/60 §256]
[174] Humi [INQ000659851/38 §152]

contact, and digital healthcare could miss that or fail to provide the necessary privacy for such conversations. Loss of mental health care and treatment during the pandemic — and particularly the loss of face-to-face meetings — resulted in respondents reporting a deterioration in their mental health and diminished therapeutic relationships that were not suitable for assessing complex mental health issues and risk.[175] For those suffering from episodes of severe mental illness, it is again near enough impossible to treat them remotely and dangerous to proceed otherwise.[176] Other services relevant to Disabled people that did not translate well remotely included housing support,[177] domestic abuse and safeguarding services.[178]

43. ADAPTATIONS: While in many ways positive, innovations involving making use of outside spaces[179] needed to remember accessibility needs. For Disabled people, for example, use of pavements for outdoor dining (re)created barriers, representing a new 'adjustment' for the non-disabled which failed to take into account the needs of some Disabled people with mobility needs. For those with sensory or mobility impairments, particularly wheelchair users or people who are blind, pavements became hugely difficult to navigate safely and independently. For Disabled people who relied on cars, parking bays allocated to blue badge use began to be re-purposed, limiting access to town centres.[180] In accessing vaccine centres, it was common for the issue not to be thought through in terms of both physical and sensory access.[181] Failure to meet basic accessible communications needs meant that DPO had to reiterate calls for adaptations which are already required by law.[182]

[C]. CO-PRODUCTION

44. DEFICIT: The Inquiry's Module 2 report has already made significant findings. There was a failure of foresight with "*clear consideration*" not given to the adverse impact of Covid-19 and the impact of restrictions on Disabled people prior to the decision to implement lockdown. Further, once it became clear that specific groups of Disabled people were at even greater risk, "*this ought to have been acted upon and mitigated swiftly*" by government. As to both *why this was not done* and *how it could be achieved,* the Inquiry has recognised that "*[it] was important that those charged with making decisions that would profoundly affect disabled people had ready access to expert advice (including advice informed by disabled people themselves)*".[183]

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[175] DPO [INQ000655852/13 §37] Osborn [INQ000588211/4 §5]
[176] Osborn [INQ000588211/4 §§5, 45, 56, 57, 96.1]
[177] DA Group [INQ000652188/104 §371] Housing & Homelessness Roundtable [INQ000659913/24]
[178] Domestic Abuse & Safeguarding Roundtable [INQ000587973/25]
[179] See for example Business Leaders Roundtable [INQ000659796/13]
[180] DPO [INQ000655852/42 §118]
[181] M4 DPO Opening 13.12.24 [§5.2] M4 DPO Closing [INQ000474971/14 §34]
[182] M4 DPO Closing [INQ000474971/14 §35]
[183] M2, 2A, 2B and 2C Report [Vol. II §10.38]

More broadly, a key lesson that the Inquiry has drawn is that "*understanding and accounting for these inequalities in pandemic planning can help to inform the design of more targeted interventions and allow for more tailored information to be provided to communities at greater risk*".[184]

45. FUNCTION: Professors Watson and Shakespeare report a general trend in the UK and around the world that "*the responses to Covid-19 do not seem to have been designed with the need for disability inclusion, or the needs of disabled people in mind*".[185] This was despite early United Nations Guidance on the need to "*meaningfully engage*" Disabled people "*at all stages*" in the design process[186] and the Disability Unit's cross-government advice of October 2020 that "*Disabled people and their families are not typically involved in HMG policy making on covid…and the result has been that some interventions have not adequately taken into account their needs*".[187] To mitigate the adverse impacts of a future pandemic, an essential starting point is effective engagement with Disabled people and DPO, to understand those impacts, followed by collaborative work with Disabled people and DPO in co-producing and co-designing innovative and accessible solutions to mitigate the impacts.[188] As the DPO submitted at the conclusion of Module 2, the practical benefit of co-production and co-design is to bring diverse lived experience and, where necessary, rebel voices into the room. The general advice across the various experts is that intersectionality and equity must be embedded in all waves of planning, response and recovery.[189]

46. DATA: For this to happen the data vacuums and silences must be filled; but as with all other Modules, the expert evidence is damning about the gaps in data collection, the failure to collect and analyse *disaggregated data* in respect of almost all characteristics and the failure to consider intersectional impact.[190] Professor Das-Munshi explains that data on protected characteristics of those suffering SMI, *if included at all*, is usually included *for the purposes of adjustment* rather than provided as disaggregated, and that those who may have experienced the worst impacts, were the least represented in studies.[191] Among its many consequences, the lack of data prevents community and representative organisations from demonstrating need

[184] M2, 2A, 2B and 2C Report [Vol. II §15.11]
[185] Watson & Shakespeare [INQ000588216/7 §12]
[186] UN (May 2020) [M9/INQ000184685/13, 16-17 §§1-2] WHO 26.03.20 [M9/INQ000279961/6]
[187] DU 19.10.20 [M9/INQ000083956/2 §9]
[188] DPO [INQ000655852/56 §§152, 154] Watson & Shakespeare [INQ000588216/23 §§77, 85-86] Osborn [INQ000588211/36 §§95, 115] Das-Munshi [INQ000588210/7 §13] Bécares & Nazroo [INQ000588214/58 §246].
[189] Osborn [INQ000588211/39 §112]
[190] Das-Munshi [INQ000588210/6 §§8, 11, 13, 15, 72, 87, 90, 91, 119-120] Bécares [INQ000657973/5 §§11, 25, 27-28, 29, 66, 111-112, 114-115] Marmot & Bambra [INQ000588215/13 §73.6] Bécares & Nazroo [INQ0005882124/8 §30] Wenham [INQ000657974/24 §64.4] For general overview of data in the care sector, see M6 DPO Closing 25.09.25 [§§4-13]
[191] Das-Munshi [INQ000588210/23 §§58, 119]

to access funding.[192] As well as disaggregated data, there is a role for qualitative data and "*convenience samples*", in particular to capture unique experiences and marginalisations,[193] and "*boosting*" or "*over-sampling*" groups that are under-represented, for nationally representative population cohorts or surveys.[194]

47. REPRESENTATION: For effective co-production, the role of representative organisations such as DPO requires sufficient status and funding.[195] The pandemic showed the role of the Third Sector in bridging gaps in care and reducing social isolation, providing crucial practical support ranging from facilitating access to services to practical and emotional support, equipment for those who are digitally excluded and advocacy and being essential partners in the acquisition of data.[196] The need to enhance and fund representation extends to a role for intersectional support organisations; as without them, swathes of experience and need are lost.[197] Given that trust and connection to hitherto marginalised communities is one of the reasons for the poverty of data, partnership with community groups is essential so that data can be trusted not only by government but by those who are governed.[198] Overall, representative groups such as DPO need to be facilitated to become design consultants and co-leaders, and not just expected to be volunteers.[199]

DANNY FRIEDMAN KC	**KATE BEATTIE**	**SHAMIK DUTTA**
		CALEB SIMPSON
MATRIX CHAMBERS	**DOUGHTY STREET CHAMBERS**	**BHATT MURPHY SOLICITORS**

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[192] Bécares [INQ000657973/15 §64]
[193] Das-Munshi [INQ000588210/32 §§93, 93.1-93.3, 96] Bécares [INQ000657973/4 §§7-9]
[194] Das-Munshi [INQ000588210/42 §120]
[195] M9 DPO Closing 22.01.26 [§53] Mallick [M9/INQ000652758/10 §§29, 33] DR UK [INQ000511434/5]
[196] Watson & Shakespeare [INQ000588216/23 §81] Das-Munshi [INQ000588210/7 §§13, 107, 112, 117] Nazroo [INQ000588213/25 §108]
[197] Bécares [INQ000657973/15 §§63, 123-124]
[198] Watson & Shakespeare [INQ000588216/23 §80]: see also Freeguard [M2/INQ000260629/48 §§95, 97, 113-4] John [M2B/INQ000286066/37 §§6.75-6.79] [M2B/T4/129/14-132/3] Bennée [M2B/INQ000366137/64 §216]
[199] M6 DPO Closing 25.09.25 [§12] Fernandes-Jesus et al [M2/INQ000273352] Cullingworth et al "*They have been a saving grace in all this": the role of the third sector in disabled people's experiences of COVID-19 and implications for sector–state relations* Voluntary Sector Review 2022: 1–18, pp 1-2, 15