IN THE UK COVID-19 INQUIRY
MODULE 10: IMPACT ON SOCIETY

OPENING SUBMISSIONS ON BEHALF OF
CLINICALLY VULNERABLE FAMILIES

A. INTRODUCTION

1. This opening statement is made on behalf of Clinically Vulnerable Families ('**CVF**'). CVF is a grassroots organisation born of the pandemic. It represents those who are clinically vulnerable ('**CV**'), clinically extremely vulnerable ('**CEV**') and severely immunosuppressed, across all four nations (collectively referred to as '**Clinically Vulnerable**').[1] These individuals have underlying health conditions, or other risk factors, which place them at higher risk of severe outcomes from Covid-19, including greater mortality and developing Long Covid. CVF also represents the households and family members of Clinically Vulnerable individuals ('**CV families**' / '**CV households**'), in other words households that include at least one member who is either CV or CEV.

2. CVF's mission is to support, inform and advocate for Clinically Vulnerable people and their households as they face an ongoing threat posed by Covid-19. For Clinically Vulnerable people, the pandemic is by no means over and many of those who remain at high risk from Covid-19 continue to lead restricted lives. They are left to shoulder the burden of taking 'personal responsibility' for protecting themselves, without society wide protective measures and in the absence of public understanding that they continue to face very real risks. CVF's work to ensure that this group can access the protections that will enable them to once again participate and flourish in society, on an equal footing to others, remains pressing.

3. Module 10 examines the "*impact of Covid on the population of the United Kingdom with a particular focus on key workers, the most vulnerable, the bereaved, mental health and wellbeing*" and investigates "*the impact of the pandemic and the measures put in place to combat the disease and any disproportionate impact.*"[2] CVF intends to assist the Inquiry by giving a voice to a group who continue to be impacted both by the virus itself

[1] The definitions set out at §4 of CVF's Module 10 statement [INQ000657970] are adopted.
[2] Module 10 Provisional Outline of Scope, p.1.

and the UK's response to it, but who have been largely forgotten since the inaptly named "Freedom Day". CVF seeks to highlight the uneven impact of the pandemic on the people who continue to face greater risks to their lives from Covid-19 than any other category of person. CVF provides the unique perspective of Clinically Vulnerable people in circumstances where there is limited information, data or understanding of those perspectives.

4. CVF's focus in this Inquiry, and in Module 10, can be summarised to three overarching themes, as follows:

4.1. **Safety**: Clinically Vulnerable people must be kept safe from Covid-19 and future pathogens.

In order to keep those most vulnerable to Covid-19 and other pathogens safe, physical environments must be made safer and more resilient to outbreaks of infectious diseases, and the right to protective measures must be recognised and protected in law rather than stigmatised. The ongoing overshadowing of the experiences of Clinically Vulnerable individuals and their households is itself evidence of bad planning for future pandemics – CVF will encourage the Inquiry to recommend measures that can and should be taken now to build the resilience of the UK's population generally – and Clinically Vulnerable people in particular – towards future pandemics.

4.2. **Support**: Clinically Vulnerable people – those most impacted by the Covid-19 virus and the UK's response to it – must be better supported.

CVF's evidence will clearly demonstrate that Clinically Vulnerable individuals and households experienced heightened or compounded impacts across each of the thematic areas which Module 10 explores. Similarly, CVF's evidence demonstrates the increased harm suffered due to the pandemic by those for whom clinical vulnerability intersected with other vulnerabilities (such as key worker status, domestic abuse, homelessness, immigration status or imprisonment). However, those most impacted did not receive the support they needed.

4.3. **Status**: Clinically Vulnerable people must be recognised as a distinct group. Safety and support measures will fall short until clinical vulnerability is given sufficiently meaningful status.

There was inadequate collection of data in relation to the experiences of Clinically Vulnerable individuals and households, and, consequently, a limited understanding of the particular difficulties they experienced. CVF sought to fill

these gaps, gathering and analysing its own data, via surveys, other forms of outreach and engagement with members of its network. In Module 10, CVF will present this evidence to underline the practical invisibility of Clinically Vulnerable people, arising from the failure to recognise their status and to address their distinct needs. CVF will submit that any assessment of the pandemic's impact must acknowledge its inherent incompleteness, given that the effects on Clinically Vulnerable people were not adequately understood.

5. CVF's overarching submission in Module 10 is that to ensure Clinically Vulnerable people are afforded due respect, recognition, protection and support, presently and in any future pandemic, equality legislation and guidance must be reviewed to ensure that clinical vulnerability is given sufficiently meaningful status, either as a distinct protected characteristic, or otherwise (as discussed further below). This requires clear and enforceable requirements – so that 'reasonable adjustments' and other protective measures are normalised and not left to discretion or 'personal responsibility'. Absent serious reconsideration of the way in which clinical vulnerability is understood in the UK's equalities frameworks, Clinically Vulnerable people risk being once again avoidably left behind.

B. SUBMISSIONS

(1) Safety

6. For Clinically Vulnerable people and households, the impact of the pandemic is ongoing because many indoor environments remain unsafe against infectious diseases, particularly where transmission is airborne. The withdrawal of protections associated with "Freedom Day" and subsequent "Living with Covid" policies did not correspond to a diminution of risk for those at heightened susceptibility to severe disease. Rather, these policy decisions shifted responsibility from systems to individuals, in circumstances where people lack the tools to assess their risk and protect themselves effectively.[3] This is particularly salient for shared indoor air, where structural measures such as ventilation, filtration, occupancy and respiratory protection, over which individuals often have very little control or specialist knowledge, determine baseline safety far more than individual behaviours.[4]

[3] INQ000657970 §§158, 195–196.
[4] INQ000657970 §§116–118, 354

7. Healthcare environments exemplify this continuing problem. The removal of universal masking and the absence of consistent airborne infection control deter high-risk patients from accessing necessary care, leading to delays, cancellations and the deterioration of health conditions, as CVF's polling and member accounts attest.[5] Evidence of superior protection from FFP2/FFP3 respirators has been publicly available and borne out in real-world reductions in ward-based infection risk;[6] yet this understanding has not been translated into consistent practice or public communication. Indeed, shortly prior to the Module 10 hearings, despite national reporting indicating that the NHS was overwhelmed by an influenza epidemic, there is ongoing debate about the appropriateness or otherwise of requiring mask-wearing in healthcare settings.[7] This is inexplicable, in circumstances where simple protective measures can reduce the burden on public healthcare while ensuring that Clinically Vulnerable individuals can access healthcare safely.

8. Accordingly, CVF invites the Inquiry to recommend national airborne infection control standards across the NHS and social care, encompassing ventilation, filtration, routine availability and normalisation of respirators for staff and, where appropriate, patients, and safe care pathways that reduce exposure from the point of entry to discharge, together with remote and flexible pathways by default where clinically justified.[8]

9. Unsafe environments also extend to workplaces, education, public and civic life – including the environments which are the focus of Module 10. For example:

    9.1. In the workplace, the absence of enforceable rights to Covid-related adjustments continues to leave Clinically Vulnerable people exposed. Safety at work is a function of system design (including with respect to ventilation, density, access to respirators, remote work and sick pay), not merely individual resilience. CVF invites a recommendation that public health frameworks establish a right to reasonable Covid-related adjustments for Clinically Vulnerable workers, supported by clear Equality and Human Rights Commission ('**EHRC**') guidance, and that employers be required to demonstrate how airborne risks have been addressed as part of routine risk assessment.

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[5] INQ000657970 §§99–105, 185–192
[6] INQ000657970 §§110-114
[7] See https://www.theguardian.com/society/2025/dec/11/nhs-bracing-for-worst-ever-winter-crisis-in-next-fortnight-amid-rising-flu-cases; https://www.theguardian.com/society/2025/dec/10/health-nhs-chiefs-flu-symptoms-must-wear-facemasks.
[8] INQ000657970 §§375-376.

9.2. As the Inquiry's Cultural Institutions Roundtable Summary Report notes, there has been variable retention of protections in cultural settings, and there are ongoing concerns about enclosed environments and changed audience behaviours since reopening. The report expressly recognises the differential impact on Clinically Vulnerable people: "*Representatives described sustained changes in audience behaviour after reopening and highlighted that clinically vulnerable and older audiences were less confident about returning, particularly for live events in indoor settings.*"[9] CVF members similarly report that many cultural venues and community spaces removed previous safety measures when they reopened, despite clear evidence of audience caution among older and clinically at-risk groups and a need for effective safety measures. CVF's witness evidence records exclusion from public and cultural life as protective measures were withdrawn.[10]

9.3. Faith communities provided online and outdoor services that were particularly valuable to vulnerable congregants,[11] but barriers to safe participation persisted.[12] One CVF member reported that "*Our church refused to consider improving ventilation due to perceived discomfort for other worshipers, which was prioritised over the safety needs of vulnerable people. We offered to fundraise for HEPA filters to make the worship space safe for elderly and vulnerable people, but the PCC obstructed this. They prioritised the comfort of others over our safety, even knowing our son had nearly died from Covid. It was a moral injury.*"[13] CVF submits that explicit indoor air quality standards and guidance for religious venues, support for portable filtration, and clear permission structures to wear effective masks without challenge would materially improve safety and inclusion.[14] As the Roundtable Summary Report notes, "*Faith communities found innovative ways to observe rituals and connect with others, including online services and outdoor gatherings.*"[15] These measures are straightforward to implement and should be available as a matter of course for Clinically Vulnerable people.

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[9] Cultural Institutions Roundtable Summary Report, INQ000659832, p.5.
[10] INQ000657970, §§36-39 and Quotes 6-8.
[11] The Faith groups and places of worship Roundtable Summary Report notes that "*Representatives described how restrictions on religious gatherings and practices caused a profound sense of distress and loss among faith communities… [Faith groups] supported one another providing practical and emotional support to more vulnerable members of their communities*" - INQ000587912, p.2.
[12] INQ000657970, §§40-46.
[13] INQ000657970 page 19, Quote 13.
[14] INQ000657970 §§354–355, 380–382.
[15] INQ000587912, p. 3.

9.4. In the justice system and in institutional settings, as in-person hearings resumed, CVF members reported reduced flexibility for remote attendance and pressure to remove masks, including in circumstances of severe immunosuppression or significant caring responsibilities.[16] As the Justice System Roundtable Summary Report notes, "*the pandemic made it harder for many victims to access justice, including reporting crimes to the police or attending court hearings. People from vulnerable groups were fearful and reluctant to engage*."[17] As noted below, in detention and asylum settings, people with clinical vulnerabilities were often placed in congregate accommodation without adequate screening or infection control. CVF submits that justice sector guidance should provide for remote or hybrid attendance as a reasonable adjustment for those at heightened risk, and that institutional accommodation policies should integrate airborne infection control and individual risk assessment for Clinically Vulnerable residents.

10. Furthermore, across all sectors, the substantial scaling back of national Covid prevalence surveys and free community testing compounded the risks faced by Clinically Vulnerable people. The "Living with COVID-19" strategy promised scaled-down surveillance, but the Coronavirus Infection Survey was paused in March 2023 and the Covid-19 and Respiratory Infections Survey ended on 28 June 2023, leaving high-risk households 'in the dark' about local prevalence and trend risks. Without reliable prevalence data, individual risk assessment becomes guesswork and self-exclusion increases. CVF invites recommendations to restore representative prevalence studies and wastewater monitoring (that would capture community and asymptomatic infections), with accessible testing for high-risk households and communications tailored to elevated-risk groups on treatments, prophylaxis and local risk levels.[18] This should include clear consistent pathways for Clinically Vulnerable people to access timely assessment and treatment, with proactive communication to patients and healthcare workers about eligibility, referral routes and time-critical treatment windows.

11. Finally, stigma and hostility intensify the risks faced by Clinically Vulnerable individuals, and compound the impacts and harms (e.g., mental health harms), further detailed below. CVF's polling observed a rising proportion of respondents reporting mask-related harassment since 2022, with reports increasing from 48% in September 2022 to 65% in

[16] INQ000657970, §§299–306.
[17] Justice System Roundtable Summary Report, INQ000656301, p.4.
[18] INQ000657970, §359.

January 2024. CVF members describe being pressured by others to remove their masks and facing verbal or physical aggression when adopting self-protective measures.[19] The Key Workers Roundtable Summary Report similarly records abuse directed at public-facing staff around the enforcement of protections.[20] CVF invites the Inquiry to recommend that public messaging clearly explains the protective benefits of high-grade masks for the wearer and the community, explicitly recognising the right to wear masks in public services and workplaces. Furthermore, it urges the Inquiry to recommend regulatory guidance (e.g., by the EHRC, see below at paragraph 33) that discourages blanket prohibitions and supports simple, proportionate adjustments.[21]

12. CVF's overarching position is that safety for Clinically Vulnerable households requires structural change. Airborne infection control must be mainstreamed across healthcare and public services. Indoor air quality should be regulated in the same way as other important issues of public health, with CO_2 and air filtration standards, effective monitoring, and enforcement for buildings that fail to meet these standards. Surveillance and data must be restored to enable informed participation, the right to protective measures must be respected rather than stigmatised, and essential systems (from courts to accommodation) must incorporate adjustments as a matter of course. These are not special privileges; they are the minimum conditions for equal access to society for those whose elevated risks are well-established. Module 10 provides the opportunity to recognise these gaps and to recommend durable safeguards so that Clinically Vulnerable people are not, once again, asked to bear disproportionate risk simply to participate in everyday life.

(2) <u>Support</u>

13. It is important to recognise that Clinically Vulnerable individuals and households experienced the pandemic's harms more severely and more persistently than the general population, and that the support response, both during the acute phases and since, did not reflect this reality. CVF's evidence, including its 2025 "Impact on Society Survey"[22] and lived-experience accounts, demonstrates that where risks and barriers such as unsafe healthcare environments, lack of tailored mental health support, weak

[19] INQ000657970 §§ 112-114.
[20] Key Workers Roundtable Summary Report, INQ000659704, pp. 43-46.
[21] INQ000657970 §§376, 357.
[22] CVF Impact on Society Survey, INQ000657072.

employment protections, and persistent social exclusion converged with clinical vulnerability, the cumulative effect was to deepen disadvantage.[23]

14. In CVF's submission, future planning should prioritise targeted support for Clinically Vulnerable people across precisely those domains that Module 10 examines, so the needs of high-risk groups are built into policy and service design rather than added as an afterthought. CVF will highlight the following in respect of the thematic issues identified by the Inquiry in its Provisional List of Issues.

15. First, the mental health and wellbeing impacts on Clinically Vulnerable people were distinctive in both severity and duration, and they continue to be felt. For example:

    15.1. Clinically Vulnerable individuals and their families experienced longer periods of isolation due to shielding. As the mental health charity, Mind, has identified, the pandemic had a "*disproportionate impact on the mental health of people shielding*" and "*[t]his group felt particularly socially isolated throughout the pandemic and were therefore more prone to experiencing problems with their mental health*.[24] The Systematic Evidence Review commissioned by the Inquiry concluded that increases in mental health problems in the initial phase of the pandemic were disproportionately concentrated among people already less well, including Clinically Vulnerable individuals who were shielding.[25]

    15.2. The review also found that the mental wellbeing of people with chronic illness continued to worsen during the easing of restrictions and the summer of 2020.[26] The reintroduction of stricter lockdowns led to further deterioration for many in this population group, with shielding or consistently staying at home associated with an increased risk of elevated depressive symptoms.[27]

    15.3. CVF's 2025 survey reports persistently elevated levels of anxiety, depression and loneliness, with notable peaks around "Freedom Day" and the subsequent "Living with Covid" policy, reflecting acute to chronic stress as protective measures were withdrawn and risk management became an individual burden.[28] As one CVF member has explained, "*The constant pausing / unpausing and uncertainty of when to shield really affected us all - we felt safer shielding and would rather have*

[23] See INQ000657970, §§22–23.
[24] Dr Sarah Hughes, CEO of Mind [INQ000652569_0028].
[25] INQ000659787_0076.
[26] INQ000659787_0053.
[27] INQ000659787_0054.
[28] INQ000657970, §§23, 26–30, 150.

just been supported to do [this] throughout."[29] Another CVF member notes, *"I was terrified about the reopening. I felt safer during the lockdowns as more people were being careful. But when the government reopened everything again, people were less careful and places were less safe for me to go."*[30]

15.4. Respondents repeatedly described feeling abandoned as public policy and messaging moved away from risk reduction, and as discussed above, many were left to navigate exclusion from safe public spaces and services absent clear, tailored guidance. CVF will underline that these are not merely issues of confidence (as they are often portrayed). Rather, they reflect legitimate and rational concerns about the increased risks of severe illness, long-term disability, or death at times and in places where protective norms diminished, particularly for the severely immunosuppressed and older people experiencing immunosenescence (i.e., the gradual deterioration of the immune system, brought on by natural age advancement).[31] The lack of recognition of these legitimate concerns compounded harm, as one CVF member explains: "*I was referred to a clinical psychologist in the hospital's mental health team after I'd had my maximum Macmillan counselling sessions. I think they felt I wasn't making any progress. I told the psychologist that the Macmillan counsellor had treated my concerns like a phobia and kept trying to get me to do things I didn't feel were safe. Like going to a restaurant. I remember saying I felt like she was trying to rehabilitate me into something completely wrong for me. Her response was "You don't have a phobia. A phobia is an irrational fear and I can see that Covid is a real, legitimate concern." I realised I was not mad. I was completely right to feel as concerned as I did, as a vulnerable cancer patient."*[32]

15.5. Barriers to safe access to healthcare compounded these harms and continue to do so: CVF's evidence records repeated delays and cancellations of appointments by Clinically Vulnerable people as universal masking and other airborne infection controls were removed, with many respondents describing healthcare attendance as effectively a choice between personal safety and necessary care.[33] This

[29] INQ000657970 page 13, quote 2.
[30] INQ000657970 page 21, quote 16.
[31] See INQ000657970, §30, 3, and Case Study (iii).
[32] INQ000657970, page 14, Quote 4.
[33] CVF polling indicates that 54% of members had delayed or cancelled healthcare as at June 2022, rising to 91% by October 2022 and 90% in November 2023, with 93.4% reporting difficulty safely accessing healthcare or support services; the most frequently cited barriers were lack of staff/patient masking, poor ventilation, crowding, and refusal of simple safety requests. See INQ000657970, Part C (Impact on Access to Key Services/ Support)

inevitably increased the mental health harms to Clinically Vulnerable individuals who felt they could not safely access much-needed healthcare and other support.

15.6. The mental health harms to Clinically Vulnerable people intertwined with physical health and employment pressures. Prolonged isolation, reduced safe access to exercise and routine care, and unmanaged conditions drove deterioration in mental and physical wellbeing and exacerbated existing conditions, producing a cycle in which unsafe environments (such as unsafe workspaces and healthcare institutions)[34] led to increasing isolation, avoidance of care, further deterioration, and deepening isolation.[35]

16. All of the above underscores that Clinically Vulnerable individuals should be suitably supported. As discussed above, safety is a prerequisite for access, not a discretionary addition. Systematic measures to improve indoor air quality and reduce exposure risks across healthcare, workplaces and public venues would reduce treatment delays, mitigate downstream costs and ensure that Clinically Vulnerable individuals are appropriately supported and do not suffer serious and avoidable mental health harms as a result of their inability to access basic services. As CVF has stated in previous Modules, to avoid such compounding impacts, future preparedness should embed airborne infection control as a routine standard across healthcare and social care, including ventilation and filtration, normalised access to respirators, and safe care pathways from arrival to discharge for those at heightened risk, alongside remote and flexible care models where clinically justified.[36]

17. Second, financial stress and job insecurity (which were often interrelated) for Clinically Vulnerable households was a recurring theme during the relevant period. CVF's evidence to the Inquiry includes reports of exclusion from or delay in access to support due to categorisation problems, particularly where individuals were "only CV" rather than CEV, together with practical barriers to accessing essentials and increased costs for self-protection. For example, one CVF member explains that "*[b]eing a clinically vulnerable teacher who was not officially shielded during the pandemic was an incredibly stressful experience. ... The lack of specific guidance and support made the situation challenging. [There was a need] for comprehensive assistance and clearer guidelines …. The government's emphasis on CEV individuals sometimes led the public to response with dismissive remarks such as 'You are only CV, what are you worried*

[34] See INQ000657970, §234.
[35] INQ000657970, §§185-192.
[36] INQ000657970 §§116–118, 375–377.

about?"[37] Similarly, another CVF member explains, "*When I was told to shield, my school (employer) said that on their risk assessment, that as I was only CV, that I had to work.*"[38] These blunt categorisations were unsuitable to ensure adequate protection of Clinically Vulnerable individuals in employment.

18. Key workers and those in public-facing roles who were also Clinically Vulnerable were particularly exposed. CVF's survey indicates that, among the 33 CVF members who identified as keyworkers, the majority reported serious failings in workplace safety and rights protections, namely:

- 58% were asked to return to work in unsafe conditions;
- 55% experienced direct discrimination related to their Clinically Vulnerable status;
- 36% were denied reasonable adjustments (such as PPE or remote work) (and of those given adjustments, 59% said they were inadequate);
- Only 30% reported receiving a personal risk assessment;
- 24% had to take unpaid leave or resign to protect health;
- 21% said they were ineligible for furlough or financial support;
- 12% could not access sick pay when needed.[39]

19. These experiences are consistent with the Module 10 key worker roundtable themes noting unclear guidance, ambiguity around enforcement, sustained public-facing abuse during enforcement, and gaps in mental health and financial support. For example, the Report Summary notes that "*the pandemic led to workers trying to juggle an important and increasingly demanding job with the pressures they often faced in their personal lives. Many were anxious about their own health, the health of clinically vulnerable family members, or had caring responsibilities*".[40] The report noted that the lack of support "*placed many clinically vulnerable staff, or staff in clinically vulnerable households, in a position where they were being asked to choose between earning money and protecting their family's health.*"[41]

20. Furthermore, evidence shows that many Clinically Vulnerable workers (whether key workers or otherwise):

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[37] INQ000657970, page 73, Quote 47.
[38] INQ000657970, page 75, Quote 48.
[39] INQ000657970, §234, Figure 7.
[40] INQ000659704, page 40.
[41] INQ000659704, page 55.

20.1. faced structural obstacles in obtaining appropriate workplace support and accessing benefits, arising from the absence of enforceable, risk-based rights and the consequent reliance on employer discretion, which in many cases led to refusal of basic adjustments, forced resignation or dismissal;[42]

20.2. faced restrictions in access to statutory protections (e.g., statutory sick pay, furlough) and priority services (e.g., priority food delivery), with direct knock-on effects for income security and workplace safety.[43] Precarious and zero-hours workers were especially exposed, with limited access to sick pay or furlough and heightened pressure to work despite infection risks;[44]

20.3. faced difficulties accessing benefits: Universal Credit claims were initially overwhelmed and later rendered unsafe for many by the resumption of mandatory in-person Jobcentre appointments.[45] Disabled Clinically Vulnerable workers faced challenges accessing PIP and those on legacy benefits were excluded from the £20 uplift applied to Universal Credit, compounding hardship for many Clinically Vulnerable workers and households;[46]

20.4. could not access meaningful financial support, because the Test and Trace Support Payment was narrowly drawn and often insufficient, leaving many who self-isolated to avoid infection without appropriate financial support.[47]

21. These pressures were intensified by the withdrawal or suspension of paid social care and the inability of carers safely to attend, forcing many CV workers to assume extensive unpaid caring responsibilities alongside employment, with documented long-term effects on health and labour market participation.[48] As one CVF member explains, "*All support for my relative with severe mental illness disappeared overnight. And support had been very limited to start with. I was left with 24/7 unpaid caring responsibilities on top of my job on top of my own health conditions. It was unmanageable and unbearable and has had a long-term impact on my health.*"[49] Furthermore, these pressures were not transitory, as Clinically Vulnerable households remained cautious due to concerns around risk exposure, while costs accumulated.

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[42] INQ000657970, §§18, 225–235. §§18, 129–131, 231, 244–245
[43] INQ000657970 §§141–143, 126
[44]INQ000657970, §§238–239
[45] INQ000657970 §§126-128
[46] INQ000657970 §§137-139
[47] INQ000657970, §240
[48] INQ000657970 §§55(c), 119–125.
[49] INQ000657970 page 39, Quote 23.

22. As Professor Herrick has explained in her Module 10 statement, changes to the 'shielding list' in May 2020 "*meant that many who had previously been on the list could now no longer use this designated status to access support services or benefits and were forced to return to work, despite the risks and their (technically unchanged) clinical vulnerability*".[50]

23. Future economic support frameworks should explicitly include Clinically Vulnerable households, ensure parity across benefits, rectify classification errors quickly, and guarantee prioritised access to essential services during periods of elevated risk. CVF also invites the Inquiry to recommend a structured right to reasonable adjustments for Clinically Vulnerable workers, including remote work where practicable, supported respirator use, and redeployment during surges, supported by appropriate statutory and regulatory guidance.[51]

24. Third, intersecting vulnerabilities amplified impacts for particular groups. For example:

    24.1. CVF's evidence shows that survivors of domestic abuse experienced heightened coercive control during the pandemic, with clinical risk weaponised to limit movement, deny access to care and support, and isolate victims.[52] CVF members experiences include instances where clinical vulnerability was systematically exploited within a controlling relationship, with shielding used to isolate and destabilise victims. One member explains, "*My medical vulnerability was used against me by my abuser who restricted access to care, cut off support networks, and used my health risks as tool to increase his control. I was denied financial autonomy and the ability to attend essential medical appointments or seek legal and practical help. This form of coercion was difficult to detect because it exploited real clinical risks and took place in the enforced isolation of shielding, which removed me from view cutting me off from my closest friends and it made outside intervention almost impossible when I was struggling the most.*"[53] The Module 10 domestic abuse roundtable's accounts of increased severity of abuse, reduced safe accommodation capacity, and difficulties accessing services are consistent with the evidence of CVF's members.

[50] INQ000661715_0004.
[51] INQ000657970, §§357–358, 366–374.
[52] INQ000657970, §§295-298.
[53] INQ000657970, §§294.

24.2. Clinically Vulnerable people within the immigration and asylum system or in prisons and other places of detention faced acute risks from congregate settings without adequate screening or protective measures,[54] as reflected in roundtable materials. The justice system itself did not uniformly accommodate ongoing risk, with CVF members reporting pressure to remove masks in court, reduced access to remote attendance and inconsistent recognition of reasonable adjustments, especially as restrictions relaxed.[55] CVF submits that safeguarding, accommodation and justice procedures should be designed to recognise and reduce the unique risks faced by Clinically Vulnerable people, ensuring that safety measures are enabling rather than exclusionary.[56]

25. In summary, CVF will seek to persuade the Inquiry that support for Clinically Vulnerable people across each of the thematic areas identified in the Provisional List of Issues must be anchored to the realities experienced by Clinically Vulnerable individuals and households and evidenced across Module 10's themes, namely: pervasive and enduring mental health harms, persistent barriers to safe healthcare, material financial and employment detriment, compounding physical health impacts, and intensified risks where vulnerabilities intersect. Targeted, practical and sustained support for Clinically Vulnerable households and individuals will not only address past failings but also build the societal resilience that Module 10 seeks to promote.

(3) Status

26. There were significant issues at the height of the pandemic regarding the correct and consistent identification of those who were particularly vulnerable to Covid-19 (i.e., at higher risk of severe outcomes from Covid-19,) due to underlying health conditions or other risk factors such as older age and pregnancy.

27. First, and as CVF has explained in Module 3, the distinction between CEV and CV put millions of CV people on the wrong side of an arbitrary dividing line and left them without the support associated with being CEV (including priority access to food, the right to work from home, and priority access to vaccination).[57] Professor Herrick has noted that the categories "*were both confusing and easily confused [which] was problematic as*

[54] INQ000657970, §§ §273–279, 284-291.
[55] INQ000657970, §§299-306.
[56] INQ000657970, §§357-365.
[57] See Module 3 Closing Submissions.

membership of the categories was tied to particular public health guidance and advice and, for the CEV, (limited) government support packages".[58]

28. Secondly, the fact that, for some Clinically Vulnerable individuals, their CEV designation – and the protected measures which resulted from it – came to an end prematurely. This was not because the clinical risk of CEV people had diminished, but due to external, non-clinical considerations; for example: pressures on healthcare institutions, operational constraints and the drive to push workers to return to work. This caused further hardship. Clinically Vulnerable individuals whose elevated risk persisted were placed in greater danger once they no longer qualified as CEV. This also had knock-on effects, including financial detriment where at-risk individuals felt compelled to resign or reduce hours to avoid workplace exposure, and discriminatory impacts arising from the misalignment between ongoing clinical risk and the curtailed designation.

29. These definitional issues not only negatively impacted the lives of Clinically Vulnerable people, they also led to inadequate collection of data in relation to the experiences of Clinically Vulnerable individuals and households, and, consequently, there remains a limited understanding of the particular difficulties they experienced.

30. As became evident in previous Modules, the needs of Clinically Vulnerable people often went unaccounted for even during the acute stage of the pandemic. Until those people identified as being at higher risk of severe health outcomes from an infection like Covid-19 are recognised and afforded protected status, their needs will neither be properly understood or fully met. Whether children or adults, it will tend to be the same people who are Clinically Vulnerable in a pandemic or epidemic, namely those with certain underlying health conditions.

31. CVF notes 'Recommendation 8' in the Inquiry's Module 2 report, namely that the UK government and devolved administrations "*should each agree a framework that identifies people who would be most at risk of becoming infected by and dying from a disease and those who are most likely to be negatively impacted by any steps taken to respond to a future pandemic. The framework should set out the specific steps that could be taken to mitigate the risks to these people. Equality impact assessments should form part of this framework.*"[59] CVF supports this recommendation and requests that the Inquiry goes further to protect Clinically Vulnerable people not just during pandemics but in "peace time" too, when infectious disease in public settings is still a serious, life-

[58] INQ000661715_0002-0003.
[59] Modules 2, 2A, 2B, 2C: Core decision-making and political governance – Volume II, at p.317.

limiting issue for Clinically Vulnerable families. CVF has set out extensively in its evidence to the Inquiry the concerning impacts that the easing of restrictions, "Freedom Day," policies such as "Eat Out to Help Out" and the treatment of Covid-19 as an issue of "personal responsibility" have had, and continue to have, on Clinically Vulnerable people, including that:

31.1. Data was not collected during the pandemic in a manner that properly captured clinical vulnerability and the experience of Clinically Vulnerable people. For example, surveys carried out during the pandemic often did not collect data on Clinically Vulnerable groups.[60] Professor Majeed has confirmed in his Module 10 statement that Clinically Vulnerable populations relied on fragmented primary care records, leading to gaps in real-time monitoring.[61] The Systematic Evidence Review also identified "*a lack of sufficiently detailed or disaggregated data*" on CV and CEV groups.[62] While CVF sought to fill this gap, it was unable to do so across the board.[63] Gaps in data collection inhibit society's ability to properly understand and respond to issues faced by Clinically Vulnerable people: as Lara Wong, CVF's CEO notes, "*Although individuals with "underlying health conditions" were frequently mentioned both in the media and by politicians, official statistics for Clinically Vulnerable populations were viewed through the lens of "disability" or "economic inactivity" with only limited data existing for those officially classified as CEV. CVF believes this general lack of visibility of Clinically Vulnerable people particularly non-CEV Clinically Vulnerable people will have contributed directly to their exclusion from necessary protections via reasonable workplace adjustments, and targeted economic support.*"[64] Despite the pandemic, and the focus it brought on the heightened risks faced by Clinically Vulnerable people, these gaps have worsened over time, increasing significantly following "Freedom Day."[65]

31.2. Clinical vulnerability is often an "invisible" health problem. One CVF member, who is CEV due to cancer, expressed concern about the ongoing failure to ensure societal recognition of those who are immunocompromised: "*the big issue was that I was still immunocompromised – but no-one can see that, can they? People expect those who are going through cancer to look emaciated and sick. But*

[60] See e.g., INQ000657970, §34.
[61] INQ000659865_0004.
[62] INQ000659787_0073-0074.
[63] See e.g., INQ000657970, §77, 241, 248.
[64] INQ000657970, §248.
[65] See e.g., INQ000657970, §158

immunocompromise doesn't 'look' poorly. It's an invisible health problem."[66] This ongoing lack of understanding and recognition of clinical vulnerability has an enduring and dangerous impact on the protections afforded to Clinically Vulnerable people in society.

31.3. CVF's members experience ongoing issues securing access to public spaces in ways that recognises and responds to their particular needs. For example, one member explains "*I have not seen any local public spaces take any steps to make themselves safer for vulnerable people. I contacted several local arts venues... asking about ventilation or adjustments under the Equality Act 2010... Typically I got no response... Eventually I gave up even trying to participate in a society so eager to exclude me."*[67] CVF remains concerned that the failure to recognise clinical vulnerability as a protected characteristic, or to otherwise provide effective guidance as to the applicability of the Equality Act 2010 to Clinically Vulnerable people, means that there are concerning barriers – born due to the pandemic and enduring today – to Clinically Vulnerable individuals' access to public spaces.

31.4. Clinically Vulnerable individuals face ongoing discrimination at work. For example, one CVF member explains that "*I was (and still am) the only one masking at work… My boss asked me 'how are you going to manage act 2 of this opera when everyone is in the room?'… I felt uncomfortable that it was being suggested that I'm now unable to do my job to the best of my ability, that my reluctance to catch Covid is affecting my employment.*"[68] Similarly, the Inquiry's experience is itself indicative of these issues: while CVF is grateful to the Inquiry for adopting sound ventilation and mask policies, the extensive effort and debate needed to get there reflects broader societal challenges in microcosm, and, given the Inquiry's atypical nature (being the national Covid-19 Public Inquiry), it is concerned that many other employers are likely to face much greater hurdles. CVF remains concerned that these employment-related obstacles are due to the absence of recognition of clinical vulnerability as a protected characteristic or similarly protected status under Equality legislation and/or guidance.

31.5. Clinically Vulnerable people (as well as those living in Clinically Vulnerable households) should not need permission to wear a mask where it is medically necessary: this should be a right, not a privilege, whether arising from the already

[66] INQ000657970 page 15, case study (iii).
[67] INQ000657970 page 17, quote 6.
[68] INQ000657970 page 16, quote 5.

existing right to reasonable adjustments as a disabled person, or where disability does not apply, through a newly recognised protected characteristic of clinical vulnerability (see below).

32. Steps must be taken to address the gaps in data on the impact of Covid-19 on Clinically Vulnerable people. Existing data collection should be routinely disaggregated by factors including those in clinical risk groups.

33. There are several complementary legal and policy routes by which protection for Clinically Vulnerable people could be strengthened. While some Clinically Vulnerable individuals may obtain protection under the Equality Act ('**EqA**') 2010 through existing protected characteristics (most commonly disability, age or pregnancy), a structural gap remains where clinical risk as such is not expressly recognised.

34. There are many conditions which will result in clinical vulnerability which do not necessarily qualify for protection as a disability under the EqA. Clinical vulnerability relates to the elevated risk of severe outcomes from infection, rather than relating to day-to-day functional limitations. The EqA definition of disability does not apply to health conditions or treatments which do not have a 'substantial' and 'long-term' negative effect on a person's ability to perform normal daily activities. For example, the risks to a person from a virus may temporarily significantly increase due to intermittent treatments. This would not necessarily be a "disability" under the EqA but would pose a serious risk to an individual, who under the current law would be left without protection if, for example, their employer refused to make adjustments to protect them.

35. Accordingly, CVF urges the Inquiry to recommend that clinical vulnerability is made as a distinct protected characteristic in the EqA 2010. In parallel, CVF urges the Inquiry to recommend that the Equality and Human Rights Commission ('**EHRC**') updates its statutory Employment Code and other Codes (including Services and Public Functions) and to revise and expand its non-statutory online guidance, to address the obligations owed specifically to Clinically Vulnerable individuals and families by employers and public sector bodies, in light of their risk-based needs and by reference to clear examples of reasonable adjustments relevant to Clinically Vulnerable workers, service users and their households.

C. CONCLUSION

36. There is an urgent need to restore trust and confidence that the lives and wellbeing of all Clinically Vulnerable people matter, and that their distinct concerns and needs will be

addressed, both now and in a future pandemic or health emergency. While the scale of the challenge faced by the Chair is considerable, given competing demands and entrenched attitudes, CVF submits that its recommendations are simple to introduce, and will go an enormous way to addressing the needs of Clinically Vulnerable people.

37. Accordingly, on behalf of Clinically Vulnerable people, CVF urges the Inquiry to (1) focus on improving the **safety** of public buildings, by making them more resilient to airborne viruses and respecting the right to individual protective measures, (2) make recommendations which would increase **support** for Clinically Vulnerable people, namely targeted mental health support, workplace protections, and financial security, and (3) enhance the **status** of Clinically Vulnerable people, including their legal status as an equality group, to ensure their needs are better recognised, understood and addressed.

38. CVF is grateful for the Chair's willingness to understand CVF's issues of concern. CVF looks forward to further participating during the Module 10 hearings.

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