

1 Businesses explained that some businesses felt that they
 2 had been wrongly categorised as non-essential, which led
 3 to resentment when other businesses providing similar
 4 goods or services were allowed to stay open.

5 Restrictions and closures led to financial
 6 difficulties for many businesses, particularly those
 7 that did not have the financial reserves to adapt.

8 Hospitality Ulster stated:

9 "Our industry, particularly in Northern Ireland,
 10 still feels the financial legacy of Covid ... [it has]
 11 left them in debt and that has left them struggling the
 12 whole way through this."

13 The furlough scheme and VAT reductions were
 14 described as "a lifeline for some businesses". However,
 15 the impact of reduced revenue in the retail sector meant
 16 that some stores, particularly smaller ones, permanently
 17 closed. The British Independent Retailers Association
 18 said that footfall in physical stores had yet to return
 19 to pre-pandemic levels, partly due to increased consumer
 20 preference for online shopping.

21 The position of hospitality businesses, many of
 22 which were already burdened with significant debt before
 23 the pandemic, saw their situation worsen "due to
 24 increased costs and forced closures for non-essential
 25 businesses".

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1 The travel and tourism sector also faced
 2 "significant financial challenges", in part due to the
 3 restrictions on international travel, lasting until
 4 March 2022.

5 Staff across sectors faced increased workloads
 6 during the pandemic, increasing work-based stress.
 7 Participants noted that all sectors faced high levels of
 8 job insecurity during the pandemic. Despite the
 9 furlough scheme, the pandemic led to significant job
 10 losses.

11 VisitBritain observed that:

12 "between February 2020 and May 2021, 81% of job
 13 losses across the economy were in the accommodation or
 14 food services sector. The travel sector was
 15 particularly hit by staff losses and by the time
 16 international travel reopened in March 2022, they had
 17 lost nearly half of their staff. This significant
 18 reduction in workforce made it challenging for the
 19 sector to resume operations effectively, and led to
 20 a skills gap." UKHospitality Scotland said that "people
 21 who were furloughed often found jobs in different
 22 sectors".

23 When venues and services did reopen, participants
 24 "pointed out the challenge of implementing Covid-19
 25 guidelines like social distancing and face mask

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1 mandates, while simultaneously working to stabilise
 2 their operations and boost their financial recovery.
 3 The impact of the furlough scheme and loss of staff
 4 during the pandemic also meant businesses faced staff
 5 capacity issues, which limited their ability to reopen
 6 within a short time frame".

7 Consumer behaviour had changed. Individuals of all
 8 ages adapted to digital payments, leading to a
 9 substantial decline in cash usage. The general
 10 consensus was that there was a deeper appreciation for
 11 the local community, and "local businesses became spaces
 12 for connection, improving community relationships,
 13 increasing a sense of belonging and reducing
 14 loneliness".

15 The representative from the Association
 16 of Convenience stores said, "It really changed shopping
 17 habits to be more local. Retailers were able to sustain
 18 a more locally tailored model. There was some
 19 recognition about how important it was to have retail
 20 services close to where you live, and I think that
 21 changed consumer behaviours."

22 There were differences on the impact on rural and
 23 urban areas. It was observed that "businesses in city
 24 centres were hit hardest because fewer people were
 25 commuting to them for work. Businesses in suburban and

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1 rural areas were thought to adapt more successfully and
 2 bounce back more quickly, as they had local populations
 3 to serve".

4 There was also increased rural tourism, as travel
 5 restrictions eased and foreign travel remained
 6 impossible or difficult. However, there was
 7 a perception that this "sparked a backlash from some
 8 communities". VisitBritain said, "All of a sudden you
 9 had huge numbers travelling to rural communities at a
 10 time when the local authorities had closed all public
 11 toilets and cafés and these areas often didn't open
 12 carparks."

13 The pandemic also changed expectations around work,
 14 including an increased desire for hybrid or fully remote
 15 roles. Roundtable participants said this created
 16 problems for recruitment and skills, and capacity
 17 building within sectors. A representative from BEAM,
 18 commenting on the business events and accommodation
 19 sector said, "I think everybody has just reevaluated
 20 their lives and habits. We've lost an awful lot of
 21 experience from our industry."

22 There were also more positive impacts.

23 The Federation of Small Businesses noted "more of
 24 a focus on mental health at work" with "staff more open
 25 to discussing their emotions".

8

Positive innovation also arose out of the restrictions with permanent changes we're all aware of. It was observed that businesses adapted "by rapidly accelerating online capabilities, making use of outside spaces, and adapting to changes in consumer behaviour ... by allowing late notice cancellations without paying fees. These adaptations often helped businesses to reach more customers locally and across the country, helping them financially".

UKHospitality Scotland noted that many hospitality businesses started offering "takeaways and meal ingredient kits" for the first time. There was a general shift whereby "retail businesses shifted to online sales or introduced 'click and collect' services".

Hospitality Ulster recalled "a company where you bought it online, they had a van with a keg, and went down to your door and pulled you a pint". And retail Northern Ireland said this:

"The hit on non-essential retail meant a lot had to innovate; to introduce click and collect like they hadn't before, so it did reinforce that sometimes, periods of crisis are the best for innovation".

My Lady, those are a selection of the points that arose in that roundtable meeting, giving you a flavour

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1 of the impact on that sector.

2 Community-level sport and leisure.

3 At this roundtable, the discussion focused both on
4 the impact of restrictions on delivery of
5 community-level sport and leisure, and the impact of
6 these restrictions on the level of individual physical
7 activity.

8 Again, there was discussion of the challenges of
9 implementing guidance, the financial impact on
10 organisations and their workforce, and the adaptations
11 and innovations that emerged.

12 At the start of the pandemic, community-level sport
13 and leisure venues were required to close immediately,
14 as part of the restrictions put in place. Although
15 participants understood that the pandemic was an
16 unprecedented situation, they said the manner and timing
17 of communications caused difficulties. It was said
18 that:

19 "Changes were often announced very late and without
20 sufficient consultation. When changes to the guidance
21 happened the night before they were due to be
22 implemented, this exacerbated the challenges faced by
23 those required to implement the changes. Furthermore,
24 the guidance sometimes lacked detail and clarity about
25 why decisions were being made. This was particularly

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1 important where decisions related to specific types of
2 venues or activities which were to be closed or
3 reopened. Overall, this made it difficult for
4 organisations to adapt and communicate changes
5 effectively to their members and staff to ensure
6 compliance."

7 The financial impact on the sector was said to be
8 "widespread, immediate, and negative". There was
9 "considerable financial strain" on organisations,
10 regardless of their size, although larger organisations
11 had a greater capacity to stay afloat, and so suffered
12 fewer closures.

13 The Sport and Recreation Alliance described the
14 impact that the restrictions on professional and elite
15 sports had, saying:

16 "There was enormous pressure at ... grassroots level
17 ... [because of the] link between the ability to
18 generate income at elite level and how that is then
19 reinvested at grassroots."

20 Additional funding from the government and the
21 National Lottery played a crucial role in supporting
22 organisations financially. There was a distinction in
23 the availability of support to private and public
24 organisations across local authority areas:

25 "Representatives reflected that there was more

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1 limited funding for private gyms and leisure centres,
2 pointing to a lack of furlough support and grants.
3 Ukactive added that private gyms and leisure centres
4 were still required to pay rent at a time when they had
5 no income and had to lobby the government for support.
6 Grassroots community clubs also faced challenges
7 accessing government support, for example, due to
8 differences in the way local authorities administered
9 grants."

10 The makeup of the workforce included both paid and
11 volunteer staff, as well as sole traders like
12 instructors and coaches. Whilst a significant number of
13 employed staff were furloughed during the pandemic,
14 those who were self-employed were not eligible for
15 furlough, impacting negatively on their mental health.

16 There was a decline in volunteer numbers, which put
17 a strain on those who remained, though the
18 representative from Sport Wales suggested that there was
19 a pre-existing decline due to societal change, saying:

20 "I think it just made the slope steeper and
21 accelerated it."

22 Again, representatives described positive steps
23 taken by the sector to adapt to the pandemic. They gave
24 examples of organisations pivoting quickly to online
25 exercise classes, outdoor programmes, loaning gym

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1 equipment and home workout packages to support people to
 2 stay physically active.

3 Venues were repurposed for other activities. Sport
 4 and Recreation Alliance noted:

5 "... more ... facilities being used for something
 6 else. Many professional clubs have community trusts who
 7 ran food banks and community support."

8 Participants said that the pandemic resulted in the
 9 "most significant recorded decline in physical activity
 10 levels in England", with approximately "1,223,000 fewer
 11 adults meeting recommended activity levels". In some
 12 areas, such as swimming, participation rates had not
 13 fully returned to pre-pandemic levels.

14 There was a consensus consistent with your findings
 15 in earlier modules, as highlighted by Ms Blackwell
 16 King's Counsel yesterday, that the impact was not felt
 17 equally. Participants confirmed that:

18 "... lockdown restrictions had exacerbated existing
 19 disparities in physical activity levels for ethnic
 20 minorities, those from lower socioeconomic backgrounds,
 21 and people with poor mental health."

22 Again, my Lady, that is just a flavour of what is
 23 contained in the report, and further detail is within
 24 individual statements, some of which came from people
 25 who attended, and they will be adduced in due course.

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1 Cultural institutions.

2 At this roundtable, the discussion focused on the
 3 impact on institutions, workforces, and communities as
 4 consumers of culture.

5 The first lockdown resulted in the immediate closure
 6 of cultural venues. Creative Scotland noted that:

7 "... performing arts ... [were] particularly
 8 affected given how heavily reliant performing arts shows
 9 and activities are on in-person interaction and direct
 10 contact."

11 Organisations, again, struggled with guidance.
 12 Participants:

13 "... described the guidance as unclear, both
 14 initially and as the pandemic progressed, making it
 15 difficult for them to interpret the rules and implement
 16 them in practice. Confusion about the guidelines also
 17 meant some organisations sought advice from sector
 18 organisations and trade unions, while others were left
 19 to interpret available information independently, adding
 20 to the pressure they felt. This confusion continued as
 21 the pandemic went on, restrictions eased, and
 22 organisations planned for and implemented different
 23 approaches to reopening."

24 The pandemic accelerated the shift to performances
 25 and cultural activities being produced and accessed

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1 online across the sector. There was an increase in
 2 demand for high quality content for television and
 3 streaming services, because people were spending more
 4 time at home. However, this has not necessarily
 5 persisted since. The Music Venue Trust said:

6 "There are very, very few gigs that are live
 7 streamed nowadays."

8 Many had to find jobs outside their profession,
 9 which led to a loss of skills in the sector. BECTU, the
 10 Broadcasting, Entertainment, Communications and Theatre
 11 Union, said:

12 "We had lots of people working in supermarkets or
 13 doing whatever they could during that period just to
 14 keep themselves going. Undoubtedly, it has impacted
 15 upon the skills within the sector."

16 There was a "strong consensus" amongst participants
 17 that financial support, available to individuals working
 18 in the sector, did not recognise the position of
 19 freelancers and sole traders. There were particular
 20 concerns expressed for those that had been on maternity
 21 leave or those who were early in their careers who could
 22 not provide evidence of past income.

23 Participants also suggested that access to financial
 24 support through the Cultural Recovery Fund was "more
 25 straightforward in devolved nations", which in turn had

1 a positive impact on workforce retention in Scotland,
 2 Wales and Northern Ireland.

3 The Musicians' Union said:

4 "We found the [Culture] Recovery Fund, the way it
 5 was allocated in the devolved nations, we know of quite
 6 a lot of members in Wales and Scotland who were given
 7 grants. Individuals found it much easier to access some
 8 of that money. We saw very little of that in England."

9 The dissemination of information through a largely
 10 freelance workforce was difficult. Participants said
 11 those who were not union members or part of
 12 a representative body did not always receive information
 13 that would have helped.

14 There were "exceptional levels of stress and
 15 uncertainty across the sector". Equity, the actors'
 16 union, explained building resilience became more
 17 important for their members as the pandemic continued.
 18 Their members emphasised the importance of ensuring
 19 income stability, dignity at work, and proper mental
 20 health support.

21 Again, the pandemic was said to have highlighted and
 22 exacerbated longstanding inequalities in the cultural
 23 sector, including barriers for working parents and the
 24 underrepresentation of groups, with those from ethnic
 25 minority or working class backgrounds being mentioned in

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1 discussions.

2 At the height of the pandemic, there was a shift to
3 cultural organisations becoming more closely linked with
4 their communities. Arts Council England saw this as
5 a positive development for the sector:

6 "Many of our organisations connected with their
7 local communities in a way they'd never done before. We
8 saw quite big organisations seeing themselves as very
9 much community-based in their local places".

10 The reopening of venues placed additional pressure
11 on the workforce as they risked contracting Covid-19 in
12 enclosed working environments. BECTU said that staff
13 were "fearful about being exposed to the virus, while
14 facing exhaustion from working longer hours to cover
15 Covid-related staff shortages in their organisation".

16 When audiences did return to public venues, there
17 was a changed atmosphere. There were obvious concerns
18 for those vulnerable to infection about the safety of
19 reopening. The changes in behaviour went further. It
20 was observed by one participant that:

21 "People had maybe forgotten how to behave when they
22 go to the theatre or events. We saw quite a huge uptick
23 in abuse of staff, front-of-house, and just generally
24 ... singing and interrupting and shouting."

25 However, BECTU said changes in behaviour could not

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1 all be attributed to the pandemic:

2 "The habits have changed. Late ticket buying since
3 the pandemic, but the other thing we're also seeing is
4 spending overall is down by audiences. I think it's
5 been reinforced by a post-Brexit world, the environment
6 and overall challenges that are being experienced by
7 people in their domestic lives."

8 My Lady, I will now turn to faith groups and places
9 of worship.

10 At this roundtable, there was discussion of the role
11 of faith during the pandemic, the challenges for faith
12 communities, the impact on religious gatherings,
13 pastoral care and the longer-term impact on religious
14 communities.

15 Severe disruption to religious gatherings and
16 practices during the pandemic bought "a deep sense of
17 distress and loss for people from faith communities".
18 Participants sharing how many religious practices
19 initially stopped and were then modified throughout the
20 pandemic. Some faith communities were able to adapt by
21 transitioning to online gatherings, which broadened
22 reach.

23 Participants described other innovative ways in
24 which different faiths observed rituals during the
25 restrictions, such as drive-in church services,

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1 collective prayers in streets, online coffee faith
2 gatherings, live social media gatherings and the Ramadan
3 at Home campaign, which involved virtual meals and live
4 stream readings of the Qur'an and outdoor services in
5 April and May 2020.

6 However, it was not possible to accommodate all
7 religious practices online, such as the Eucharist or
8 Holy Communion ceremonies, and other rituals such as
9 baptism.

10 There were serious questions about the doctrinal
11 legitimacy of moving rituals online for, in particular,
12 Orthodox Jews. The representative for the Jewish
13 Leadership Council explained that:

14 "in Sephardi communities, the senior Rabbi issued
15 guidance permitting online prayer in the first period of
16 lockdown, but it could not take place thereafter. Use
17 of technology is also not permitted on the Sabbath for
18 Orthodox Jews so online gatherings were not appropriate
19 in this context, limiting the access of religious
20 gatherings for some Jewish communities. In turn, this
21 had an impact on community connection and support."

22 Online services also relied on religious leaders
23 being able to use technology confidently, or find help
24 from others to do so. The representative for Hindu
25 Council UK described how older priests struggled to use

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1 technology in comparison to younger members of the
2 clergy.

3 Despite the challenges, faith was described as a
4 "source of strength and meaning for many people". The
5 representative for Churches Together in Britain and
6 Ireland, highlighted that 89% of church leaders in
7 Scotland and Northern Ireland felt that faith helped
8 people in their congregations during the pandemic. That
9 help was both practical and spiritual. Religious
10 communities supported vulnerable people, for example
11 with essentials such as food parcels and medication, as
12 well as through the provision of emotional support via
13 the phone to isolated individuals.

14 The representative from the Muslim Council of
15 Britain told other participants that:

16 "The way people demonstrated their sense of
17 godliness was their service to others".

18 Participants said local faith leaders also played
19 a particularly vital role, providing guidance to their
20 communities and acting as a trusted source of
21 information about key issues like restrictions and
22 vaccines.

23 Representative also said that it felt "offensive"
24 that the reopening of faith spaces for private prayer
25 was delayed until the same time as reopening

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1 non-essential retail, in June 2020 in England Wales and
 2 Scotland, and public worship, and weddings in July 2020.

3 That was not the case in Northern Ireland, where
 4 places of worship reopened for private prayer on 19
 5 May 2020, ahead of non-essential retail on 12 June 2020.

6 Participants also highlighted the disproportionate
 7 impact the pandemic had on some faith communities,
 8 compounding existing inequalities as recognised in
 9 earlier modules. The Muslim Council of Britain
 10 representative described a more significant impact on
 11 the Muslim community due to "existing inequalities,
 12 including high levels of deprivation, unemployment, and
 13 social exclusion".

14 Faith communities also experienced racism and were
 15 targeted by conspiracy theorists. The representative
 16 for the Jewish Leadership Council shared that there was
 17 a "negative impact on the wellbeing of the Jewish
 18 community caused by a conspiracy theory that Covid-19
 19 was a Jewish disease, and this led to an increase in
 20 antisemitism".

21 The pandemic impacted the partial care which faith
 22 communities were able to provide to their members.
 23 Remote alternatives such as phone calls were generally
 24 not felt to be an adequate replacement for in-person
 25 care. However, as restrictions were lifted, religious

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1 leaders risked potential infection. The representative
 2 for Churches Together in Britain and Ireland said this:

3 "There was harm in every choice. If you were not
 4 there for people when their loved ones were dying, you
 5 knew that absence was going to cause harm".

6 The representative for Cytûn, Churches Together in
 7 Wales, explained that "some members of the clergy,
 8 particularly those who were more risk averse, wanted
 9 more guidance on how to protect themselves and others
 10 from the virus, with greater clarity about whether they
 11 should conduct in-person pastoral visits or not".

12 Faith communities also said they struggled with
 13 guidance. Local religious leaders were at the forefront
 14 of interpreting and communicating that guidance, which
 15 was "an additional task alongside their day-to-day
 16 roles", and "put more strain on religious leaders".

17 There was also apprehension amongst leaders about
 18 sharing their interpretation of the guidance, in case it
 19 could put people at risk. Some representatives,
 20 including those from the Muslim Council of Britain and
 21 the Hindu Council UK, said this apprehension was
 22 exacerbated by limited engagement with government.
 23 However, Cytûn had found that some engagement was
 24 helpful, giving the example of the Faith Communities
 25 Forum.

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1 Nonetheless, there was a growing frustration with
 2 the guidance as the pandemic went on. There were
 3 differences in guidance between the four nations, which
 4 was said to be challenging for religious leaders to
 5 interpret and share, particularly those close to the
 6 borders.

7 Representatives said the guidance "was not always
 8 reflective of the nuances of faith communities and
 9 places of worship". This led to "difficulties for
 10 religious leaders in understanding and applying
 11 government guidance in a way that was relevant for their
 12 religious community".

13 Some longer-term impacts on religious communities
 14 were described positively. For some, the pandemic
 15 "reignited the importance of faith", albeit the unused
 16 sense of community activity and support during the
 17 pandemic has not always been sustained.

18 The Jewish Leadership Council explained that
 19 services have changed to accommodate wider lifestyle
 20 changes arising out of the pandemic. However, not
 21 everyone has returned to their places of worship after
 22 the pandemic. In particular, representatives described
 23 "how the pressure of the pandemic and the additional
 24 tasks caused burnout amongst volunteers".

25 I turn now to key workers.

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1 This roundtable brought together representatives
 2 from unions and organisations across multiple sectors,
 3 including education, fire and rescue, funerals, burials
 4 and cremation, police and justice, retail, transport,
 5 distribution and warehousing. The roundtable did not
 6 consider health and social care workers who have been
 7 considered during Modules 3 and 6.

8 Again, people struggled to understand and implement
 9 rapidly changing government guidance. Participants said
 10 guidance was often broached and lacked sector-specific
 11 tailoring, creating confusion and fear. Frequent
 12 changes made people unsure if they were implementing
 13 guidance correctly.

14 The representative from the National Association of
 15 Head Teachers said:

16 "There was conflicting and contradictory guidance.
 17 A month later you'd be told not to do X, you should do
 18 Y. That shifting of the goalposts was a problem".

19 Participants described rapid changes that occurred
 20 "late on a Friday evening or on a weekend", giving
 21 sectors insufficient time to prepare. This was said to
 22 have led to a "complete lack of credibility at
 23 a frontline level", and public confrontations. In the
 24 police sector, it was said conflicting guidance on
 25 issues like mask wearing "undermined confidence in

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1 government guidance".

2 Participants also suggested unclear workplace safety
3 guidance left key workers exposed to risk. For
4 funerals, burials and cremation, a primary concern was
5 safely handling the deceased without knowing the cause
6 of death. The National Burial Council raised that "in
7 the early stages, bereavement workers were not told
8 whether individuals had died from Covid-19, limiting
9 their ability to assess exposure risks. It was only at
10 a later stage that registrars were permitted to disclose
11 this information".

12 Even when guidance was issued, the National
13 Association of Funeral Directors said it was "a lot
14 lighter than what people had decided they needed",
15 making it hard to reassure frontline staff.

16 In transport distribution and warehousing it was
17 said inconsistent protocols arose from varied
18 organisational safety measures and the use of
19 third-party logistic companies. The National Union of
20 Rail, Maritime and Transport Workers, RMT, gave the
21 example of a bus company using "a plastic shower curtain
22 to separate drivers from passengers, which they said was
23 ineffective".

24 Similarly, GMB Union voiced concerns that its
25 education staff members felt unsafe due to a lack of

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1 personal protective equipment, especially when dealing
2 with vulnerable children or giving care.

3 NASUWT, the Teachers' Union, reported the impact of
4 following ventilation advice in winter:

5 "When schools fully reopened in winter 2021,
6 temperatures were so low that members reported children
7 and staff with blue hands and lips, as the ventilation
8 advice was to open windows. Wrapped up for winter,
9 unable to see their own breath, it was just not
10 a suitable learning environment".

11 It was said that some key workers initially felt
12 a sense of pride as their essential roles were
13 recognised. GMB union reported people felt "empowered
14 by the opportunity 'to do their bit' during a national
15 crisis". However, that was not everyone's experience
16 and was said to be short lived.

17 There was some anger and upset at being
18 underappreciated compared to health and care workers.
19 And transport, distribution and warehousing workers
20 noted the gap between media praise and their reality of
21 low pay, leaving them feeling undervalued.

22 The National Burial Council noted that burial
23 workers felt like an "unseen workforce".

24 Education sector workers were described as being
25 "demonised in the media for concerns they raised about

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1 the reopening of schools". Many felt that there was
2 a false public perception that schools were closed, and
3 that staff were not working, which impacted their
4 wellbeing.

5 The fear of contracting Covid-19 was also acute
6 among key workers who worried for their own safety and
7 that of their families, especially if they were in
8 contact with clinically vulnerable people. The National
9 Police Chiefs' Council described the pressure on police
10 officers as "intense from the off, mentally and
11 physically, the unknowns were mentally taxing".

12 Fear was compounded in the funerals, burials and
13 cremation sector by increased workload and government
14 modelling suggesting massive death tolls.

15 For fire and rescue staff, the concern about
16 spreading the virus to their families "had a knock-on
17 impact on their mental health" because "the risk that
18 you could bring something home was so high and scary".

19 In education, the National Association of
20 Head Teachers shared that members were so concerned for
21 their families that some moved out of their homes to
22 prevent spreading the virus. Some left the profession,
23 because they did not feel safe enough to go into work.

24 Delivery drivers for parcel companies, who were also
25 transporting test kits, were also described as facing

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1 a "world of unknown" risks.

2 The risk of infection was a particular concern for
3 people from ethnic minority communities, who experienced
4 poorer Covid-19 health outcomes, as reflected in the
5 evidence which you have heard in earlier modules and
6 will hear in coming weeks.

7 Participants noted the public-facing key workers
8 faced the highest risk of contracting Covid-19, and
9 morale declined as more colleagues died.

10 Food manufacturing workers, especially in close
11 proximity settings like bakeries, saw disproportionately
12 high death rates during the first wave of the pandemic.

13 The GMB Union reported that they:

14 "... saw some of the highest fatality rates of any
15 key worker group."

16 The Bakers, Food and Allied Workers Union noted that
17 "some members of their union died from contracting
18 Covid-19 in the workplace, or they brought the virus
19 home and it led to the death of members of their
20 families, particularly older relatives".

21 In the education sector, NASUWT, The Teachers'
22 Union, shared the account of a member "adamant that he'd
23 caught Covid from a [pupil] who became ill whilst at
24 school", and "sadly died within 3 weeks" of
25 hospitalisation, adding that "the impact on colleagues

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1 is immeasurable". The National Education Union also
 2 reported a "high prevalence of Long Covid amongst
 3 staff".

4 Key workers faced "tough choices about balancing
 5 work and personal responsibilities". The stress was
 6 intensified by the feeling that they had to "disregard"
 7 restrictions when going to work.

8 The Federation of Burial and Cremation Authorities
 9 put it this way:

10 "Essentially, how do I live with these conditions in
 11 my individual life? Also, everything I am being told to
 12 do privately, I have to disregard when I go to work to
 13 be able to do my job."

14 Education workers were described as taking on extra
 15 pastoral and social care roles, such as supporting
 16 bereaved children, often "without specialist training".
 17 The funerals, burials and cremation sector experienced
 18 an "ongoing intense pressure" from the unprecedented
 19 number of deaths, which had "a significant impact on
 20 workers' mental health", leading to burnout, people
 21 leaving the sector, and "in some cases, suicide
 22 attempts".

23 Overall, a lack of comprehensive and readily
 24 available mental health support was said to be
 25 a consistent problem across sectors, worsening feelings

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1 of isolation, anxiety, and burnout.

2 My Lady, I will turn now to the justice system.

3 This roundtable considered the impact on the justice
 4 system and on immigration and asylum. I touch on the
 5 detailed discussions held across three breakout groups
 6 only briefly. The report will of course be available
 7 for use with witnesses, from whom you will hear later in
 8 the hearing, including some of the participants in this
 9 roundtable.

10 The roundtable considered the impact of the
 11 operation of criminal justice institutions. People said
 12 that the role of the police adapted during the pandemic,
 13 taking on extra responsibilities like enforcing Covid-19
 14 rules and stepping in to help people when public
 15 services, such as social services, closed.

16 The National Police Chiefs' Council stated that:

17 "Policing had to go into a place where some services
 18 withdrew ... we were asked to do home visits around
 19 children and probation visits. There were gaps that
 20 policing [was] asked to fill."

21 This was described as a change in focus and a change
 22 in the policing role, as a lot of calls were around
 23 Covid-19 and breach of restrictions. Police
 24 investigations were said to have slowed because limits
 25 on in-person contact made it harder to collect evidence

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1 and witness statements. The National Police Chiefs'
 2 Council also noted difficulties in:

3 "Collecting medical evidence, prison visits, going
 4 to businesses that were closed, trying to secure
 5 evidence and generally dealing with people with Covid,
 6 that all made witness gathering really difficult."

7 Social distancing also led to more individuals being
 8 released on pre-charge bail conditions or under
 9 investigation, causing reported delays in charge
 10 decisions.

11 The discussion also considered the victims of crime.
 12 It was noted that the pandemic significantly hindered
 13 victims' access to support from family, friends, and
 14 organisations, as legal services and law centres were
 15 reduced or moved online, creating "significant obstacles
 16 for victims seeking legal advice and essential emotional
 17 and practical support".

18 This lack of support was said to have
 19 disproportionately affected individuals facing language
 20 barriers. For example, Medical Justice said that
 21 engaging family networks as translators was disrupted by
 22 social distancing, which meant victims "understood less
 23 about what was happening with their case".

24 Victims from vulnerable groups, such as those with
 25 physical conditions, disabilities or older people, were

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1 also reluctant to engage with the justice system due to
 2 fears of contracting Covid-19, according to Victim
 3 Support.

4 Court delays further undermined victims' confidence
 5 in a timely outcome with a National Police Chiefs'
 6 Council observing that some people were told that their
 7 case would not be heard for two to three years, leaving
 8 them in a "state of limbo". This uncertainty
 9 discouraged participation in the justice system, with
 10 many withdrawing from the legal process.

11 Technological barriers also made it "almost
 12 impossible for the most vulnerable person victims to
 13 access justice", as many were unfamiliar with online
 14 processes, lacked the required technology, or had
 15 insufficient Internet access.

16 As one participant pointed out, parties "didn't have
 17 a basic phone or enough data to participate in hearings,
 18 never mind a laptop or tablet". However, some victims
 19 preferred remote proceedings. As an online pilot scheme
 20 in Scotland indicated, it removed "the fear of seeing
 21 the accused person at court which made the victim feel
 22 safer and better able to engage in the court process".

23 There was also discussion of the impact on prisons.
 24 Issues of capacity, regimes, isolation, and access to
 25 services were all raised by participants as contributing

32

1 to the negative impact on prisons during the pandemic.

2 The prison population initially declined during the
3 pandemic and this was said to be due to paused court
4 proceedings. However, court delays soon increased the
5 number of prisoners held on remand, worsening
6 pre-pandemic overcrowding issues once restrictions
7 eased.

8 The pausing of the End of Custody Temporary Release
9 scheme, which allowed low-risk prisoners near the end of
10 their sentence to be released early, was said to have
11 led to worse conditions, including overcrowding and
12 a more restrictive regime to curb the spread of
13 Covid-19.

14 As you have heard, prisoners were subjected to
15 restrictive regimes, including being locked in their
16 cells for around 23 hours a day for many months, which
17 had a profound negative impact on their mental health.

18 Medical Justice said that:

19 "Prisoners didn't have the ability to do the things
20 we'd advise our patients to do, to contact someone
21 supportive, to go for a walk, get some fresh air. These
22 are fundamental to all of our mental health, that was
23 all gone, a situation that is as inherently about as
24 damaging as you could think of, especially to this
25 vulnerable group. I think there is no way to justify

33

1 that medically. It was completely contradictory to
2 treat people in that way. Prisoners still feel the
3 consequences of that."

4 The isolation was exacerbated by reduced visitation
5 rights, limiting connection and support from friends and
6 family. The suspension of activities and offender
7 behaviour programmes also made it harder for prisoners
8 to demonstrate reduced risk for parole applications.

9 Finally, there was discussion of the impact on
10 immigration and asylum. Representatives from the
11 Migration Observatory explained that the a number of
12 people moving to the UK initially dropped significantly
13 in 2020 due to pandemic-related travel and other
14 restrictions, but then rose in 2021, eventually
15 surpassing pre-pandemic figures as restrictions eased.

16 Despite the fall in overall asylum applications, the
17 Migration Observatory said there had been a substantial
18 rise in irregular crossings, particularly by small boat.

19 However, participants also said that there were
20 difficulties in obtaining migration data during the
21 pandemic, because traditional methods such as the
22 International Passenger Survey were disrupted. This
23 made it unclear who was entering and leaving the UK,
24 hindering any reliable understanding of migration
25 patterns.

34

1 Representatives from the Migration Observatory also
2 suggested that although certain asylum application
3 interviews could be skipped during the pandemic, this
4 actually hindered the progression of applications,
5 because it resulted in less information being available
6 about individual cases. They added that delays in
7 processing asylum applications have continued, noting
8 that by 2023, over half of the initial immigration
9 decisions for asylum seekers involved individuals who
10 had been waiting for more than 18 months.

11 They thought this demonstrated the lasting impact of
12 pandemic-related disruptions on the immigration system,
13 saying:

14 "All those changes caused by the pandemic made it
15 harder to progress applications. Moving into the
16 post pandemic: applications, small boat arrivals jumped,
17 everything jumped. Then you saw a system that was stuck
18 with progressing applications."

19 The Immigration Law Practitioners Association said
20 that the introduction of a Covid-19 concession scheme
21 extended the leave to remain for people whose visas
22 expired in July 2020. However, the absence of clear
23 guidance on the various coronavirus immigration schemes
24 reportedly caused significant confusion and legal
25 uncertainty about individuals' immigration status.

35

1 Regarding a separate scheme, the Exceptional
2 Assurance Concession, the Immigration Law Practitioners
3 Association stated:

4 "It was only years after its introduction and after
5 consistently seeking clarification from the Home Office
6 that we found out that 'exceptional assurance' wasn't
7 any form of assurance in law. It was a form of
8 'protection' but did not constitute lawful residence or
9 presence in the UK."

10 Representatives described how the pandemic increased
11 social isolation for migrants and asylum seekers, as
12 they were cut off from their usual support networks and
13 essential services.

14 Project 17, which works to end destitution amongst
15 migrant families, said that clients were interrogated
16 for using public spaces because they lacked private
17 gardens. They said:

18 "Clients were interrogated for being on the park
19 bench because they had no garden. They were trapped in
20 their bedrooms then."

21 The mental health and wellbeing of detained migrants
22 was said to be substantially negatively impacted. As
23 you have heard, Bail for Immigration Detainees said that
24 migrants were subjected to extended periods of solitary
25 confinement to reduce the spread of Covid-19. They

36

1 highlighted that the lack of clear communication about
 2 the reasons and expected duration of confinement
 3 resulted in increased fear and anxiety.

4 The representative for Bail for Immigration
 5 Detainees said:

6 "Because people were confined in their cells: they
 7 lived in fear that they might get Covid, might die,
 8 would not know what was happening in the outside world."

9 Another representative, from Project 17, compared
 10 the experience in detention centres to being in a war:

11 "It's like being in the blitz: hiding under the bunk
 12 and hoping you dodge the bomb. You can't do anything --
 13 someone else is controlling your life and the impact of
 14 that is tremendous."

15 The Immigration Law Practitioners Association also
 16 noted that some guidance was not provided in formats
 17 that migrants could understand, and cited literally
 18 skills as a significant barrier.

19 My Lady, I reiterate that this is but a flavour of
 20 the valuable insights that were shared across all the
 21 discussions at this roundtable, but I will now turn to
 22 housing and homelessness.

23 At this roundtable, the discussion covered the
 24 impact of the pandemic on housing availability, the
 25 impact on living conditions, the impact on the housing

37

1 and homelessness workforce, the impact on the health and
 2 wellbeing of homeless people, and the impact on access
 3 to homelessness support services.

4 Participants said that initially there was just one
 5 set of guidance for the sector, which was "generic and
 6 lacking detail". This was remedied to some extent as
 7 the pandemic continued. Local authorities in England
 8 developed additional guidance, whilst devolved
 9 governments issued their own.

10 Some organisations, such as The Wallich, also
 11 developed their own guidance. However, relationships
 12 with local authorities was said to be variable, and it
 13 was felt that coordination and support for the sector
 14 varied geographically.

15 Government interventions, such as the Everyone In
 16 initiative in England, were put in place. This involved
 17 providing housing to people who were homeless or living
 18 where they could not socially distance. Participants
 19 commended this initiative for adopting a person-centred
 20 approach that prioritised individuals' needs over
 21 immigration status.

22 St Mungo's stated that there was a 37% decline in
 23 rough sleeping during the pandemic, in part due to
 24 people accessing safe accommodation in this way.

25 However, Centrepoint explained that the initiative
 38

1 could not provide support for those with complex needs,
 2 such as care leavers, those with mental health
 3 conditions, people with drug and alcohol addictions, and
 4 those who had experienced trauma.

5 Cymorth Cymru said to the Inquiry that:

6 "There were some women put in some genuinely
 7 dangerous situations around people who may well have
 8 been perpetrators. I think women with complex trauma,
 9 sex workers who were really struggling to understand how
 10 to make ends meet, they were put in very dangerous risky
 11 situations in some of the congregate accommodation."

12 Further, the initiative was described as a "missed
 13 opportunity" to have a long-term impact on reducing
 14 homelessness in England.

15 The general consensus amongst participants was that
 16 whilst interventions "eased the financial strain of the
 17 pandemic for some households ... that ceased once the
 18 pandemic ended".

19 The ending of pandemic housing initiatives was said
 20 to have disproportionately affected those at higher risk
 21 of homelessness, such as individuals with insecure
 22 immigration status, women, and young people.

23 There were concerns that the pandemic has normalised
 24 the use of temporary accommodation. The representative
 25 from St Mungo's was concerned that it is not thought of

39

1 as a "short-term blip" but is "the new normal".

2 The quality of the housing is also said to have
 3 decreased during the pandemic, as it was more difficult
 4 to organise repairs and maintenance. The pandemic
 5 exacerbated the divide between the maintenance of
 6 private rental properties and social housing. It was
 7 felt that some private landlords used Covid-19 as an
 8 excuse to avoid conducting necessary repairs. Acorn
 9 noted there were:

10 "Things like people who didn't have hot water for
 11 two months."

12 The pandemic meant that people spent more time at
 13 home, sometimes in overcrowded conditions. This
 14 disproportionately affected those from lower
 15 socioeconomic backgrounds, as they were more likely to
 16 be living in poorer quality housing.

17 The representative from St Mungo's said:

18 "I think people's experience of lockdown was based
 19 on the quality of their housing and the amount of space
 20 they had. Particularly for people who were poorer,
 21 people who had been in temporary accommodation before
 22 the pandemic, it's a small 6 foot by 10-foot room you're
 23 in, maybe with a shared bathroom."

24 Energy costs also rose, as people spent more time at
 25 home, adding financial pressure. And that was

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1 particularly the case for those in older housing.

2 The housing and homelessness workforce were not
3 recognised as key workers until later in the pandemic.
4 This impacted them psychologically and practically.
5 They were described as feeling "undervalued, forgotten
6 about and fearful about contracting Covid-19, all of
7 which impacted morale". It also meant that they did not
8 receive support such as access to childcare and PPE, all
9 of which made it more difficult for them to carry out
10 their work.

11 Participants reflected positively on how the sector
12 managed to continue offering services in challenging
13 circumstances and adapted to meet needs.

14 There was also widespread praise for the work of
15 volunteers to support the sector during the pandemic.
16 For example, St Mungo's reported that about 400 people
17 volunteered to help, collectively contributing over
18 20,000 hours towards promoting awareness of rough
19 sleeping.

20 Participants believed that the sector's efforts and
21 initiatives like Everyone In helped prevent the
22 worst-case scenarios for Covid-19 deaths among homeless
23 people. St Mungo's said that the vaccination programme
24 provided an opportunity to engage with people not just
25 about Covid-19, but also other, unmet health needs.

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1 My Lady, I now turn to domestic abuse and
2 safeguarding.

3 My Lady, you've already recognised in your Module 2
4 findings that more ought to have been done to anticipate
5 the risks in this area. The roundtable heard that the
6 pandemic's restrictions had a "profound impact" on
7 victim-survivors of domestic abuse. Representatives of
8 support organisations spoke of the "huge rise in calls
9 and emails seeking support". Hourglass, an older
10 people's domestic abuse charity, spoke of an "explosion
11 in casework".

12 The nature of sexual assault was said to have
13 changed during the pandemic, with a rise in complex
14 sexual abuse cases, as perpetrators had greater access
15 to victim-survivors.

16 Hourglass said that sexual abuse cases reported
17 towards older people doubled during the pandemic. The
18 National Police Chiefs' Council reported a rise in
19 family homicides during lockdowns, although homicides by
20 intimate partners reduced slightly.

21 It was suggested by the National Police Chiefs'
22 Council and Southall Black Sisters that the reduction
23 may have been because perpetrators felt more in control
24 of victim-survivors as they were less able to leave
25 during lockdown restrictions.

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1 Perpetrators used the pandemic to assert control in
2 other ways. One example given was refusal to comply
3 with a child custody arrangement, on the basis that the
4 child had to isolate at the perpetrator's home. The
5 representative for ManKind initiative shared how
6 perpetrators were able to broaden their tactics of abuse
7 towards male victims, such as preventing access to
8 children, intensifying economic pressures, and forcing
9 men to go into work, putting them at risk of catching
10 Covid-19.

11 Although the pandemic did not generally lead to
12 first-time perpetrators, in some cases the financial and
13 other pressures of the pandemic coincided with the
14 beginning of abusive behaviour.

15 As lockdown eased, there was an increase in
16 reporting and referrals to support services. It was
17 suggested that victim-survivors may not have known,
18 during lockdown, whether they were able to report abuse
19 in an emergency or whether the police would be able to
20 do anything about the situation.

21 Representatives of were concerned that the messaging,
22 "Stay home, stay safe" did not acknowledge the fact that
23 some people did not feel safe at home. The messaging
24 discouraged people who were experiencing domestic abuse
25 from seeking help for fear of breaking the restrictions.

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1 There was a general sense that guidance lacked clarity
2 on how restrictions applied to domestic abuse.

3 The restrictions did not apply to those at risk of
4 "harm", but participants did not consider that the
5 definition of "harm" was made sufficiently clear.

6 Organisations in the third sector said that they had
7 to step in to communicate what "harm" meant and to
8 provide clarity on whether people could leave home or
9 access support. The representative from the National
10 Police Chiefs' Council said:

11 "We experienced a lot of confusion about
12 restrictions. We did a lot of things with the media at
13 the time saying, 'You can keep seeking help, you can
14 leave your home if you're living in fear. If you're
15 fleeing your perpetrator, you can leave'."

16 The impact also impacted victim-survivors' access to
17 support. They could not rely on their normal support
18 networks, which "made them feel alone, isolated, and
19 more fearful". The restrictions limited access to
20 extended family, and to safe community spaces like
21 libraries. As the Convention of Scottish Local
22 Authorities put it:

23 "Not only did we put people in their own homes with
24 a perpetrator, we took all the services away."

25 Statutory services for those suffering from domestic

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1 abuse, such as social services, were often closed or
 2 offered more limited support during the pandemic. This
 3 meant that the signs of domestic abuse were not being
 4 picked up by the safeguarding teams when they might
 5 otherwise have been. Closures impacted community-based
 6 services which saw an increase in the number and
 7 complexity of cases, creating strain at a time when they
 8 already had high demand.

9 Southall Black Sisters service saw a 138% increase
 10 in calls to their helplines between the end of April and
 11 June 2020. Larger third-sector organisations, such as
 12 Women's Aid, also faced increased pressure.

13 Representatives also felt that pre-existing funding
 14 challenges during the pandemic put domestic abuse and
 15 safeguarding charities under greater pressure. Rape
 16 Crisis England and Wales said that "the sector doesn't
 17 just need funding in response to a crisis, but long-term
 18 sustainability to built resilience, respond to
 19 place-based needs, and reduce the fragmentation of care
 20 pathways".

21 Some reported positive impacts from the move to
 22 operating online during the pandemic. For example, the
 23 representative from the Local Government Association
 24 said that they were able to meet more regularly with the
 25 police, local authorities, and other key partners. Some

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1 also shifted to offering outdoor services. The Rape
 2 Crisis England and Wales centres developed alternative
 3 therapies such as Walk and Talk, although this could not
 4 work for all, such as those with some disabilities.

5 Again, some groups were impacted more acutely.
 6 Spaces that were normally used to house older
 7 victim-survivors were closed during the pandemic and so
 8 they would end up staying in an abusive household for
 9 longer, having nowhere else to go.

10 Emergency accommodation is often preferred over
 11 a refugee for older women, allowing for more
 12 independence and privacy, but this was scarcely
 13 available during the pandemic.

14 Further, many refugees -- sorry, many refugees could
 15 not make their service accessible to deaf victims whilst
 16 abiding by restrictions and pandemic measures. Wearing
 17 masks made lip-reading impossible.

18 Participants also raised the issue of perpetrators
 19 being able to control the digital connection of
 20 victim-survivors. The representative from the Latin
 21 American Women's Rights Service said this:

22 "One of the different ways through which
 23 perpetrators abused victims was data control -- if
 24 you're providing services only remotely and you don't
 25 have credit on your phone, no access to wi-fi, or your

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1 perpetrator turns this off, victims would be isolated
 2 and could not contact statutory services."

3 Those working in the sector were not recognised as
 4 key workers, but they were still expected to continue to
 5 deliver services. This made their work feel less
 6 valued. Representatives emphasised the importance of
 7 recognising domestic abuse and safeguarding workers as
 8 well as additional support workers like British Sign
 9 Language interpreters as key workers in a future
 10 pandemic.

11 My Lady, finally, I turn to funerals, burials and
 12 bereavement support.

13 You heard yesterday from Ms Blackwell King's Counsel
 14 about the many ways in which the restrictions impacted
 15 on the bereaved, and this was explored in detail at this
 16 roundtable. As one participant summarised, "bereavement
 17 during the pandemic was not like bereavement in normal
 18 times".

19 To take some examples, the Covid-19 Bereaved
 20 Families for Justice UK representative told the Inquiry
 21 that, "For Afro-Caribbean families, the coming together,
 22 the wake, is so important. People could not be there".

23 The Covid-19 Bereaved Families for Justice Northern
 24 Ireland representative similarly said, "We normally have
 25 wakes as part of our culture, a time for people to

47

1 reflect, share memories, bring positives to your life at
 2 a time when it is sad. That was completely lacking and
 3 missed."

4 Mind said:

5 "Some communities struggled to understand why they
 6 couldn't run funerals as per their cultural norms.
 7 There was a lack of thought and understanding about how
 8 the impact on different cultural ways of bereavement was
 9 happening."

10 They highlighted examples from Haredi Jewish
 11 communities and some Asian communities with whom they
 12 work.

13 Restrictions on numbers at funerals also "caused
 14 arguments and disagreements within group members'
 15 families" which had a "lasting impact on the
 16 relationships between some bereaved family members".
 17 Inconsistency in the restrictions on attendance across
 18 the UK was highlighted, as well as the "upset and
 19 frustration" caused by the differences in restriction
 20 between waves of the pandemic.

21 Some individuals were also left "feeling furious"
 22 and "thinking repeatedly about whether they had let
 23 their loved ones down by adhering to guidelines or not
 24 pushing enough for a funeral that was consistent with
 25 their wishes". People shared the "guilt" that the

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1 bereaved felt through a lack of acknowledgement of their
 2 loved ones' "last hours". Participants said that many
 3 of their members continued to feel "very angry about
 4 what happened to their loved ones at the end of their
 5 lives".

6 As Cruse Bereavement Support's representative put
 7 it:

8 "I spoke to someone we supported last week who said
 9 the way the funeral went in the pandemic and the
 10 difficulty they've had processing that, they've not been
 11 able to go to a funeral since ... that sense of anger is
 12 really palpable. Someone said, 'We did everything
 13 right. I still lost someone. I followed the rules.
 14 I couldn't support them and give them the dignity in
 15 death that they wanted to have'."

16 Bereavement support organisations talked about
 17 "complex grief, where people continue to experience
 18 intense, lasting symptoms of grief for a long time after
 19 their loved one has died. This is often accompanied by
 20 persistent sadness and rumination about the loss.
 21 Bereaved families campaign groups spoke about how many
 22 of their members have been diagnosed with post-traumatic
 23 stress disorder, with some experiencing suicidal
 24 thoughts following pandemic bereavement and its
 25 associated isolation".

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1 Some participants told the Inquiry that "during the
 2 second wave, prolonged isolation from their loved ones
 3 meant that many people were going through a phase of
 4 anticipatory grief in advance of their loved one dying".
 5 Further, individuals felt "left behind by society" as
 6 conversation turned to moving on from the pandemic.
 7 Participants shared the "agony and resentment" that
 8 their members experienced when hearing others having
 9 excited conversations about seeing family and friends
 10 after lockdown ended.

11 Participants also covered restrictions on support.
 12 There was often a waiting list for support, with the
 13 number of sessions being "felt to be too short to
 14 discuss the complexity of what happened to bereaved
 15 individuals".

16 Participants said that mental health services were
 17 overwhelmed. Some were able to find support through
 18 signposting online, or through other charities and local
 19 hospices, but the offer was "often limited and felt
 20 unsuitable for pandemic bereavement". One member of
 21 Scottish Covid Bereaved found private counselling
 22 helpful but said this was something they accessed
 23 through work and thought not many could afford it.

24 Issues such as burnout and difficulties in
 25 maintaining a distinction between personal life and

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1 volunteering, led a number of volunteers to step back.
 2 This meant others had an increased caseload, and "ended
 3 up feeling burnt out and exhausted", which was said to
 4 have led to them leaving after the pandemic. Cruse
 5 Bereavement Support said, "Charities are still dealing
 6 with the ongoing impact of the pandemic but it's more
 7 challenging to provide support."

8 The need for bereaved people to have support
 9 relevant to their culture and delivered by people who
 10 understand them was highlighted, with the representative
 11 from Mind suggesting that a lack of culturally sensitive
 12 provision may explain why people were reluctant to use
 13 bereavement support.

14 The "general fear and economic instability" that
 15 was present during the pandemic made it even harder for
 16 people who were experiencing grief during this time.

17 The National Bereavement Alliance thought that
 18 financial worries were likely to have intensified
 19 people's experiences, given that a fall in income being
 20 on a lower income are risk factors for poorer
 21 bereavement outcomes.

22 Those who were furloughed or lost their jobs also
 23 lost access to the networks, stability and structure
 24 that work can provide.

25 Participants described how bereaved families

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1 campaign groups offered peer support, putting pressure
 2 on those groups while they were grieving themselves.
 3 Covid-19 Bereaved Families for Justice Northern Ireland
 4 said:

5 "People were being referred to us who were suicidal
 6 and in crisis, and the addition of that on our group was
 7 huge. Bereavement is as individual as a fingerprint,
 8 and what people need is different, and we tried to meet
 9 that for each person."

10 Scottish Covid Bereaved said, "This is a family that
 11 none of us wanted to be part of, but we are."

12 You will, my Lady, hear directly from all of the
 13 Core Participant bereaved groups and from Cruse and
 14 Cruse Scotland during the course of this hearing.

15 My Lady, as I mentioned at the beginning, each
 16 report identifies lessons learned relevant to the
 17 particular roundtable. I do not set out all those
 18 lessons today, but I will, in closing, identify some of
 19 the key themes.

20 First, the impact on mental health was a theme that
 21 ran through all the discussions. Participants
 22 repeatedly emphasised the significant and detrimental
 23 impact on mental health and on wellbeing, made worse by
 24 the lack of access to appropriate support, and that the
 25 impact had been particularly acute for vulnerable

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1 groups, exacerbating existing inequalities.

2 Second, you will note that participants repeatedly
3 said that a lack of clarity in communications and
4 guidance exacerbated the negative experiences of the
5 pandemic and of measures in response.

6 My Lady, you may consider in due course whether the
7 perception and experience of guidance and communications
8 serves to illustrate the conclusions that you have
9 already reached on the need for clarity and for
10 consultation, and co-production where appropriate.

11 Indeed, participants gave examples where decision
12 makers and others worked together, with those most
13 impacted, with businesses and institutions, and with the
14 third sector, to positive effect. In light of this,
15 there were repeated calls for greater consultation,
16 collaboration, and co-working.

17 Third, participants in many discussions also said
18 there were gaps in understanding how people were
19 impacted by the pandemic, and raised the need for better
20 data gathering and management of data to inform planning
21 and the response to the next pandemic.

22 Finally, participants recalled some instances of
23 positivity, resilience and innovation, though it was
24 emphasised that some adaptations designed to temper the
25 worst impacts of the pandemic did not work for everyone.

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1 Digital expansion was a success story for many, and
2 for the most part led to the use of technology which
3 increased accessibility. But some were left behind or
4 disadvantaged by a lack of face-to-face contact.

5 My Lady, as I bring this introduction to a close, we
6 extend our gratitude once again to all of those involved
7 in each of the nine roundtable discussions. Together,
8 they have provided you with a crucial insight into the
9 impact of Covid-19 on society as a whole. The reports
10 I have summarised are part of the record of your
11 investigation and will inform the further work to be
12 done on this module over the next three weeks' hearings
13 and beyond.

14 My Lady, that concludes the opening submissions of
15 your Inquiry team. After the break, you will hear from
16 each of the Core Participants who wish to make an
17 opening statement.

18 **LADY HALLETT:** Thank you very much indeed, Ms Rahman. I'm
19 extremely grateful. It was an awful lot to summarise
20 and it was an excellent summary.

21 Can I also echo your thanks to all those who
22 participated in the roundtables and of course all those
23 who organised the roundtables. It's produced a huge
24 amount of really valuable material.

25 **MS RAHMAN:** Thank you, my Lady.

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1 **LADY HALLETT:** Thank you.

2 Mr Weatherby, after the break?

3 **MR WEATHERBY:** [off microphone]

4 **LADY HALLETT:** After the break. Half past.

5 (11.14 am)

6 (A short break)

7 (11.30 am)

8 **LADY HALLETT:** Sorry if I caught people by surprise.

9 Mr Weatherby.

10 **Submissions on behalf of Bereaved Families for Justice UK**
11 **by MR WEATHERBY KC**

12 **MR WEATHERBY:** Thank you, my Lady.

13 From the start of the Inquiry, Covid Bereaved
14 Families for Justice UK has sought to amplify the voices
15 of the bereaved from across the four corners of England,
16 Scotland, Wales and Northern Ireland, in order to ensure
17 that lessons are learnt and future lives are saved.

18 It's impossible to properly learn lessons or change
19 the future without a clear and deep understanding of
20 lived experience of what has passed. And that, of
21 course, is the importance of understanding impact, as
22 you have clearly recognised in making this the subject
23 of this, the final module.

24 In his evidence to Module 1, Matt Fowler said that,
25 right from the get-go, he and Joanna Goodman, the

1 co-founders of the group, felt that the important thing
2 was change.

3 We need to learn lessons, we need to learn about
4 things that went wrong, and we need to put something in
5 place to prevent those mistakes from being carried out
6 again in the future.

7 They did not know each other, but both lost their
8 fathers, Ian and Stuart, at the start of April 2020,
9 early in the pandemic. Incensed at what they saw as the
10 absence of planning and an incompetent government, they
11 joined up to campaign, along with 7,000 others, for the
12 authorities to wake up and rapidly advance measures
13 which would minimise the ongoing effects of the poor
14 start to the pandemic response.

15 In her statement for this module, Rivka Gottlieb
16 vividly explains how she took up this mantle:

17 "There was no room for my grief, but I was very
18 angry at the circumstances surrounding my father's
19 death, and I swore that I would not rest until the
20 government's mishandling of the early days of the
21 pandemic had been exposed, examined, and those
22 responsible held accountable. I was deeply concerned
23 and distressed at what I saw as repeated failures as the
24 pandemic continued with wave after wave. I felt as
25 though I was watching a car crash in slow motion over

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1 and over again. The subsequent loss of life following
 2 the first wave felt devastating as nothing was being
 3 learned."

4 Rivka went on to explain that she is:

5 "... haunted by the implications of Covid grief and
 6 by the knowledge that, had lockdown been called one week
 7 earlier, my father's life -- and that of so many in
 8 subsequent waves -- may have been saved."

9 The impact on Matt, Jo and Rivka, was therefore not
 10 simply bereavement but anger at the circumstances. This
 11 was not only a natural disaster, but one contributed to
 12 by human failure, which left them with what another
 13 bereaved family member was to describe as an open wound.

14 Earlier lockdowns did, of course, occupy the
 15 attention of the Inquiry in Module 2, but Rivka's
 16 evidence follows this through with the impact on her and
 17 many, many others of the knowledge of what might and
 18 should have been.

19 Additionally, the bereavement of the families has
 20 been exacerbated by conspiracy theorists, and Covid
 21 deniers. And in the last couple of years, there's been
 22 something of a backlash from some politicians and
 23 commentators in parts of the media arguing against
 24 lockdowns and other substantial deviations from normal
 25 life that were imposed during the heights of the

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1 pandemic. This politicisation of emergency
 2 interventions such as lockdowns, mask wearing and travel
 3 restrictions, has again exacerbated the trauma of loss.

4 The position of the families has always been
 5 unequivocal on this point. No one is an advocate for
 6 interfering with the normal freedoms of life. No one
 7 welcomes lockdowns. But a public emergency of the scale
 8 of Covid made such interventions necessary and crucial.

9 The point isn't whether lockdowns were good or
 10 lockdowns were bad; the impact evidence from both the
 11 bereaved and others, without equivocation, emphasises
 12 that there were substantial negative effects on mental
 13 health, the provision of ordinary services for older
 14 people, and those with particular needs, and family life
 15 and freedom of movement, but that emphasis only
 16 underlines the conclusions already reached by this
 17 Inquiry: that if the UK had reacted more swiftly, if it
 18 had had preparedness and planning that was fit for
 19 purpose, then measures such lockdowns and similar
 20 interventions would have been able to be shorter and
 21 more focused, as in certain other countries. Indeed,
 22 some lockdowns and similar interventions may have been
 23 avoided altogether. Not only would many lives have been
 24 saved by earlier decisive action, but the other negative
 25 impacts of those interventions would have been minimised

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1 too.

2 So the evidence to be heard in Module 10 will elicit
 3 the impact not only of the pandemic itself, but of the
 4 failures of response that we've learned from earlier
 5 modules. It will also highlight factors resulting in
 6 disparities of outcome, as helpfully set out yesterday
 7 by Kate Blackwell, King's Counsel, and Ms Rahman, King's
 8 Counsel, today.

9 To borrow from the Joseph Rowntree Foundation: we
 10 may have been in the same storm, but we were not all in
 11 the same boat.

12 Covid Bereaved Families for Justice UK is well
 13 placed to comment on disparities, because its membership
 14 is not only spread across the whole of the UK but it's
 15 very diverse indeed. It has bereaved family members
 16 from the many different ethnic communities across the
 17 country and people from a wide range of cultural and
 18 religious heritages and beliefs, people with clinical
 19 vulnerabilities, those themselves suffering from Long
 20 Covid, people with physical difficulties, people with
 21 mental ill health. Some are young, some are older, men,
 22 women, people of different sexualities and various
 23 lifestyles, key workers of various types, professors,
 24 engineers, teachers, unpaid carers, the unemployed,
 25 people who are retired, the well heeled and the

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1 economically challenged. All devastated by a disease
 2 which could and did affect us all, but not impacted in
 3 the same ways.

4 In earlier modules this Inquiry has already heard
 5 evidence that some disparities of outcome occurred by
 6 chance or from the characteristics of the virus itself.
 7 But many were the consequences of structural and
 8 institutional discrimination of various kinds, or
 9 occurred because of existing inequalities. The
 10 statistics noted by Ms Blackwell did not occur by mere
 11 probability.

12 This module will hear both individual accounts of
 13 impact but also expert evidence regarding inequality and
 14 discrimination. We hope it will underline and emphasise
 15 that proper policy must not adopt a colour blind or, as
 16 Ms Blackwell quoted from one report, a one-size-fits-all
 17 approach.

18 Putting it bluntly, pretending we are all the same
 19 means ignoring the needs of diverse communities and of
 20 poverty. It means that those who are vulnerable, not
 21 only because of clinical needs or disabilities of
 22 various sorts, but also through discrimination and
 23 economic inequality, will continue to be underserved.

24 Solving structural discrimination is, of course,
 25 beyond the terms of reference. However, recognising it,

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1 and recognising that it must be considered and mitigated
 2 in preparedness and planning, is not.

3 Professor Nazroo, in one of his reports for this
 4 module, also comments that, beyond recognition of
 5 structural discrimination, combating institutional
 6 discrimination is easier, at least in concept, because
 7 it relates to existing bodies with human and
 8 institutional structures, through which such
 9 discrimination can be directly challenged.

10 Counsel to the Inquiry has already highlighted the
 11 lack of data regarding ethnicity at the time of the
 12 pandemic. Without data, the institutions were not in
 13 a position to recognise their right own institutional
 14 failings in this regard, and disparities of outcome and
 15 impact followed. This is a simple example of what needs
 16 to change.

17 A key theme of family members regarding impact was
 18 summed up by Matt Fowler in Module 1. He said:

19 "Those that we lost, we lost without dignity."

20 Andrew Langford of Cruse notes that Covid
 21 bereavement was symptomatically more complex and
 22 challenging for the bereaved to deal with in terms of
 23 the initial impact and then the ongoing ramifications.

24 The predominant features of information communicated
 25 to Cruse by bereaved people included anger and guilt

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1 relating to the circumstances of death and isolation.
 2 The inability to carry out mourning rituals left people
 3 bereft.

4 Restrictions on visitation and contact after
 5 admission to institutions is a pervasive issue,
 6 highlighted by almost all of the Covid Bereaved Families
 7 for Justice members who contributed to the
 8 organisational statement provided by Rabinder Sherwood.

9 Katherine Poole describes ongoing guilt at the fact
 10 that her father, who had been enduring mental health
 11 problems and had been on a section when he contracted
 12 Covid, was unable to see him for a month prior to his
 13 death.

14 Naomi Fulop asserts that it is a source of great
 15 pain to her that she was unable to be with her mother
 16 when she died.

17 Many have highlighted the lack of communication
 18 prior to death, both with their loved ones after
 19 admission to hospital and with clinicians. The lived
 20 experience evidence of bereaved families is visceral in
 21 this regard.

22 Jane Wier-Wierzbowska, in Module 6, spoke about an
 23 open-ended trauma, a wound that won't close, guilt that
 24 won't abate, regarding the death of her mother, isolated
 25 from her in a care home for ten months due to visiting

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1 restrictions.

2 Linda Dinsdale gave evidence in Module 6 that she
 3 was utterly traumatised by the knowledge that her
 4 daughter, Cheryl, had died alone and frightened
 5 in a nursing home.

6 Lynn Goulding lost her husband, Charles, with whom
 7 she had not spoken since his admission. She describes
 8 being stuck in the grieving process due to the lack of
 9 information and insight she was given into her husband's
 10 death, and the lack of control she had over the events
 11 as they happened.

12 Rabinder Sherwood herself will give evidence of the
 13 inadequate care both of her parents received in the
 14 period leading up to their deaths, just ten days apart.
 15 She relates pressure to sign DNACPRs, use of the matrix
 16 that was referred to yesterday, inadequate information
 17 supplied to the family, and a consequent belief that
 18 each of her parents died alone and scared.

19 Rabinder comments that many bereaved family members
 20 who contributed to the organisational statement said
 21 that they had residual feelings of guilt, and were left
 22 wondering whether they could have done more, but the
 23 reality was that poor information flows and visiting
 24 restrictions had prevented that.

25 The huge challenges of the emergency obviously

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1 stretched the limits of what was achievable by
 2 hard-pressed services and staff, but the impact was
 3 nevertheless severe.

4 Had problems of isolation and communication been
 5 foreseen, as they should have been, then it may well
 6 have been possible to deploy measures and resources to
 7 mitigate those problems and impacts.

8 The Inquiry has already heard a significant amount
 9 of evidence regarding DNACPRs and advanced care. You
 10 will, no doubt, recall Susan Sullivan's case as set out
 11 so powerfully before you by her late father, John.
 12 Others too, Glen Grundle has described his experience of
 13 DNACPR with respect to his mother Milda, and Katherine
 14 Poole only discovered after her father's death that he
 15 was subject to such a notice. These are issues which
 16 have left lasting upset and trauma.

17 Family members have recalled with distress the
 18 shortcomings in the way that they and their loved ones
 19 were treated after death, how they were ushered out
 20 quickly and with belongings in a plastic bag.

21 Others, including Katherine Poole, have recounted
 22 that they were unable to see their loved ones after
 23 death. Josephine Hanlon from Glasgow was particularly
 24 distressed by the fact that her partner, Ernie, was
 25 buried in a body bag.

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1 All three of our Covid Bereaved Families for Justice
 2 members' statements raise the issue of mourning rituals.
 3 Rabinder Sherwood tells of the difficulty of honouring
 4 the rituals of the Sikh religion in the face of the
 5 restrictions and in place. Her mother was not allowed
 6 to be buried with her 5Ks, Sikh symbols she had worn in
 7 life.

8 Isolation, and the lost opportunity of bringing
 9 people together to celebrate the life of the departed
 10 are repeated themes. Rivka Gottlieb relates that her
 11 father did not have a fitting send-off in compliance
 12 with Jewish mourning rituals that had led to a lack of
 13 closure.

14 As already recognised, a common complaint is the
 15 lack of consistency and clarity in guidance around
 16 funerals, a point which surely should be solved for the
 17 future, in terms of planning. 40% of those responding
 18 to a consultation conducted by the UK Commission on
 19 Bereavement who wanted bereavement support did not
 20 get it.

21 Clare Farnsworth was one of those who sought support
 22 but was unsuccessful. Existing charities were
 23 overwhelmed and there was a lack of government
 24 provision. Dr Royston says Covid exacerbated existing
 25 deficits, deficits which were, once again, foreseeable.

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1 Many families report difficulties in experienced in
 2 accessing information after death. Glen Grundle's
 3 statement in particular raises these issues: poor access
 4 to hospital and nursing or care home records is
 5 a recurring complaint.

6 And furthermore, there is both concern and confusion
 7 about post-death investigative processes with inquests
 8 largely ruled out, and an absence of accessible
 9 processes as being encountered where families believed
 10 that there were serious failures in care.

11 Clare Farnsworth has raised the question: did
 12 concerns regarding the coroner's system becoming
 13 overwhelmed in the pandemic lead to cases where there
 14 were significant concerns, such as hospital acquired
 15 Covid being overlooked?

16 Rabinder Sherwood and Rivka Gottlieb make the point
 17 mentioned by CTI yesterday that the broader impacts of
 18 rule breaking at government level, such as Partygate,
 19 has exacerbated hurt and grief with a widespread belief
 20 that there was one rule for them and another for
 21 everyone else.

22 This has created a culture of low confidence in
 23 government and damaged confidence in institutions and
 24 public life in general. This has not only made loss
 25 greater, but made the bereaved fear that in the future

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1 compliance with public health measures may well be less.
 2 We urge the Inquiry to make practical and direct
 3 recommendations to promote change for the future, given
 4 that most of the impacts that will be evidenced in these
 5 hearings were foreseeable and are plainly seen now.

6 Given the limitations of time, we'll set out
 7 proposed recommendations, if we may, in our closing
 8 submissions.

9 We do not minimise the huge challenges a health
 10 emergency brings, but failures next time can be averted
 11 by action now. Among the failures that this Inquiry has
 12 heard evidence, the failure to prevent and mitigate the
 13 human impacts are clear. So is the mantra: planning and
 14 preparedness and proper resourcing is all.

15 Thank you.

16 **LADY HALLETT:** Thank you very much indeed, Mr Weatherby, I'm
 17 very grateful.

18 Mr Bindman, I think you're next.

19 **Submissions on behalf of Bereaved Families for
 20 Justice Northern Ireland by MR BINDMAN**

21 **MR BINDMAN:** Thank you, my Lady.

22 My Lady, in an early communication to other members
 23 of the Northern Ireland Covid Bereaved Families for
 24 Justice, Martina Ferguson and Brenda Doherty wrote:

25 "We can't change the past. We wish we could. We've
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1 lived, loved, and lost during this pandemic. It's been
 2 a truly heartbreaking time for us all and we understand
 3 grief can be a very lonely journey. That is why we are
 4 channeling all our efforts to try and help to make
 5 a difference in the future."

6 Those sentiments remain as true today as they did
 7 when they were written years ago.

8 Like the other Covid Bereaved Families for Justice
 9 from across the United Kingdom, the Northern Ireland
 10 Covid Bereaved Families for Justice is grateful for the
 11 opportunity it has been given in this module to tell the
 12 Inquiry of the impact the Covid pandemic has had on them
 13 and Northern Irish society as a whole.

14 As we said in our written submissions, of course the
 15 Inquiry has heard about the impact of the pandemic from
 16 the beginning of Module 1, and in each module since, and
 17 by this stage can be in no doubt about the pervasive and
 18 enduring nature of the pandemic for the most vulnerable,
 19 for the bereaved, for key workers, and for those whose
 20 mental health and wellbeing avenues suffered as a
 21 result.

22 It is therefore right that the Inquiry finishes its
 23 work by returning its focus directly and specifically to
 24 the impact of the pandemic and the response to it upon
 25 the population. Because it is that impact which gives

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1 significance to the Inquiry's work and which makes it so
 2 important that lessons are learned for the future.

3 It will be apparent to your Ladyship from the
 4 written statements and submissions that the Northern
 5 Irish Bereaved Families have lodged with you that the
 6 inevitable grief of people who lost loved ones during
 7 the pandemic has very frequently been exacerbated by
 8 a feeling that "Had we been better prepared, had things
 9 been done differently, then not only might individual
 10 loved ones still be with us but society a whole would
 11 not have suffered the damage that it did."

12 Something that your Ladyship's conclusions already
 13 reached suggest is correct.

14 In the report into understanding grief in Northern
 15 Ireland during the pandemic prepared by the Cruse
 16 Bereavement Services, and that report will be adduced
 17 into evidence in due course, it highlights that there
 18 remains a palpable sense of anger amongst many of the
 19 bereavement in Northern Ireland, that they followed
 20 guidance in good faith whilst others, including those in
 21 power, did not; and regret that their loved ones died
 22 alone as a result.

23 In Northern Ireland, as in Great Britain, the
 24 Inquiry will once again hear about the harm caused by
 25 the disempowerment of family carers, the excruciating

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1 emotional pain caused by the absence of information
 2 about loved ones, the provision of inadequate and
 3 impersonal care, the continuing effects of which still
 4 dominate the thoughts of many, many of the families that
 5 we represent.

6 We heard from Anne Elliott in the impact film that
 7 Northern Ireland has a very strong tradition of wakes
 8 and funerals and how it, to quote her, breaks her heart
 9 that she feels she wasn't able to pay her brother the
 10 respect he deserves because of the restrictions placed
 11 on those normal grieving rituals. However, like so many
 12 of those in the Northern Ireland Covid Bereaved Families
 13 for Justice, Anne's thoughts are not just for herself
 14 but that, although everyone knows it to be otherwise,
 15 somehow, she has let Basil down.

16 This unwarranted sense of guilt has, I'm afraid,
 17 been compounded by the way an overstretched and
 18 unprepared system sometimes appeared to deal with those
 19 who had lost loved ones in the aftermath of their loss.
 20 Thus, Anne, like many of the others in our group, has
 21 spoken of the anguish caused by the fact that she never
 22 got her brother's personal effects from the hospital
 23 after he died.

24 Hazel Gray, on the other hand, did get her parents'
 25 personal property back, but in orange bags marked "For

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1 incineration only".

2 Your Ladyship will understand why she describes this
 3 as an absolute insult and feels that a vet would have
 4 had a better understanding of returning property to an
 5 animal's owner.

6 Pat and Katie Louden have come forward to describe
 7 how their husband and father, Derek, had his wedding
 8 ring taken off him whilst he was ventilated. His only
 9 wish had been to be buried with his wedding ring, but
 10 the hospital refused to return it back the night he died
 11 because of a protocol. The Loudens never even got
 12 Derek's phone back even though it obviously contained
 13 important and irreplaceable memories, and its loss
 14 interfered with their ability to obtain closure.

15 Trevor Patterson has described how following the
 16 death of his older brother Samuel, the family was
 17 advised to allow the incineration of Samuel's
 18 possessions, with the result that they lost virtually
 19 all of his belongings save for his father's ring.

20 The Inquiry has already heard similar accounts from
 21 Julie McMurray, who was only told that her husband's
 22 belongings had been located in a phone call, about seven
 23 months or so after his death. And Catriona Myles, who
 24 was devastated to find her father Gerry McLarnon's
 25 belongings returned in almost the same form as it had

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1 been sent. Pyjamas, underwear, and robe unworn, and
 2 toiletries unopened, she believes because Covid patients
 3 were put into paper gowns and wore nappies so as to cut
 4 down on human contact.

5 To add to their torment they do not know to this day
 6 whether their wish that a family photograph to be placed
 7 in his coffin was ever allowed.

8 Only time prevents me from giving more and more such
 9 examples. What is all too common however, is that not
 10 only did these failures cause inevitable but unnecessary
 11 distress but that all too often, even when families
 12 tried to investigate why these wrongs had occurred, they
 13 reasonably felt that they were met with faceless
 14 bureaucracy rather than efficiency or even sympathy.

15 Northern Ireland Covid Bereaved Families for
 16 Justice therefore urges the Inquiry to look closely at
 17 the impact of how both hospitals and care homes return
 18 the belongings of loved ones who have died both because
 19 families deserve care, dignity, and basic humanity at
 20 every stage of the bereavement process but also because
 21 it really should not be beyond the wit of a 21st century
 22 healthcare system to prepare and make sure that these
 23 casual cruelties are never again repeated, whatever the
 24 future may throw at us.

25 In a similar vein, Anna Smith has reported that she
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1 had to ultimately instruct a solicitor to get her
 2 mother's medical records after they were initially
 3 provided only partially, and the fact that she could not
 4 make a complaint to the Information Commissioner
 5 seemingly because the data she sought related to someone
 6 who was deceased. Like other group members, including
 7 Glen Grindle from whom the Inquiry will hear in person,
 8 she felt, and continues to feel, a helplessness in
 9 relation to the inability to recover information
 10 regarding her mother's death.

11 These indignities and the experience of death and
 12 bereavement caused and continue to cause painful scars
 13 on the lives of those we represent. Anyone who has ever
 14 lost someone they dearly loved knows you comfort
 15 yourself with final memories, loving goodbyes,
 16 collective mourning and treasured possessions. For many
 17 of those in our client group, those things were denied
 18 and in their place came guilt, trauma, and a lack of
 19 closure.

20 Whilst our group recognises the extreme and
 21 unprecedeted pressure those charged with the care of
 22 their loved ones were under, it must be the case that in
 23 any future pandemic, the extraordinary cost to those who
 24 will be left behind of denying basic dignity and family
 25 support in someone's last weeks must be front and centre

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1 in any decisions on how to manage the response.

2 Partly to that end, and to try to make a difference
 3 in the future, one of the things members of Northern
 4 Ireland Covid Bereaved Families for Justice would like
 5 to see are documented or enshrined rights for the
 6 bereaved in relation to funerals and access to
 7 bereavement support which can only be set aside in the
 8 most exceptional of circumstances.

9 Finally, my Lady, members of the Northern Ireland
 10 Covid Bereaved Families for Justice would like to take
 11 this opportunity of recognising that whilst they lost
 12 loved ones during the pandemic, many other people
 13 suffered in different ways, whether it be because of the
 14 mental health stresses you will hear about in this
 15 module, the heroic efforts required of essential
 16 workers, or the daily dangers faced by the most
 17 vulnerable, including the clinically and clinically
 18 extremely vulnerable. To this end, they will adopt in
 19 their closing submissions many of the observations made
 20 by non-bereaved Core Participants, including the need
 21 for structural and process contingencies around
 22 childcare for essential workers, support for the
 23 mentally ill and vulnerable and their families, but
 24 would simply like, at this stage, to thank the many,
 25 many individuals who did their best to mitigate the

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1 disastrous impact of many aspects of the pandemic and
 2 the governmental and medical responses to the pandemic
 3 which were both wrong and avoidable.

4 Thank you, my Lady.

5 **LADY HALLETT:** Thank you very much indeed, Mr Bindman.

6 Mr Stanton.

7 **Submissions on behalf of Covid-19 Bereaved Families for
 8 Justice Cymru by MR STANTON**

9 **MR STANTON:** Thank you, my Lady.

10 My Lady, the eight priority issues of Covid-19
 11 Bereaved Families for Justice Cymru in this module are
 12 as follows: first, the lack of bereavement support, both
 13 formal and informal.

14 The group's collective experience is of an almost
 15 total absence of formal bereavement support in Wales
 16 during the first 18 months of the pandemic, at a time
 17 when it was most needed, with death and grief on an
 18 unprecedented scale in isolating circumstances, and
 19 without the ability to carry out normal religious and
 20 cultural practices.

21 Treatment plans were practically non-existent, and
 22 when counselling was sought, families were often told
 23 they were not ready because they were still grieving and
 24 to seek counselling outside of the NHS.

25 Health bodies gambled on bereavement modelling that

1 suggested most people would recover from grief with no
 2 or minimal intervention but this failed to take into
 3 account the exceptional circumstances and huge loss of
 4 life experienced during the pandemic.

5 The Cymru Group recognises the pressures that were
 6 placed on health service. However, it is precisely in
 7 such a crisis that adequate and effective bereavement
 8 support is most needed, and the resources in place
 9 during the pandemic were wholly inadequate.

10 In addition to the absence of a structured
 11 framework, many families found interactions immediately
 12 after death to be impersonal and disrespectful with
 13 personal property returned soiled, important items such
 14 as wedding rings missing, or else returned accompanied
 15 by alarming warnings that they might still be infected
 16 which caused some families to destroyed treasured
 17 keepsakes.

18 The bodies of some deceased relatives were lost,
 19 sometimes for weeks, within overwhelmed morgue systems,
 20 which added trauma to grief.

21 Taking account of the failures identified with both
 22 the provision of structured bereavement support and also
 23 with basic interactions immediately following death, the
 24 group commends the recommendation within the 2022 report
 25 of the UK Commission on Bereavement that the

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1 professional bodies and employers of anyone whose role
 2 brings them into contact with bereaved people must
 3 ensure that adequate bereavement training is provided,
 4 and this needs to include the circumstances of
 5 bereavements arising from hospital acquired infections
 6 which have particular features and challenges.

7 Second, visiting and funeral restrictions.

8 Visiting restrictions in hospitals and care homes
 9 were one of the most painful and damaging aspects of the
 10 pandemic for bereaved families. Vulnerable patients,
 11 many elderly, spent long periods entirely alone, without
 12 family support and advocacy, and for many, this
 13 prolonged isolation contributed to a marked
 14 deterioration in their health and to their death.

15 Families describe lasting guilt, believing they did
 16 not try hard enough to visit and to return their loved
 17 ones home. Some even describe feelings that the NHS had
 18 kidnapped their relative. These feelings of guilt
 19 intensified when later evidence revealed just how
 20 dangerous hospital and care home environments were.

21 A recurring theme is the absence of patients or
 22 resident advocates within clinical and care settings to
 23 facilitate communication between parents and their
 24 families. One patient, who was himself gravely ill with
 25 a nosocomial Covid-19 infection, spent the night trying

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1 unsuccessfully to contact the family of another dying
 2 patient. Ultimately, he could do nothing more than sit
 3 with them during their final hours.

4 The rules governing visits felt arbitrary and
 5 irrational. Families recount situations where patients
 6 with mobility were able to meet relatives outside or in
 7 hospital concourses before returning to their wards,
 8 while bedridden patients were denied visitors entirely.

9 There was also widespread variability in
 10 PPE requirements and IPC compliance, which caused many
 11 families to question the rules.

12 Funeral restrictions were inhumane and a national
 13 disgrace. They have left huge numbers of people
 14 permanently scarred, and almost every family bereaved
 15 over the pandemic speaks of the trauma of this
 16 experience and how there was an inability to properly
 17 honour and mark the death of their loved one.

18 These experiences include the separation of families
 19 and friends, with difficult decisions having to be made
 20 about who was able to attend and travel together, and of
 21 curtailed and disrespectful services.

22 Evidence disclosed by the Inquiry shows that funeral
 23 and visiting restrictions are the most common adverse
 24 impacts reported by bereaved families. Given the
 25 profound and widespread damage caused by visiting and

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1 funeral restrictions, the Cymru Group is concerned to
 2 ensure that there is genuine learning from this painful
 3 experience. The group is troubled that while some
 4 witnesses acknowledge the need for flexible and
 5 sensitive approaches in the future, the serious harms
 6 that were caused do not appear to have been fully
 7 recognised.

8 The group firmly believes that future approaches
 9 should be premised on an understanding that there will
 10 be no restrictions on funerals, except where it is shown
 11 that the risks to public health cannot be managed
 12 through reasonable and proportionate measures such as
 13 PPE and ventilation.

14 The poor standards of IPC in our hospitals and
 15 care homes is a longstanding and serious failure that
 16 was the cause of far too many deaths. Denying families
 17 access to their loved ones did little to alleviate these
 18 dangerous conditions, but it did cause profound
 19 emotional harm to both patients and families that,
 20 again, could and should have been avoided through
 21 appropriate and adequate PPE and ventilation.

22 Third, the bereaved were not provided with adequate
 23 information about the circumstances in which their loved
 24 ones died. The unprecedented loss of life and the
 25 lonely and isolated circumstances in which many people

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1 died meant that there was more need than ever to explain
 2 the circumstances in which a death occurred.

3 However, just as with bereavement services and
 4 funerals, when need was at its greatest, the existing
 5 systems and services were found badly wanting, leaving
 6 many families feeling powerless and completely in the
 7 dark about what had happened in their loved one's final
 8 moments.

9 Complaints processes were lengthy, confusing, and
 10 traumatic, and many complaints would have been avoided
 11 altogether had there been adequate and timely
 12 communication in the first place.

13 The families wish to emphasise that by seeking
 14 answers, they are not looking to blame exhausted
 15 healthcare workers who did their best under extreme
 16 pressure. They simply want to understand how their
 17 loved ones died, given that they were kept away and
 18 uninformed.

19 The absence of this information has created a vacuum
 20 which, out of necessity, many desperate families filled
 21 with their own narratives, leading in some cases to
 22 false narratives taking hold, which can be very hard to
 23 shift.

24 Many other families found the process so difficult
 25 they could not continue, and instead have tried to learn

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1 to live with the fact that they will never know,
 2 constantly wondering: what if?

3 The Cymru Group is critical of the lack of inquests,
 4 particularly where the facts indicated systemic
 5 failures, such as cluster outbreaks in hospitals and
 6 care homes in which large numbers of residents died
 7 following the transfer of untested hospital patients.

8 The lack of transparent and thorough investigations
 9 has left a burning sense of injustice, and this includes
 10 the failure of the Welsh national nosocomial
 11 investigation into deaths from hospital-acquired
 12 Covid-19, which was a huge missed opportunity to provide
 13 the bereaved families in Wales with much needed answers
 14 and closure.

15 It's hard to overstate the importance of nosocomial
 16 infection for the group. So many members described
 17 their sense of dread when a loved one was admitted to
 18 hospital unconnected to Covid-19, and the feeling of
 19 inevitability that they would become infected and die,
 20 which tragically happened in so many cases.

21 Fourth, the deprioritisation of older people and
 22 a lack of dignity in death. It is acknowledged that
 23 this issue was addressed in detail within Module 6,
 24 however, the group wishes to briefly raise it again in
 25 the context of bereavement. The elderly were most

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1 seriously impact by Covid-19, yet, despite having made
 2 the biggest contribution to the fabric of our society,
 3 they were abandoned and deprioritised in their time of
 4 need.

5 For bereaved families to know that their elderly
 6 loved ones died while lonely, scared and confused,
 7 without adequate and appropriate treatment, without
 8 adequate pain relief and hydration, and with decisions
 9 taken without consent, such as treatment plans and
 10 DNACPR notices, only compounds their grief.

11 The pandemic caused and allowed thinking, even among
 12 some healthcare professionals, that elderly people were
 13 dispensable. This collective failure should never be
 14 allowed to happen again.

15 Fifth, photography of sick, dying, and deceased
 16 patients. One of the most shocking revelations for
 17 families was to discover that one health board had
 18 authorised extensive photography of patients, including
 19 the dying and the dead. Thousands of images were later
 20 published in books, websites, social media, media
 21 outlets, and even displayed for sale in galleries. Some
 22 images depicted semi-naked intubated patients or
 23 body bags and identifiable personal belongings.

24 One patient was filmed by a news channel whilst he
 25 was being treated with CPAP oxygen. His family saw this

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1 on TV with no discussion or prior warning given.

2 Within another family there is uncertainty whether
 3 a published image shows their dying husband and father,
 4 with some family members thinking it does and others
 5 not, which has caused unnecessary trauma.

6 The group is doubtful that such serious and invasive
 7 breaches of patient confidentiality and privacy can be
 8 justified by the public interest in recording the
 9 pandemic. And given the deep distress caused to so many
 10 families, the Inquiry is asked to consider the impact of
 11 this practice.

12 Sixth, inadequate memorials and remembrance.

13 National moments of reflection and memorials are
 14 powerful ways to validate feelings of grief, promote
 15 healing, and foster a sense of unity. They also serve
 16 as a reminder of the importance of community and shared
 17 humanity. However, the absence of an official national
 18 Covid-19 memorial in Wales and the inadequacy of
 19 remembrance events has angered families.

20 As one group member put it:

21 "By not organising a proper memorial or place of
 22 remembrance in Wales, the sheer way they are trying to
 23 brush it under the carpet like it never happened, is an
 24 insult to us all."

25 The National Covid Memorial Wall in London is

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1 a fitting memorial, and many group members have found
 2 tremendous comfort through contributing to, and visiting
 3 it.

4 The Cymru Group continues to campaign for a similar
 5 memorial at the Senedd in Cardiff, and the group feels
 6 strongly that this process ought to be led by the Welsh
 7 Government on behalf of the people it represents.

8 Seventh, ongoing impacts on wellbeing and mental
 9 health.

10 The enduring adverse impact of the pandemic on the
 11 mental health of the general population, of which
 12 evidence will be heard later this week, comes as no
 13 surprise to the group's members. Many bereaved continue
 14 to experience anxiety and depression from the experience
 15 of losing a loved one in such terrible circumstances,
 16 requiring ongoing medication, therapy, and other
 17 treatments.

18 As already mentioned, a very common experience of
 19 bereaved families is a feeling of guilt and not doing
 20 more or trying harder for a loved one. Feelings of
 21 guilt are also experienced by people who blame
 22 themselves for passing on an infection to a loved one,
 23 including, sadly, by children who have bottled up these
 24 feelings and find it very difficult to talk about.

25 The failure to be there when a loved one died, as so

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1 many promised they would, but were unable to keep, and
 2 to say a proper goodbye, continues to haunt bereaved
 3 families, and has caused huge problems in processing
 4 grief.

5 Finally, the failure to learn lessons and a lack of
 6 accountability. A big part of the reason why bereaved
 7 families came together and continued to campaign is to
 8 effect change to prevent others from ever having to go
 9 through the trauma they have experienced. However, to
 10 see the lack of improvement, with waiting lists still
 11 double pre-pandemic levels, healthcare estates that
 12 remain inadequate, that testing capability and capacity
 13 has not been maintained, and still woefully inadequate
 14 IPC and PPE, leaves them with a sense of futility.

15 By way of example, my Lady, the most recent
 16 available data from February shows that 79% of current
 17 inpatient Covid-19 cases in hospitals in Wales were
 18 hospital acquired.

19 Similarly, the failure of the Welsh Government to
 20 properly explain and to take responsibility for their
 21 actions during the pandemic has given rise to
 22 overwhelming anger and frustration, exacerbated grief,
 23 and prolonged the bereavement process for members of the
 24 Cymru Group.

25 Thank you, my Lady.

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1 Bereaved are grateful to the Chair and to the Inquiry
 2 for that opportunity. The Scottish Bereaved have learnt
 3 that, whilst each death has had its own unique impact,
 4 many of the experiences, impacts and traumas are shared
 5 throughout the United Kingdom.

6 The Inquiry has heard, and will no doubt hear again,
 7 of the emotional impact of losing a loved one to
 8 Covid-19 on family members. Of the financial hardships
 9 which arose as a result. Of decisions made in London
 10 and Edinburgh leading to Covid entering nursing homes
 11 and care homes and hitting the most vulnerable. Of
 12 inconsistent irrational rules around visitation. Of
 13 being forced to make the almost impossible decision
 14 between being with a loved one in their final moments or
 15 being present at their funeral. Of later finding out
 16 that DNACPR notices had been put in place without
 17 a family knowing. Of the lack of death rituals, the
 18 lack of opportunity to say goodbye to their loved ones.

19 All these impacts and many more continue to be felt
 20 by the bereaved.

21 While this module is focused on the pandemic's
 22 impacts rather than the decisions taken, both before and
 23 during it, the Scottish Covid Bereaved consider that
 24 it's those decisions which have either caused or
 25 exacerbated impacts felt. Though governments, NHS and

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1 **LADY HALLETT:** Thank you very much indeed, Mr Stanton.
 2 Ms Mitchell.
 3 Sorry, Mr Wagner, were you expecting to go next?
 4 **MR WAGNER:** I think I wasn't. I don't know. I thought
 5 I was fifth but I probably -- (overspeaking) --
 6 **LADY HALLETT:** Story, you stood up. So unless anyone needs
 7 to get away?
 8 **MR WAGNER:** No.
 9 **LADY HALLETT:** Okay, Ms Mitchell.

10 **Submissions on behalf of Scottish Covid Bereaved by DR
 11 MITCHELL KC**

12 **DR MITCHELL:** I'm instructed by Aamer Anwar on behalf of the
 13 Scottish Covid Bereaved.

14 As the Second World War fades from living memory,
 15 the pandemic has been the most single most emotionally,
 16 socially and economically impactful event of most of our
 17 lives. It changed the way that we work, the way that we
 18 learn, how we access our healthcare system, it has
 19 affect the nation's finances, which has and will have
 20 a significant impact on all of us.

21 The Covid-19 pandemic has left no part of our lives
 22 untouched. Of the very many impacts, the greatest has
 23 fallen on those who have lost loved ones.

24 Throughout the course of the inquiry, the voices of
 25 the bereaved have been heard. The Scottish Covid

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1 scientific bodies may not be core participants in this
 2 module, the Scottish Bereaved consider that they would
 3 be well served to give Module 10 their close attention.

4 The voices of the bereaved, and through them the
 5 deceased, deserve to be heard by them.

6 The Scottish Bereaved note, as we approach the sixth
 7 anniversary of the pandemic reaching these shores, that
 8 our bereaved who are still waiting on a decision from
 9 the Crown Office and Procurator Fiscal Service as to
 10 whether their loved one's death will be the subject of
 11 a fatal accident inquiry or a criminal prosecution.
 12 While the bereaved note that over 6,000 deaths have been
 13 reported to the Crown, families are having to wait far
 14 too long on knowing what is happening in relation to
 15 their loved one's death, and inevitably even longer to
 16 find out answers that they have desperately been
 17 seeking.

18 This delay and uncertainty continues to have an
 19 impact on the bereaved.

20 In this module, perhaps more than any other, the
 21 voices of the bereaved will speak far more loudly and
 22 far more eloquently than submissions or any expert can.
 23 The Scottish Bereaved look forward to taking part in
 24 this module, giving their evidence in the hope that it
 25 will assist the Inquiry and my Lady fulfil the terms of

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1 reference.

2 These are the submissions of the Scottish Covid
3 Bereaved.

4 **LADY HALLETT:** Thank you very much indeed for your help,
5 Ms Mitchell. Very grateful.

6 Now, Mr Wagner.

7 **Submissions on behalf of Clinically Vulnerable Families by**
8 **MR WAGNER KC**

9 **MR WAGNER:** Thank you.

10 My Lady, good morning -- or good afternoon. I act
11 for Clinically Vulnerable Families, alongside
12 Hayley Douglas and Margherita Cornaglia, and we are
13 instructed by Kim Harrison and Shane Smith of
14 Slater & Gordon.

15 In this module, CVF will give a voice to a group
16 which continues to be impacted by both the virus itself,
17 and the UK's response to it, but who have been largely
18 forgotten since the inaptly named "Freedom Day". One of
19 the ways it will do so will be through the statement of
20 CVF founder Lara Wong, which will be followed by her
21 oral evidence next week, and I won't attempt to
22 summarise that statement here but commend it to you and
23 to the public.

24 As the Inquiry has progressed, CVF has distilled its
25 overall position into three basic principles: safety,

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1 support and status. And that's how I'll structure my
2 submissions today.

3 First, safety.

4 In order to keep those who are most vulnerable, to
5 Covid-19 and to other pathogens, safe, physical
6 environments must be made safer and more resilient to
7 outbreaks of infectious diseases. For clinically
8 vulnerable people and households, the impact of the
9 pandemic is ongoing, and this is because many indoor
10 environments remain unsafe against infectious diseases,
11 particularly where transmission is airborne.

12 The withdrawal of protections associated with
13 Freedom Day and living with Covid policies, did not
14 necessarily go alongside a reduction of risk for those
15 with heightened susceptibility to severe disease.
16 Instead, those policy decisions shifted responsibility
17 from systems to individuals, in circumstances where
18 people lacked the tools to assess their risk and protect
19 themselves effectively.

20 This is especially important in relation to shared
21 indoor air, where structural measures such as
22 ventilation, filtration, occupancy, and respiratory
23 protection, over which individuals have very little
24 control or specialist knowledge, determine whether an
25 environment is safe far more than individual behaviours.

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1 This is a fundamentally important point for CVF, and
2 I want to put it metaphorically in neon lights in these
3 submissions. Clinically vulnerable individuals cannot
4 reliably make themselves safe in indoor settings. The
5 responsibility falls on those who control the
6 environment, such as employers, those who run cultural
7 settings, indeed this Inquiry itself.

8 This especially applies to structural factors like
9 ventilation and policies, and until the people who take
10 control -- sorry, until the people who control the
11 environments take responsibility, or who are forced to
12 take responsibility by governments, clinically
13 vulnerable people will simply not be safe. They cannot
14 pull themselves up by their own bootstraps, and should
15 not be expected to, no more than other people with
16 protected characteristics.

17 To pick up on the analogy, Mr Weatherby KC borrowed
18 from the Joseph Rowntree Foundation, we were all in the
19 same storm, but not all in the same boat.

20 Clinically vulnerable people in unsafe workplaces,
21 social environments and the like, are in a leaky boat
22 without any way of bailing out the water, and it should
23 not be their responsibility to build a safer boat,
24 especially while they are in it.

25 Just to give some examples which reflect the topics
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1 being investigated in these modules -- in this module.
2 First, in the workplace, the absence of enforceable
3 rights to Covid-related adjustments continues to leave
4 clinically vulnerable people exposed to danger. There's
5 been a regular refrain during the pandemic, often
6 repeated in this Inquiry by witnesses, that clinically
7 vulnerable people were fearful or nervous or anxious to
8 return to the workplace.

9 It's very important to CVF that the genuine risk to
10 clinically vulnerable people is not made out to be
11 a pathology.

12 And this is part of the point I've put in neon
13 lights. There is a genuine risk, because many indoor
14 environments are unsafe for clinically vulnerable
15 people. Safety at work is determined by real
16 objectively measurable factors such as system design.
17 This includes ventilation density, access to
18 respirators, access to remote work, the availability of
19 sick pay. It's not merely about individual resilience.

20 Similarly, in healthcare environments, the removal
21 of universal masking and the absence of consistent
22 airborne infection control deter high-risk patients from
23 accessing necessary care. This leads to delays,
24 cancellations, and the deterioration of health
25 conditions, as CVF's polling and member accounts show,

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1 and you have heard, my Lady, from CVF in Module 3.

2 In cultural settings, the Inquiry's cultural
3 institutions roundtable summary report says that it's
4 been -- there has been a variable retention of
5 protections in cultural settings. It says:

6 "Representatives described sustained changes in
7 audience behaviour after reopening, and highlighted that
8 clinically vulnerable and older audiences were less
9 confident about returning, particularly for live events
10 in indoor settings."

11 But they were less confident because it was unsafe.

12 CVF's witness evidence records exclusions from
13 public and cultural life as protective measures were
14 withdrawn. And again, clinically vulnerable people
15 cannot reliably make themselves safe and shouldn't be
16 expected to.

17 Faith communities provided online and outdoor
18 services that were particularly valuable to vulnerable
19 congregants, but many of those were taken away and
20 barriers to safe participation persist. One CVF member
21 reported that, and I quote:

22 "Our church refused to consider improving
23 ventilation due to perceived discomfort for other
24 worshipers, which was prioritised over the safety needs
25 of vulnerable people. We offered to fundraise for HEPA

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1 filters to make the worship space safe for elderly and
2 vulnerable people, but the PCC obstructed this. They
3 prioritised the comfort of others over our safety, even
4 knowing that our son had nearly died from Covid. It was
5 a moral injury."

6 This emphasis on comfort, my Lady, really comes down
7 to a cultural issue, that people do not necessarily see
8 the issues that clinically vulnerable people face, and
9 therefore they don't expect to have to make any
10 accommodation for them. And that will not change unless
11 the culture changes.

12 Finally, in the justice system, as in-person
13 hearings resumed, CVF members reported reduced
14 flexibility for remote attendance and pressure to remove
15 masks, including in circumstances of severe
16 immunosuppression or significant caring
17 responsibilities.

18 And in detention and asylum settings, people with
19 clinical vulnerabilities were often placed in
20 accommodation without adequate screening or infection
21 control.

22 Staying on safety, another theme which unites all of
23 these topics is that stigma and hostility intensify the
24 risks faced by clinically vulnerable individuals. And
25 this goes back to the point I was making about culture.

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1 That stigma and hostility compounds the harms,
2 especially to mental health. CVF's polling found
3 a rising proportion of respondents reported mask-related
4 harassment since 2022. Those reports increased from 48%
5 in September '22 to 65% in January '24.

6 CVF members describe being pressured by others to
7 remove have their masks, and that they face verbal or
8 physical aggression when adopting self-protective
9 measures. The key workers' roundtable summary reports,
10 my Lady, report abuse directed at public-facing staff
11 around enforcement of protections.

12 This stigma and hostility to clinically vulnerable
13 people has to stop, but instead, it seems to be getting
14 worse. And again, it goes back to culture.

15 That's why CVF will invite the Inquiry to recommend
16 that public messaging clearly explains the protective
17 benefits of high-grade masks for the wearer and the
18 community, and explicitly recognising the right to wear
19 masks in public services and workplaces. And CVF will
20 also ask the Inquiry to recommend regulatory guidance,
21 for example by the Equality and Human Rights Commission,
22 that discourages blanket prohibitions and supports
23 simple proportionate adjustments.

24 And on safety recommendations, CVF's overarching
25 position is the only way to make clinically vulnerable

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1 people safe in society is structural change. Infection
2 control must become a priority in healthcare and public
3 services. Indoor air quality should be regulated in the
4 same way that other important issues of public health
5 are, with CO2 and air filtration standards, effective
6 monitoring, and enforcement for buildings that fail to
7 meet these standards.

8 Essential systems, from courts to accommodation in
9 prison settings, for example, must incorporate
10 adjustments as a matter of course. They should not be
11 special privileges, they are minimum conditions for
12 equal access to society for those whose elevated risks
13 are well established.

14 CVF's second main theme is support. Clinically
15 vulnerable individuals and households experienced the
16 pandemic harms more severely and more persistently than
17 the general population, but the support response did not
18 reflect this reality. CVF's evidence, including its
19 2025 Impact on Society Survey, shows that risks and
20 barriers, such as unsafe health environments, lack of
21 tailored mental health support, and weak employment
22 protections, and persistent social exclusion, converged
23 with clinical vulnerability, and the effect was to
24 deepen disadvantage.

25 CVF's submission is that future planning should
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1 prioritise targeted support for clinically vulnerable
 2 people across all of the domains that Module 10
 3 examines, which are, in essence one domain, which is the
 4 social environments which clinically vulnerable people
 5 have to operate in to live a normal life.

6 In this module, CVF will highlight a number of
 7 thematic issues identified by the Inquiry in its
 8 provisional list of issues, and are set out in more
 9 detail in our written submissions.

10 First, that the mental health and wellbeing impacts
 11 on clinically vulnerable people were distinctive in
 12 about the severity and duration, and they continue to be
 13 felt, which all demonstrates the urgent need for
 14 support.

15 Second, financial stress and job insecurity which
 16 were often interrelated for clinically vulnerable
 17 households, was a recurring theme.

18 Third, intersecting vulnerabilities amplified
 19 impacts for clinically vulnerable people.

20 To give a couple of examples, survivors of domestic
 21 abuse experienced heightened coercive control during the
 22 pandemic with clinical risk weaponised to limit
 23 movement, deny access to care and support, and to
 24 isolate victims.

25 And, clinically vulnerable people within the
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1 immigration and asylum system, or in prisons or other
 2 places of detention, faced acute risks from settings
 3 where they had to congregate without adequate screening
 4 or protective measures.

5 And so, CVF will seek to persuade the Inquiry that
 6 support for clinically vulnerable people across each of
 7 the Module 10 thematic areas must be anchored in the
 8 realities experienced by clinically vulnerable people.

9 Finally, status.

10 There were significant issues at the height of the
 11 pandemic around the correct identification of those who
 12 were particularly vulnerable to Covid-19. You've
 13 already heard from CVF in previous modules about the
 14 issues of making a distinction between clinically
 15 extremely vulnerable and clinically vulnerable in
 16 relation to the support that was offered to CEV but not
 17 CV, and for some, that designation came to an end
 18 prematurely.

19 How can we prevent these issues occurring again? As
 20 the Module 1 report said, preparation is everything.
 21 But it's all very well saying that we should prepare
 22 better next time, you simply cannot prepare without
 23 adequate data.

24 Data was not collected during the pandemic to
 25 properly capture clinical vulnerability and the
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1 experience of clinically vulnerable people. For
 2 example, surveys carried out often did not collect data
 3 on clinically vulnerable groups, and Professor Majeed
 4 has said in his statement to this module that clinically
 5 vulnerable populations relied on fragmented primary care
 6 records leading to gaps in real-time monitoring, and
 7 your systemic evidence review my Lady, also identified a
 8 lack of sufficiently detailed or disaggregated data on
 9 CV/CEV groups.

10 And CVF has sought to fill this gap but as a tiny
 11 charity, it's unable to do so across the board. And
 12 steps must be taken, we say, to address the gaps in
 13 data, including routinely disaggregating data by
 14 factors, including clinical risk groups.

15 And CVF very much supports Recommendation 9 of the
 16 Module 2 report that the UK Government and devolved
 17 administrations should agree a framework to identify
 18 those at most risk of being infected and dying from
 19 a disease, and the potential impact mitigation steps
 20 will have on those groups. But CVF requests in this
 21 module the Inquiry goes further: to protect CV people,
 22 not just during pandemics but in peacetime too, when
 23 infectious disease in public settings is still
 24 a serious, life-limiting issue for clinically vulnerable
 25 families.

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1 And finally, CVF, again, implores the Inquiry to
 2 consider recommending that clinical vulnerability
 3 becomes a protected characteristic in the Equality Act,
 4 a huge structural gap which will go some way towards
 5 changing the culture and also the reality of social
 6 settings for clinically vulnerable people.

7 And, in parallel, the Equality and Human Rights
 8 Commission should update its statutory Codes of Practice
 9 to reflect the importance of protecting clinically
 10 vulnerable people.

11 In conclusion, there are no easy answers to the
 12 issues identified in this module or indeed this Inquiry,
 13 but if you focus, my Lady, on safety, support and
 14 status, that will go a long way to protecting clinically
 15 vulnerable families now and in the future.

16 **LADY HALLETT:** Thank you very much indeed, Mr Wagner. Very
 17 helpful.

18 Ms Beattie, would you like to take us up to lunch?

19 **Submissions on behalf of Disabled People's Organisations by**
 20 **MS BEATTIE**

21 **MS BEATTIE:** My Lady, we act for three national Disabled
 22 People's Organisations, or DPO, run by and for disabled
 23 people.

24 They are Disability Rights UK, Inclusion Scotland,
 25 and Disability Action Northern Ireland.

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1 In opening, DPO make five points about impact on
 2 society, and what it is hoped the Inquiry can learn
 3 through this final module.

4 First, socioeconomic disadvantage. The DPO take as
 5 their starting point your Ladyship's previous report
 6 findings that although the pandemic affected everyone in
 7 the UK, the impact was not shared equally, and that
 8 prior to 2020, the pandemic preparedness of governments
 9 was biased towards biomedical advice and did not include
 10 socioeconomic advice, or indeed any socioeconomic
 11 perspective.

12 As the Inquiry has found, it should have been
 13 obvious from the outset that disabled people faced
 14 a higher risk of dying from Covid-19. That risk
 15 manifested in the numbers which many people may still
 16 not know: that six out of the ten Covid dead were
 17 disabled people.

18 Likewise, it should have been obvious that disabled
 19 people would experience, in unequal measure, the impact
 20 of lockdowns and other restrictions, food insecurity,
 21 difficulty accessing medicines and a range of health and
 22 therapeutic services, limited access to everyday
 23 personal assistance and support, and digital exclusion.

24 In seeking a dominant reason as to why that was so
 25 obvious, your Ladyship adopted the conclusion of

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1 Professor Sir Michael Marmot's report, published
 2 10 years before the outbreak of Covid-19, that
 3 biological health is strongly influenced by the
 4 "conditions in which people are born, grow, live, work
 5 and age."

6 This module will underscore that this is what came
 7 to pass.

8 Covid-19's greatest impact lesson is that we live in
 9 staggering conditions of health inequity. Mass death
 10 and uneven distribution of suffering occur not because
 11 of biomedical factors but by the synergy of those
 12 factors with the unequal distribution of socioeconomic
 13 factors, including poverty, overcrowded, inadequate and
 14 unsuitable housing, low-paid and precarious employment,
 15 social security payments that have deliberately not kept
 16 pace with price increases, and generationally degraded
 17 systems of social care, all of which disproportionately
 18 affect disabled people.

19 Second, impact and intersections. The Module 2
 20 report made the point which, despite being obvious,
 21 bears repeating: disabled people are not a homogeneous
 22 group and should not be treated as such. And yet the
 23 Inquiry has repeatedly encountered lack of
 24 consideration, understanding or even basic knowledge
 25 about the diverse situation of disabled people.

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1 Overall, this amounted to a profound revelation that
 2 through data deficiency and otherwise, the UK lacks
 3 comprehension of its human geography.

4 It does not know its people, and if you do not know
 5 your people, you cannot make policy for and with them.

6 To correct these failures, DPO commend an
 7 understanding of the social model which recognises that
 8 many of the hardships which disabled people face are
 9 determined by social, economic and political choices,
 10 and an understanding of intersectionality.

11 This identifies how disability, together with other
 12 personal and socioeconomic characteristics, leads to
 13 multiplied barriers and deepened marginalisation.

14 Intersectional analysis also reveals how overlapping
 15 characteristics create distinct and unique risks of
 16 marginalisation and harm, especially when policy
 17 responses and interventions fail to understand them.

18 DPO give multiple examples: disabled LGBTQ+ people
 19 might not have the same support from families that other
 20 disabled people enjoy, but unlike non-disabled people,
 21 they also might not have access to a friendship group to
 22 support them either.

23 Migrant disabled people might face distinct problems
 24 with digital access or be particularly compromised in
 25 their care by replacement careworkers who do not speak

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1 their language or know their culture.

2 And lockdown raises risks of abuse for women and
 3 girls, but it is particularly dangerous for disabled
 4 people who are non-verbal or who cannot physically leave
 5 home without the assistance of their abusive carers.

6 Your Ladyship has already made findings about the
 7 need for equality disaggregated data. That much is
 8 known. But Module 10 is an opportunity to deepen the
 9 understanding of intersectional impacts and to learn,
 10 especially from those with lived expertise, how to fill
 11 the data and research vacuums so that policy making is
 12 effective and responsive to the whole person.

13 Third, deaths and accountability.

14 We know that across the UK, disabled people were far
 15 more likely to die from Covid-19 than non-disabled
 16 people. And people with Down's syndrome and other
 17 learning disabilities could be up to or even over 30
 18 times more likely to die from the virus. But beyond
 19 these statistics, there was never a point in the
 20 pandemic when government and public authorities properly
 21 scrutinised the detail of these deaths in terms of their
 22 relevant impairments and circumstances, let alone
 23 examine their preventability.

24 Rather than continuing or even enhancing the
 25 reporting and investigation of deaths of disabled

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1 people, at a moment when people were dying in dependent
 2 situations outside hospitals in numbers unknown in
 3 living memory, the formal reporting of deaths reached
 4 a historic low.

5 The various health and care monitoring bodies did
 6 not necessarily inspect and did not prioritise site
 7 visits, and if deaths were reported, the holding of
 8 inquests was minimised without the anxious scrutiny
 9 which was warranted by these unparalleled circumstances.

10 The outcome, as recounted by the Covid Bereaved
 11 Families for Justice and others, was a failure of
 12 accountability to disabled people who were bereaved, to
 13 non-disabled people who were grieving the deaths of
 14 their disabled loved ones, and to disabled people more
 15 generally. It was they who were more at risk from dying
 16 from Covid, of having care withdrawn because of DNACPR
 17 decisions or use of the clinical frailty scale, or being
 18 denied treatment due to systems collapsing or
 19 unconscious bias or both, and with carers and advocates
 20 arbitrarily shut out from visiting, regardless of
 21 circumstance.

22 The legacy is a terrible human cost for those denied
 23 the opportunity to establish truth so that a person can
 24 properly begin to grieve it. When one adds to that how
 25 mourning rituals were interrupted, counselling was not

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1 available, and for disabled people, there could be
 2 additional physical and communication barriers even to
 3 finding out about the death of those close to them, or
 4 attending a funeral either face-to-face or remotely.
 5 Then we have disabled people unequally discriminated
 6 against in dying, and in bereavement.

7 And people have suffered from these exceptionally
 8 aggravated interferences with grief to the point of
 9 being disabled by them.

10 Fourth, acute isolation. Not simply that which
 11 public health measures demanded of everyone, but
 12 isolation of a different magnitude and depth altogether,
 13 which, as the DPO explain, left disabled people in
 14 dangerous, scary and undignified situations.

15 Isolation at home, where disabled people were
 16 already known to be at greater risk of domestic abuse
 17 and where the pandemic, including lockdown and NPIs,
 18 provided further ways for perpetrators to abuse disabled
 19 people.

20 Isolation of disabled people living in inadequate
 21 and inaccessible housing, who felt trapped in parts of
 22 their homes, and some of whom became entirely housebound
 23 because of inaccessibility and withdrawn support,
 24 exacerbating pre-existing physical and mental
 25 ill health.

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1 Enforced isolation in places of detention, including
 2 marked isolation with communication deprivation in
 3 prison, increased involuntarily mental health detention
 4 and easement of statutory safeguards around detention
 5 and treatment under the Mental Health Act.

6 Isolation of disabled workers required to work from
 7 home due to Covid, or who struggled to have necessary
 8 reasonable adjustments implemented by their employers.

9 And isolation of deaf people who were in some cases
 10 unable to communicate with anyone during periods of
 11 lockdown, and in the absence of British Sign Language
 12 interpretation, were left out of conversations about
 13 their own lives, including discussions about DNACPR, and
 14 left unable to access financial support and benefits,
 15 food, medicine and services.

16 Fifth, and finally, choices. Your Ladyship has
 17 already found that when it became clear that specific
 18 groups of disabled people were at even greater risk from
 19 Covid, this ought to have been acted upon and mitigated
 20 swiftly. The other choices that could have been made
 21 and could be made represent DPO's hope for the future.

22 First and foremost, the failure of the government to
 23 acknowledge the importance of disabled people's rights
 24 and the failure to do enough to protect those rights has
 25 to end. The Inquiry knows the position. When told that

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1 the UK should implement the Convention on the Rights of
 2 Persons with Disabilities, the government maintained
 3 that the rights under the Convention were already
 4 systematically considered and met by existing laws,
 5 which this Inquiry knows is not the case.

6 When challenged over the manifest inequalities,
 7 government witnesses referred to equality laws and to
 8 such equality impact assessments as were undertaken, but
 9 these were formulaic, not consulted upon with
 10 representative groups and bore many gaps.

11 For DPO, the continued oversight of Convention
 12 rights underlines the need for the Convention to be
 13 incorporated into UK law, together with properly
 14 resourced independent monitoring of compliance.

15 Second, the failure to observe the legal
 16 requirements of existing equality laws and standards on
 17 accessibility underlines the need for new
 18 accessibility-focused legislation to embed accessibility
 19 across all aspects of life.

20 Whilst the pandemic removed in some areas what has
 21 been described as inertia about accessibility, many of
 22 the innovations that made some cultural events, services
 23 and experiences more accessible to disabled people are
 24 now being cut. In addition, full accessibility should
 25 not be mistaken for a switch to remote and digital

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1 provision, which can compound problems for disabled
 2 people and even limit accessibility, particularly given
 3 disproportionate digital exclusion.

4 The time and money saved by remote access can be
 5 alluring, but it can also be disabling. It remains
 6 essential that people have choice in the modes in which
 7 support is delivered to them, including that they retain
 8 access to face-to-face services, treatment and care
 9 wherever possible.

10 Finally, my Lady, on co-production. The Inquiry has
 11 recognised that those charged with making decisions that
 12 would profoundly affect disabled people needed ready
 13 access to expert advice, including advice informed by
 14 disabled people themselves. By this stage in its work,
 15 the Inquiry has evidence from multiple DPO and other
 16 civil society groups whose insights and networks could
 17 have been harnessed in this crisis but were not.

18 Advice informed by disabled people themselves
 19 requires effective and properly funded co-production
 20 with disabled people and intersectional support
 21 organisations and DPO. How government works has to
 22 change. The state has to see its people as equal
 23 partners in policy building rather than as passive
 24 recipients.

25 My Lady, DPO return to their starting point in this
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1 Inquiry, and to what has been learned about the
 2 vulnerability of emergency systems. For systems to
 3 become resilient, there needs to be a fundamental
 4 investment in collective resilience, and for disabled
 5 people, far greater understanding of the social model
 6 and of intersectional experiences that mean that certain
 7 societal groups are far more marginalised than others.

8 Those are choices that could be made, so that
 9 disabled people survive, and live in dignity amidst
 10 a crisis. Thank you, my Lady.

11 **LADY HALLETT:** I'm very grateful. Very helpful, as ever,
 12 Ms Beattie.

13 Thank you very much. I think probably we'll break
 14 now; it's been an hour and a quarter since we had our
 15 morning break. So I shall return at -- we'll have an
 16 extra five minutes -- 1.50.

17 (12.46 pm)

18 (The Short Adjournment)

19 (1.50 pm)

20 **LADY HALLETT:** No one caught out that time.

21 Ms Sergides.

22 **Submission on behalf of the DA GROUP by MS SERGIDES**

23 **MS SERGIDES:** Afternoon, my Lady. Can you hear me okay,
 24 my Lady?

25 **LADY HALLETT:** I can, thank you.

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1 **MS SERGIDES:** As the Inquiry is aware, the DA Group
 2 comprises three organisations. You're already familiar
 3 with the work of the Southall Black Sisters (SBS) and
 4 Solace Women's Aid (SWA) from Module 2. The third
 5 organisation is the Latin American Women's Rights
 6 Service (LAWRS), a by and for organisation supporting
 7 survivor-victims of domestic abuse. The Inquiry will
 8 hear from Gisela Valle, director of LAWRS, who will give
 9 evidence on behalf of all three organisations.

10 The DA Group welcomes the findings of Module 2,
 11 which concluded that the government's response to the
 12 virus was too little, too late. This was particularly
 13 apparent in the government's failure to adequately plan
 14 for the widely anticipated consequence of lockdown:
 15 a significant increase in both the scale and severity of
 16 domestic abuse.

17 As recognised in Module 2, these risks were
 18 foreseeable and indeed obvious.

19 Over the next three weeks the Inquiry will hear
 20 evidence of the impact of government failures and will
 21 focus on the lessons that must be learnt, on what
 22 changes would make a material difference in any future
 23 pandemic. In considering that evidence, we invite the
 24 Chair to bear the following points in mind: firstly,
 25 domestic abuse affected different groups of victim

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1 survivors in different ways, with a particularly severe
 2 impact on black and minoritised victim-survivors,
 3 migrant victim-survivors and disabled women.

4 Vulnerabilities and forms of discrimination rarely
 5 exist in silos. Rather, the ways in which
 6 victim-survivors experienced and responded to domestic
 7 abuse varied according to their intersecting identities
 8 and circumstances.

9 Secondly, Module 10 presents an opportunity for the
 10 Inquiry to examine, in practical terms, what would have
 11 made a real difference on the ground, for
 12 victim-survivors and the organisations supporting them.
 13 It is an opportunity to shed light on the many ways in
 14 which lockdown and the pandemic enabled perpetrators to
 15 continue and escalate abuse, including through novel
 16 forms of coercive control, whilst simultaneously
 17 restricting access to help, support, and routes to
 18 safety for victim-survivors.

19 We hope that, having heard this evidence, the
 20 Inquiry will make recommendations to ensure that, in any
 21 future pandemic, the foreseeable increase in the scale,
 22 severity and forms of domestic abuse, across all groups
 23 of victim-survivors, recognising the different impacts
 24 and different needs, is effectively mitigated.

25 Turning briefly to the evidence. The reports and
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1 data from the violence against women and girls sector,
 2 official statistics and personal accounts all contained
 3 in the DA Group's Rule 9 witness statement, as well as
 4 those publicly available, demonstrate a clear and
 5 sustained increase in domestic abuse throughout the
 6 lockdown period.

7 In March 2020, SWA recorded a 117% increase in calls
 8 to its advice line, with the highest peak in demand for
 9 its services occurring in September 2020. Both
 10 increases occurred in anticipation of lockdown.

11 Overall calls to SWA's two London advice hubs
 12 increased by 62%. As Ms Rahman KC said this morning,
 13 between April and June 2020, SPS experienced a 138%
 14 increase in calls to its advice line.

15 In November 2020, LAWRS had recorded its highest
 16 number of new domestic abuse cases, more than double the
 17 number in February 2020.

18 As reported in the domestic abuse roundtable, that
 19 rise was attributable, insofar as it is possible to
 20 know, to increased opportunities for existing
 21 perpetrators and instances of people who had previously
 22 never experienced domestic abuse seeking support. These
 23 significant trends were mirrored across the wider sector
 24 yet they were not reflected in reports to the police.

25 Where there were increased reports of domestic abuse
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1 to the police, these were almost entirely driven by
 2 third-party calls, often from neighbours who had
 3 Internet or overheard abuse through walls and gardens.

4 This raises a stark question, my Lady: why were so
 5 many women afraid to contact emergency services
 6 themselves during this period?

7 Further, the evidence consistently demonstrates not
 8 only a rise in the volume of domestic abuse, but also
 9 a marked increase in its complexity, and severity.
 10 Lockdown was unrelenting. There were few, if any,
 11 moments when perpetrators and victim-survivors were
 12 apart. The conditions of confinement, combined with
 13 heightened stress and isolation created an environment
 14 in which abuse could escalate unchecked and take new
 15 insidious forms.

16 Children were no longer partially protected by
 17 school attendance and were forced to witness domestic
 18 abuse. Access to and use of technology essential for
 19 work, education and support was tightly controlled by
 20 perpetrators, and healthcare, while available to some,
 21 remained inaccessible to many.

22 In the words of Pooja(?), supported by SWA, "The
 23 pandemic gave him more control because of not being able
 24 to go outside. It gave him more power to use. It
 25 inflated his ego, that he had this power and there was
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1 no threat of calling the police or leaving".

2 And in the words of Gemma, "He kept saying he would
 3 leave but kept using the pandemic as an excuse not to.
 4 The physical abuse escalated before I left with
 5 strangling. During the pandemic he started to sexually
 6 assault or rape me. There was also financial abuse.
 7 I felt very unsafe as I was trapped with my abuser.
 8 I couldn't go out to places to be safe away from him,
 9 I had to constantly placate him and negotiate with him."

10 LAWRS received more frequent reports of sexual
 11 violence, including marital rape and forced pregnancy
 12 with limited access to birth control. One LAWRS staff
 13 member recalls a case where the victim-survivor's
 14 husband, who previously drank only in the evenings,
 15 began drinking from morning until night and would rape
 16 her nightly.

17 Lockdown and domestic abuse did not affect all
 18 victim-survivors equally. Different groups experienced
 19 these harms in profoundly different ways. The reality
 20 is that existing structural inequalities amplified the
 21 suffering of the most marginalised groups, leaving them
 22 to endure even harsher and more harmful experiences
 23 throughout lockdown as the expert reports to this
 24 Inquiry confirm.

25 In respect of children, the Women's Aid Shadow
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1 Pandemic Report found that 53% of adult victim-survivors
 2 said their children were witnessing more domestic abuse
 3 whilst 38% said their abuser had shown increased abusive
 4 behaviour directed towards children.

5 Without the protected oversight of schools, GPs and
 6 social services, there was a greater need for mothers to
 7 protect their children whilst ever more vulnerable
 8 themselves.

9 Pre-pandemic, women from black or minoritised
 10 backgrounds were already most likely to experience
 11 domestic abuse including disproportionately experiencing
 12 particular forms of domestic abuse. Imkaan noted in
 13 their report, titled "The Impact of the Dual Pandemics:
 14 Violence Against Women and Girls and Covid-19 on Black
 15 and Minoritised Women and Girls", that violence against
 16 women and girls increased for black and minoritised
 17 women and girls, racialised discrimination and the
 18 disproportionate impact of structural inequalities also
 19 became exacerbated.

20 Those in the LGBTQ+ community were also at greater
 21 risk of domestic abuse. As described by Professor
 22 Bécares, domestic abuse and hostile behaviour at home,
 23 including feeling uncomfortable being themselves, being
 24 neglected and harassed by family and/or housemates who
 25 did not accept them, pronouns not being respected, and a
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1 lack of understanding and/or empathy about their
 2 experiences had a negative impact on respondents' mental
 3 health, compounding experiences of isolation and
 4 loneliness.

5 In respect of migrant victim-survivors, the domestic
 6 abuse commissioner has described the concept of
 7 immigration abuse, widely recognised in the sector as
 8 "a form of perpetration that uses the insecure,
 9 uncertain, or unknown immigration status of an
 10 individual or their dependents to threaten, coerce,
 11 exploit and/or subjugate them or their dependents as
 12 part of a pattern of control and/or abuse and violence."

13 Immigration abuse is used against migrants whose
 14 immigration status is insecure and against those who
 15 have secure status but are subject to a condition of
 16 no recourse to public funds.

17 The abuse feeds off the context of the hostile
 18 environment, government policy that pre-dated the
 19 pandemic and continues uninterrupted to the present day.

20 The impact during the pandemic was that migrant
 21 victim-survivors were deterred from seeking healthcare,
 22 including Covid-19 testing and treatment, and were
 23 afraid to seek help for domestic abuse due to fear of
 24 being reported to the Home Office or facing destitution.

25 The DA Group will submit that having heard evidence
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1 of the potentially large numbers of migrant
 2 victim-survivors affected by the combination of the
 3 hostile environment, the pandemic, and domestic abuse,
 4 the Inquiry must recommend that key aspects of the
 5 hostile environment, particularly healthcare charging,
 6 information sharing and restriction on access to public
 7 funds, be suspended in any future pandemic to ensure
 8 these individuals can access life-saving support and
 9 protection no matter what their status.

10 Such suspension would be an essential public health
 11 measure, allowing victim-survivors in future pandemics
 12 to seek support, obtain healthcare, and escape their
 13 abusers.

14 As set out in the expert reports, disabled
 15 victim-survivors were already 3 to 4 times more likely
 16 to experience domestic abuse prior to the pandemic.
 17 Lockdown, and the reduction of social care services
 18 forced many disabled people into even greater dependence
 19 on their perpetrators.

20 Refuge accommodation was often inaccessible to
 21 wheelchair users while reliance on technology excluded
 22 those with learning difficulties, cutting them off from
 23 vital support.

24 The DA Group's experience is that the pandemic led
 25 to a perfect storm of psychological distress for
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1 victim-survivors because of intensified abuse, isolation
 2 from support networks, and reduced access to mental
 3 health services. The combination of increased scale,
 4 severity, new forms of abuse, and the difficulties in
 5 obtaining support have led to prolonged, long-term
 6 effects on survivors' mental health which continue
 7 today.

8 You will also hear of the impact on service
 9 providers including their inability to meet surging
 10 demand, or to offer suitable emergency refuge
 11 accommodation.

12 During the pandemic, victim-survivors required clear
 13 assurances of safety and stability before they could
 14 leave their homes, yet in the context of overwhelming
 15 demand and services weakened by years of underfunding
 16 and dismantling, such assurances were often impossible
 17 to give. The DA Group will submit that in any future
 18 pandemic, the government must act swiftly to make empty
 19 properties available for emergency accommodation without
 20 making access contingent on benefit applications.

21 The success of the Everyone In scheme shows that it
 22 is possible where there is the will.

23 Listening to, and understanding the experience, of
 24 the sector, particularly those working on the front
 25 line, responding to victim-survivors' complex and
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1 multi-faceted needs is essential in order to formulate
 2 the most effective recommendations for future pandemics.
 3 That sector must be properly funded and supported if it
 4 is to be utilised.

5 This Inquiry, my Lady, is in a unique position.
 6 Across its ten modules, it has drawn on evidence from
 7 every part of society and institution and considered
 8 a wide range of issues. At its heart, however, are the
 9 lived experiences of individuals. For victim-survivors,
 10 those experiences were frightening, persistent, and have
 11 left long-lasting trauma.

12 This Inquiry has the power to place that evidence on
 13 the public record and, in so doing, to offer hope that
 14 the recommendations it makes will meaningfully reduce
 15 harm in any future pandemic.

16 It is also hoped that those recommendations are
 17 accompanied by clear caution. Without implementation,
 18 they are useless -- valueless.

19 I end with words from Raina, a victim-survivor
 20 supported by SPS:

21 "Covid was, for me, was not less than a nightmare.
 22 There were constant fights because of him being around
 23 all the time. It made me so anxious. I was living
 24 a nightmare without end."

25 I'm grateful, my Lady.
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1 **LADY HALLETT:** Thank you very much indeed for your help.

2 Now it's Ms Weeraratne. I thought you were over
3 there.

4 **Submissions on behalf of the Migrants' Rights Consortium by**
5 **MS WEERERATNE KC**

6 **MS WEERERATNE:** I'm over here, thank you so much.

7 Can you hear me? I think I'm --

8 **LADY HALLETT:** I can, thank you.

9 **MS WEERERATNE:** My Lady, I represent the Migrants' Rights
10 Consortium, or MRC, along with Rowena Moffatt and
11 Lameesa Iqbal. We're instructed by the Public Interest
12 Law Centre, and Myriam Naoual and Melissa Kizito are
13 here today.

14 My Lady, explaining the experiences of migrants and
15 how they were impacted by the pandemic, largely through
16 being intentionally excluded from essential protective
17 services, is a complex and nuanced task, and by these
18 opening remarks, we seek to highlight the central themes
19 which we say are relevant to this Inquiry's work. The
20 detail is addressed in our Rule 9 evidence and in our
21 written opening submission.

22 In its Module 2 report, as has already been
23 identified by other opening statements, the Inquiry has
24 recognised that the impact of the pandemic was unequal
25 throughout our society. There were certain groups at

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1 greater risk of contracting Covid-19, and often there
2 were groups who were already vulnerable through social
3 and economic marginalisation prior to the pandemic.

4 In that Module 2 report, the Inquiry found that the
5 government well understood that some groups, such as
6 members of certain ethnic minorities, were more
7 vulnerable to the virus than others, and that the
8 position of these groups was not considered adequately
9 or sufficiently speedily by the government.

10 There's no consideration in that report of the
11 impact on migrants specifically, and no sufficient
12 evidence of the thinking about risks to migrants at the
13 time.

14 Migrant voices have been represented in Modules 3 and 4
15 and 6, on healthcare, vaccination and social care. Our
16 task, in Module 10, is to ensure that the severe impact
17 on migrant communities, which was foreseeable and
18 distinct from that on ethnic minority groups, which
19 received perfunctory risk assessment, if any, and
20 ineffective mitigation, is recognised by this Inquiry as
21 being important to the wider public health risks and the
22 health of the population as a whole.

23 It was foreseeable and distinct for one simple and
24 readily identifiable reason, which is that, for
25 migrants, their pre-existing vulnerability was, in many

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1 essential respects, structurally embedded in our
2 services, through immigration law and policy.

3 To summarise complex immigration law, migrants are
4 subject to immigration control not only if they are
5 undocumented or in the asylum system or refugees, but
6 even if they have some status in the UK.

7 Many people subject to immigration control were and
8 are deliberately excluded from essential health and
9 welfare services, and may also be subject to no recourse
10 to public funds, or NRPF. It is this group of excluded
11 migrants that the MRC is most concerned about.

12 This suite of exclusionary immigration law and
13 policies is often referred to as the "hostile
14 environment". Deliberate and hostile because these
15 measures were aimed at creating hardship for migrants,
16 making it difficult to work, access services and basic
17 necessities such as food, with the intention of
18 deterring migrants. It included severe restrictions and
19 checks on the right to work, to rent accommodation, to
20 have a bank account, to access benefits and receive free
21 treatment from the NHS.

22 These exclusionary measures quite obviously do not
23 apply to people who are British born or, more broadly,
24 those who have acquired British nationality.

25 And this difference is significant because the

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1 pandemic's impact on these excluded migrant groups was
2 distinct and devastating as a result. And yet, let's
3 not forget that some of those who were affected by this
4 deliberately exclusionary policy were courted and
5 invited by our governments to address essential job
6 vacancies unfilled from within the UK, for example,
7 doctors, healthcare assistants, nurses, care assistants,
8 or in public transport and delivery.

9 During the pandemic, these migrants were more often
10 than not the frontline workers. They constituted a good
11 proportion of those who were clapped on Thursdays during
12 the pandemic. They worked for the nation. The
13 wide-ranging and heightened impacts on migrants are not
14 capable of easy summary. Many are distinct to the
15 overlapping or shared vulnerabilities, as with some
16 ethnic minority groups, and were identified by CTI
17 Ms Blackwell King's Counsel in her opening yesterday.

18 This is because as -- there are special risks
19 associated with targeted immigration law and policy that
20 predated the pandemic. They amplified the impact of the
21 pandemic on migrants in at least three ways. First, by
22 inclusion from mainstream welfare provision, resulting
23 in *inter alia* higher risks of destitution, poverty, and
24 infection with the virus. Secondly, by exclusion,
25 whether directly or indirectly, from essential public

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1 and private services, including healthcare services, as
 2 a result of a legal regime aimed at making life as
 3 uncomfortable as possible for those who do not have
 4 leave to remain in the UK. And thirdly, by subjection
 5 to immigration control, requiring lawful status to
 6 remain in the UK resulting in heightened insecurity and
 7 uncertainty during the pandemic, including increased
 8 vulnerability in employment, and reduced access to
 9 financial support, and which, in certain circumstances,
 10 meant administrative detention.

11 It is this legal and policy context, therefore, that
 12 is crucial also to the understanding of the evidence
 13 that demonstrates disproportionate impacts on migrants.
 14 In short, there were unassessed but foreseeable impacts
 15 which led to disproportionate mortality and infection
 16 rates and other unequal impacts for migrant people.

17 Figures on mortality rates are particularly stark.
 18 A study in the Health Service Journal in April 2020
 19 found that 83% of BAME deaths in a cohort of health and
 20 social care workers were born outside the UK. The
 21 research has concluded that migration should therefore
 22 be considered alongside ethnicity by way of explanation
 23 for these deaths.

24 And this reflects other research showing that, for
 25 example, Filipinos working within the NHS represented an

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1 estimated 22% of deaths in NHS nurses, while comprising
 2 only 3.8% of the nursing staff population.

3 Such figures cannot be ignored and mean that this
 4 Inquiry must investigate and explore the reasons for
 5 these dramatic impacts.

6 As with all other vulnerable groups represented in
 7 this module, migrant groups want to have their specific
 8 experiences during the pandemic understood and taken
 9 account of for the future. This is not to undermine the
 10 experiences of others, but to spotlight the experiences
 11 of this continually marginalised group in our society.

12 In terms of societal impacts, the MRC urges the
 13 Inquiry to assess the distinct experiences of migrants
 14 without conflating them with those of ethnic minorities
 15 more broadly. Because in spite of overlaps, to do so is
 16 wrong as a matter of principle, but also could
 17 potentially result in a missed opportunity to identify
 18 and address the experiences of the group that played
 19 a crucial part through the pandemic, but also suffered
 20 acutely, with obvious knock-on effects to public health
 21 policy at this time of crisis.

22 To that end, we've produced extensive evidence by
 23 way of Rule 9, and set out recommendations for the
 24 future. Our written opening endeavours to distil our
 25 position into four key findings that we invite the

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1 Inquiry to make. These are, firstly, that migration
 2 status is a special and distinct risk factor, amplifying
 3 pre-existing vulnerability during the pandemic in ways
 4 separate to ethnic minority status.

5 Secondly, that migrants who were subject to
 6 immigration control during the pandemic suffered
 7 negative impacts due to specific and targeted government
 8 policies, limiting access to protective and life-saving
 9 measures, for example access to healthcare, benefits,
 10 housing, adequate and equal protections at work.

11 Thirdly, that, as a result, there were distinct
 12 risks from this during the pandemic for migrants,
 13 firstly reflected in the impacts on health, housing,
 14 financial insecurity and similar, and secondly,
 15 disproportionate infection and mortality rates.

16 And fourthly, that to avoid undermining the wider
 17 public health pandemic response and amplifying the
 18 negative impact of the pandemic on all, a key mitigation
 19 to this impact on migrants is to prioritise public
 20 health over immigration enforcement.

21 There is ample evidence, we say, before this Inquiry
 22 to support these findings. It will not take a leap of
 23 imagination to reach these conclusions. Our simple
 24 message to this Inquiry and the public at large is the
 25 importance of prioritising public health over

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1 immigration control.

2 In our evidence, we have invited recommendations
 3 aimed at removing or suspending hostile environment
 4 provisions, including NRPF measures, which we are clear
 5 would have mitigated the severe impacts migrants
 6 experienced.

7 We say this should apply at all times, but is an
 8 acute need during a pandemic. Placing any person or
 9 group at risk of destitution, poverty, and in fear of
 10 those in authority, is dehumanising and stigmatising at
 11 any time but during a pandemic it also risks the health
 12 and mortality of everyone, the public at large.

13 When this is the consequence of deliberate law and
 14 policy it begs serious questions about the state of our
 15 society. The pandemic has exposed the vulnerability of
 16 an already vulnerable group of people through the
 17 effects of an unedifying suite of government policies.

18 In this module the MRC consists of nine
 19 organisations that played a significant role in
 20 supporting people who were subject to the negative
 21 impacts of immigration law and policy during the
 22 pandemic. This is the largest cohort of such
 23 organisations as this Inquiry has heard from within
 24 a single module.

25 There is evidence we have submitted of extensive
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1 hands-on experience and expertise in relation to the
 2 struggles of migrants during this period.

3 The Inquiry has the benefit of the work of MRC
 4 organisations that investigated and analysed evidence
 5 and social and environmental factors having detrimental
 6 impact on health, problems with vaccine access, the
 7 deterrent effect of NHS charging and data sharing with
 8 the Home Office.

9 This is important because data collection gaps
 10 during the pandemic have already been identified and the
 11 Inquiry will hear there are also gaps in the data on
 12 migrants gathered by official bodies at this time.

13 The evidence comes from the Joint Council for the
 14 Welfare of Immigrants, Kanlungan, Project 17, Together
 15 with Migrant Children, JustRight Scotland, Doctors of
 16 the World UK, Medact, and two trade unions, the United
 17 Voices of the World and the Independent Workers' Union
 18 of Great Britain.

19 The Inquiry will hear from Francesca Humi of
 20 Kanlungan in oral evidence on behalf of the whole group.

21 During the pandemic these organisations worked to
 22 support thousands of migrants and children and families:
 23 those who needed to access the immigration and asylum
 24 system to secure their immigration status, and avoid the
 25 uncertainty and insecurity of falling foul of

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1 immigration controls, thus risking destitution,
 2 detention and infection; those who had fallen into
 3 extreme poverty and were living in destitution and
 4 experiencing food insecurity through being excluded from
 5 the mainstream welfare system through the panoply of law
 6 and policy including NRPF, making them highly vulnerable
 7 to infection; those who needed to access less crowded,
 8 safer, more secure housing and welfare support,
 9 including those in detention, thereby avoiding the risk
 10 of infection; those who needed help and even
 11 encouragement to access healthcare when unwell because
 12 fears of charging or data sharing with the Home Office
 13 by NHS staff; those in low-paid and precarious work,
 14 many on the front line of the pandemic with no Statutory
 15 Sick Pay or adequate safety net in the event that they
 16 were unable to work, forcing them to go to work through
 17 sickness, unable to self-isolate, and thereby risk of
 18 infection; those in need of mental health support or
 19 help to receive groceries or in need of the translation
 20 of public health guidance.

21 Our evidence sets out in detail the varying and
 22 nuanced impacts on migrants.

23 And just briefly by way of illustration, some of
 24 MRC's evidence of the barriers migrants experienced by
 25 reference to accessing food is that the only means of

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1 collecting subsistence payments was in person, meaning
 2 a trip on public transport and exposure to the virus.
 3 Food vouchers were used more widely and migrants faced
 4 challenges using them because they often relied on
 5 markets and outlets providing culturally appropriate
 6 goods where vouchers were not accepted.

7 If you are on a low income, or unable to access
 8 welfare benefits and in insecure employment, the
 9 increased cost of living hit particularly hard and the
 10 voucher scheme created barriers, not solutions.

11 Some migrants were excluded from holding bank
 12 accounts, including electronic bank accounts, so they
 13 could not order groceries online. Families were forced
 14 to travel to receive cash, which meant an increased risk
 15 of infection.

16 Families with NRPF were at times ineligible to free
 17 school meals, leading to increased food insecurity
 18 without the safety net relied on by other families.

19 This affects a whole family.

20 Finally, the basic proposition is that during the
 21 pandemic prior difficulties caused by the immigration
 22 enforcement system acted to grossly exacerbate the
 23 conditions in which migrants found themselves, leading
 24 to worse conditions of destitution and food insecurity
 25 than before the pandemic and disproportionate rates of

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1 infection and migration.

2 As the Inquiry enters its final phase, we are
 3 acutely aware of the mammoth nature of the task
 4 undertaken, we're enormously respectful of the rigour
 5 and integrity with which the Inquiry has carried out its
 6 processes and its primary purpose to get to the truth
 7 and make a meaningful difference to any future emergency
 8 or pandemic.

9 Our task is to ensure that the effects on migrant
 10 communities are fully recognised.

11 Thank you, my Lady.

12 **LADY HALLETT:** Thank you very much for your help. I'm very
 13 grateful.

14 Mr Westgate, I think you're next.

15 **Submissions on behalf of Shelter by MR WESTGATE KC**

16 **MR WESTGATE:** [Inaudible - microphone not on]

17 My Lady, I appear on behalf of Shelter national
 18 party among other things (inaudible) and poor housing.
 19 What Shelter says today isn't new, and in many ways
 20 reiterates points that's made in the outset. Nor do we
 21 expect (inaudible) to change, but for the most part, the
 22 evidence suggest a consensus for deep issues which only
 23 serves to reinforce what we (inaudible). Each of
 24 Shelter's points comes back to a common starting point,
 25 there's a housing crisis in the UK [microphone not on].

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1 This was full present -- oh, I realise that I have
 2 not had my microphone on.

3 **LADY HALLETT:** Sorry, it's my fault. And my transcript is
 4 not running at the moment so I'm afraid I couldn't spot
 5 whether the stenographer could -- has anybody else got
 6 access to the transcript to know whether the
 7 stenographer has got it down?

8 Oh, I've got some nods and some shaking of heads.

9 **UNIDENTIFIED SPEAKER:** Yes, she has.

10 **UNIDENTIFIED SPEAKER:** (Inaudible - off microphone).

11 **LADY HALLETT:** Oh, there are a fair few inaudibles, I'm
 12 terribly sorry, can you start again?

13 **MR WESTGATE:** Yes, I will.

14 I appear on behalf of Shelter, a national charity
 15 that, among other things, campaigns to tackle the root
 16 causes of homelessness and poor housing and what Shelter
 17 says today isn't new and, in many ways, it reiterates
 18 points that it's made from the outset. Nor do we expect
 19 the overall picture significantly to change. For the
 20 most part, the evidence suggests a consensus on these
 21 issues, which only serves to reinforce what we say.

22 Each of Shelter's points comes back to a common
 23 starting point: that there's a housing crisis in the UK,
 24 and a chronic lack of access to decent and affordable
 25 housing to rent. This was fully present when the

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1 pandemic started.

2 The result is that the unequal impact of the
 3 pandemic, already recognised by the Inquiry in Module 2,
 4 and emphasised by Counsel to the Inquiry, developed
 5 against a background where many families were already
 6 homeless or on the brink of it. Too often, staying at
 7 home meant staying in grossly substandard accommodation,
 8 that only increased risks from Covid that added to them
 9 risks to mental and physical health and exposure to
 10 violence or abuse.

11 These points are repeatedly made not only in the
 12 specialist housing evidence but also in the evidence and
 13 submissions of others, including the DA Group, Mind, and
 14 the MRC.

15 This isn't the place to investigate how we got there
 16 but Shelter will invite the Inquiry to recognise firstly
 17 that the lack of decent affordable housing and poor
 18 housing conditions were substantial contributing factors
 19 to the adverse impacts of the pandemic, and particularly
 20 to the disproportionate harm suffered by many of those
 21 who were already disadvantaged or vulnerable.

22 In this context, housing stress needs to be
 23 recognised as a factor in its own right, otherwise it
 24 may be overlooked or downplayed in any future planning.

25 Secondly, unless this is addressed, the same pattern
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1 will emerge in any comparable pandemic. Shelter
 2 believes that this requires a sustained programme of
 3 investment to increase the number of homes in the social
 4 rented sector, and this is a theme we see in the housing
 5 specialist evidence but also in other sources that we've
 6 referenced in our written submissions at paragraph 43.

7 Shelter's more specific submissions are all subject
 8 to that general point. For example, whilst some
 9 mitigation measures were undoubtedly effective, they
 10 didn't produce a long-term solution.

11 And in the remaining time we'll address two topics:
 12 the first is to emphasise the scale of housing-related
 13 disadvantage and how it impacted, particularly during
 14 lockdown; and the second deals with mitigation and in
 15 particular, Everyone In, and if time permits, we'll say
 16 a little bit about lessons and recommendations.

17 Dealing with the state of housing, going into the
 18 pandemic, some 7.6 million households suffered at least
 19 one major housing problem relating to overcrowding,
 20 affordability, or poor quality housing. A briefing by
 21 the National Housing Federation found that 31% of adults
 22 reported mental or physical problems because of lack of
 23 space or condition of their home.

24 They observed that while many found refuge in their
 25 home during lockdown, for countless others, home has

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1 felt less like a sanctuary and more like a prison.

2 Shelter's evidence highlights the problems in
 3 particular of those in temporary accommodation, or TA.
 4 Homelessness services have, for a long time, felt
 5 obliged to use this because of difficulty sourcing more
 6 secure housing in anything like an acceptable timescale.

7 This was all the more difficult during the pandemic
 8 as the flow of available accommodation was restricted
 9 and moving more difficult.

10 TA is likely to be occupied by those in greatest
 11 need who will ordinarily be in priority and will already
 12 have become homeless, and during the pandemic they were
 13 joined by those additionally accommodated on
 14 Everyone In.

15 The numbers in TA were and remain shockingly high.
 16 In the first lockdown, there were over a quarter of
 17 a million people, then the highest it had ever been.
 18 A significant proportion were in shared accommodation,
 19 17%, in hotels and hostels. Others were living in what
 20 was described as self-contained but was in reality
 21 a single room where a whole family had to sleep, work,
 22 play and eat.

23 It's only possible for us to get a snapshot here,
 24 and we refer to the evidence of Tim Gutteridge on behalf
 25 of Shelter and the reports he exhibits which give

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1 further, and more vivid detail, but Shelter's
 2 contemporary research revealed a range of common
 3 problems, and a non-exhaustive list runs from damp,
 4 disrepair and infestation to a lack of basic facilities,
 5 meaning occupiers had difficulty washing themselves,
 6 doing laundry or preparing meals. Other options that
 7 would normally be available like going to a laundrette
 8 were closed and they couldn't use friends' facilities
 9 either because they couldn't visit them.

10 Crowding in shared facilities meant that it was
 11 impossible to maintain social distancing, some shared
 12 with people who didn't respect the rules on this, making
 13 the environment threatening and even without Covid, 29%
 14 said they felt unsafe in temporary accommodation.

15 All this is hard enough in any circumstances, but
 16 thousands of families were confined to conditions like
 17 this day after day, often cut off from the lifeline of
 18 contact with family, friends and others, who would, in
 19 pre-Covid times, have been able to help.

20 Before moving on to my next topic we note that
 21 Shelter's evidence frequently refers and references
 22 surveys and reports of the experiences of service users.
 23 It's no less reliable or valuable for this, but what it
 24 reflects is that other data collection methods often
 25 failed to capture relevant detail about the most

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1 disadvantaged groups and vital information may be
 2 missed.

3 We'll come to a specific example in the next topic,
 4 which is mitigations and in particular, Everyone In.

5 The Everyone In programme started in March 2020,
 6 when authorities were asked by the Minister to provide
 7 accommodation for those sleeping rough or at risk of it.
 8 They quickly rose to the challenge and on its own terms,
 9 the programme was undoubtedly a success. It prevented
 10 thousands of infections and hundreds of deaths from
 11 Covid.

12 It was the product of a firm expression of political
 13 will, backed with funding and the commitment and
 14 dedicated hard work of local authorities.

15 However, there were shortcomings, each of which, we
 16 suggest, could potentially have been resolved with
 17 clearer guidance and planning. Firstly, Shelter
 18 received frequent reports of people being unable to
 19 access services or being turned away. Part of this
 20 seems to have been because of the way services were
 21 delivered. Some couldn't access them via wi-fi or
 22 telephone, or because information wasn't translated.

23 A Shelter briefing recorded the example of
 24 a pregnant young woman who had been sleeping in a tent
 25 for a month but was told she had to apply online despite

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1 explaining that her phone was broken and she didn't have
 2 enough credit. Other problems seemed to have been
 3 because of differences in local practice or because of
 4 misunderstandings about who should be accommodated.
 5 People, for example, were turned away for reasons such
 6 as not being in priority need or not being verified as
 7 rough sleepers.

8 Secondly, there were issues about adequate support
 9 for those who were accommodated. The LGA evidence gives
 10 examples of good practice but elsewhere that wasn't the
 11 case. A number of people coming off the streets had to
 12 deal with mental health crises or potentially
 13 life-threatening substance withdrawal. And for related
 14 reasons, some were refused accommodation or had to leave
 15 it when it had been provided.

16 Here, the statistics presented what is potentially
 17 a disturbing gap. The ONS statistics record no
 18 significant change in mortality rates among the
 19 homeless. But a report by the Dying Homeless Project
 20 estimates 266 more deaths in 2020 compared to 2019,
 21 a 37% increase. Only ten of those were Covid-related,
 22 but 50% of them were either from drug and alcohol use or
 23 suicide, what are sometimes called "deaths of despair".

24 Yet we may never know whether any of this is linked
 25 to concerns about missing support, but Professors Bambra

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1 and Marmot explain the variation between the ONS and the
 2 Dying Homeless Project conclusions as reflecting
 3 differences in data and collection methods, as it's hard
 4 to identify deaths in this marginalised population.

5 Thirdly, a persistent problem was how Everyone In
 6 fitted with legal restrictions on accessing support and
 7 services about which you've just heard, for those
 8 without leave to remain or whose status prevented them
 9 from having recourse to public funds.

10 These limits were in primary legislation and, for
 11 years, local authorities have been required to deny
 12 support to people in that class. The initial advice
 13 from central government was inclusive and it suggested
 14 that everyone was to be accommodated, regardless of
 15 their immigration status. However, it didn't identify
 16 any power under which authorities could provide support.
 17 Later advice seemed to take a stricter line, that no
 18 recourse remained in force, while telling authorities to
 19 exercise their own judgement, but again without
 20 identifying any power.

21 And here, we do part company with the roundtable
 22 report, if it suggests that need was prioritised over
 23 immigration status for the duration of the pandemic.

24 As it continued, authorities didn't know where they
 25 stood, and this was a source of confusion, sometimes

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1 blocking help. And the Shelter briefing records that
 2 one authority initially provided support but then
 3 terminated it, having been told there was no power to
 4 provide it.

5 Eventually, the High Court did identify a power but
 6 that wasn't until early 2021.

7 As the specific programme came to an end, there was
 8 an ambition to move people on to permanent
 9 accommodation. However, that didn't materialise and, in
 10 common with others, Shelter considers this to be
 11 a missed opportunity to end rough sleeping. The numbers
 12 have now reverted to their pre-pandemic levels and
 13 Shelter's own research, in August 2021, suggested that
 14 fewer than a quarter of people accommodated had found
 15 settled housing.

16 Given the time, we only touch on the other measures
 17 to limit the risk of losing accommodation during the
 18 pandemic. That risk arose mainly because of people
 19 falling into arrears. Measures such as a stay on
 20 possession proceedings and relaxing benefit restrictions
 21 were welcome and prevented many occupiers from losing
 22 their homes, but they didn't protect renters from
 23 Covid-related arrears and a benefit freeze was reimposed
 24 in 2024, so more and more of the market again became
 25 inaccessible, which in fact is where we began.

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1 In our written submissions, we set out some
 2 suggestions about lessons learned and recommendations.
 3 We don't develop those at this stage, but as the
 4 evidence is given, we do invite the Inquiry to keep in
 5 mind four points.

6 Firstly, the need for steps to improve the supply of
 7 decent and affordable housing to rent.

8 Secondly, that in any comparable pandemic it may
 9 again be necessary to accommodate large numbers of
 10 people who would otherwise not be entitled to it, at
 11 least as the law is currently framed. There needs to be
 12 a mechanism for swiftly and clearly disapplying any
 13 disqualifications, to make it clear that authorities can
 14 and should provide help in organisational cases.

15 Thirdly, planning needs to include a recognition
 16 that more support is likely to be needed than simply the
 17 provision of bare accommodation and to assure that
 18 systems are in place for effective joint working between
 19 housing and other agencies.

20 And fourthly, it's vitally important that any such
 21 planning needs to be developed with input and advice
 22 from people with lived experience of homelessness.

23 Those are our submissions.

24 **LADY HALLETT:** Thank you very much for your help,
 25 Mr Westgate, very helpful.

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1 Mr Pezzani.

2 **Submissions on behalf of Mind by MR PEZZANI**

3 **MR PEZZANI:** My Lady, am I audible?

4 **LADY HALLETT:** I'm not sure.

5 **MR PEZZANI:** The microphone says it's on.

6 **LADY HALLETT:** That's it, yeah.

7 **MR PEZZANI:** My Lady, I make these submissions on behalf of
 8 Mind, the mental health charity. It is neither
 9 a surprising nor a novel proposition that a national
 10 health emergency will impact the mental health of the
 11 population. Describing it cogently is another matter.
 12 Every one of us in this room and throughout the nation
 13 is a witness to the psychological challenges introduced
 14 by the pandemic.

15 The causes of mental health impact are diverse and
 16 include, non-exhaustively: anxiety, isolation, the
 17 ongoing pain of bereavement and grief, confinement in
 18 crowded accommodation, exposure to abuse in a place one
 19 cannot leave, the unavailability of support networks.

20 And the effects are multifaceted. The continuum
 21 referred to yesterday by Ms Blackwell King's Counsel
 22 comprehends experiences running from relatively
 23 short-term distress to long-term life-changing severe
 24 mental illness.

25 And that diversity of impact involves its own peril.

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1 So many were affected in so many interweaving ways that
 2 to be asked to define mental health impact can appear to
 3 be a daunting, even overwhelming task. Even to
 4 understand a single individual's psychological trauma is
 5 a sensitive and difficult endeavour; to understand
 6 a nation's psychological trauma, exponentially more so.

7 Mind commends the Inquiry for taking on that
 8 endeavour, and is happy to try to assist. And Mind
 9 recognises the parameters of this is module and does not
 10 seek for the Inquiry to adjudicate or readjudicate
 11 policy decisions but Mind welcomes the Inquiry's
 12 determination to examine the impact of those decisions
 13 on people's mental health, on people's lives, and to
 14 draw lessons with a view to reducing harm in the future.

15 The particular value in the evidence of Mind and
 16 Dr Sarah Hughes, its CEO, derives, in a great part, from
 17 the work it and its affiliated local Minds did
 18 throughout the relevant period. That work was diverse
 19 and hard.

20 An example is in a local Mind, which served an area
 21 in inner city London which was very badly affected by
 22 the pandemic and had high levels of economic insecurity,
 23 social deprivation, homelessness and many vulnerable
 24 residents. That local Mind took the decision to lock
 25 down several weeks later than local Minds in other

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1 areas, to enable people to continue receiving vital
2 support in the interim.

3 Recall the intense anxiety that all of us suffered
4 in those early stages; the courage of that local Mind
5 staff to continue its work is striking.

6 Mind wishes at this preliminary stage, or starting
7 stage, to draw particular attention to the following
8 five matters, which are the subject of express evidence
9 to this module, and which touch on areas of our nation's
10 life which we can tend -- from which we can tend to turn
11 away. There are notable symmetries between the expert
12 evidence and the individual accounts of impact.

13 First, Mind welcomes the Inquiry's focus on the
14 impact of the pandemic on people with severe mental
15 illnesses. They are typically an overlooked sector of
16 our society, subject to an age-old stigma about which
17 Professor Das-Munshi is eloquent in her report. She
18 says people are reduced to discounted or devalued
19 individuals through a range of socially-mediated
20 mechanisms, which include labelling, shaming,
21 discrimination, and status loss. The resultant lower
22 status of mental health compared to physical health has
23 been described, she says, as a lack of parity of esteem.

24 For many people with severe mental illnesses, the
25 world does not always feel like a safe place. During

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1 the pandemic, their sources of safety were lost or
2 subject to sudden change, or attenuated. The result was
3 exemplified perhaps most strikingly in the introductory
4 impact film yesterday morning. It is easy to understand
5 the reason for including the account of Mark, the food
6 bank manager, who described seeing what he called
7 "the screaming man", who was literally walking around
8 the street screaming because, Mark said, all the mental
9 health services had shut and had switched to online.

10 Professor Das-Munshi's evidence links stigma to
11 disparity of esteem, a lower status of mental health
12 compared to physical health. That, too, had a palpable
13 impact on the lives of people with severe mental
14 illnesses. For example, Professor Das-Munshi describes
15 delays in psychiatric wards receiving infection control
16 and testing equipment.

17 That is evidence to this module of the link between
18 stigma, disparity of esteem, and a real impact on the
19 lives of people in psychiatric hospitals who were, by
20 definition, reliant on the institution for the
21 protection of both their mental and physical health, for
22 their safety.

23 But importantly for this module, we have evidence of
24 real effects on individuals. I refer to the account in
25 Dr Hughes' statement of the experience of Jane. Her

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1 father Mike had a severe mental illness. In March 2020,
2 he was detained in hospital under the Mental Health Act.
3 He got the virus and, three weeks after he was admitted,
4 he died in general hospital from complications from
5 a Covid-19 infection.

6 Eight days before his death, Mike's symptoms
7 progressed, and medical advice was sought, but no Covid
8 swab was taken. Jane was told that there was no
9 facility in place to treat her father's physical and
10 mental health conditions simultaneously. And the impact
11 of that experience resonated. It affected Jane's mental
12 health and it affected her family. It changed the way
13 they lived their lives. Jane and her family felt their
14 own mental health impact.

15 And so it's important to recognise that a mental
16 health impact of the pandemic on one life causes ripples
17 that spread.

18 Second, the mental health impact of the pandemic was
19 not equally felt and was subject to the inequalities
20 referred to in Ms Blackwell King's Counsel's opening.
21 If you're living in poverty, or are from a racialised
22 background, or you were suffering from a severe mental
23 illness, or you were an unpaid carer, or you were
24 a single parent, or you were living in crowded
25 accommodation, or you don't have easy access to green

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1 space, or you were trapped in a domestic setting where
2 you're subject to abuse, then you would be wise to brace
3 for a heavier mental health impact from a pandemic than
4 if you're none of those things.

5 But it is when one starts to replace those "or's"
6 with "ands" that the reality of inequality of mental
7 health impact starts to correspond with the reality of
8 many people's lives. Vulnerabilities come not as single
9 spies but in battalions.

10 As Professor Osborn observes, the larger increase in
11 first episode psychosis incidents observed in black and
12 Asian groups may be explained by structural
13 inequalities, specifically elevated exposure to stresses
14 like discrimination, social defeat, which he describes
15 as the negative experience of being excluded from the
16 majority group. Substandard living and working
17 conditions, financial difficulties, isolation,
18 loneliness, and disparities in access to health
19 services.

20 Vulnerabilities form a web. Professor Das-Munshi
21 describes this as intersectionality or the impact of
22 multiple overlapping systems of oppression, leading to
23 poor health in certain, more marginalised groups. The
24 unequal impact of the pandemic exposed that web and
25 exacerbated it. The result for the people living with

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1 those vulnerabilities was an increased risk of severe
 2 mental illness such as psychosis and the personal impact
 3 of an episode of psychosis on the individual and their
 4 family cannot be overstated.

5 Third, there are striking gaps in the data.

6 Professor Osborn says, in relation to the later waves of
 7 the pandemic, that while there was evidence regarding
 8 psychosis and eating disorders, with increased referrals
 9 post-lockdown, there was no evidence regarding diagnoses
 10 such as severe OCD, severe anxiety, depression, or PTSD.
 11 No evidence.

12 There are, thus, severe mental illnesses about which
 13 there was simply an absence of research evidence which
 14 plainly affects our ability to define the impact of the
 15 pandemic on people living with those conditions.

16 Professor Das-Munshi observes that the absence of
 17 data affected her ability to define impact on people
 18 with those illnesses. She says it makes it "difficult
 19 to draw clear-cut conclusions" and says, "This lack of
 20 evidence was particularly noticeable when trying to
 21 assess whether certain sociodemographic or protected
 22 characteristics of people with SMI contributed to more
 23 disparate outcomes."

24 Absence of data is not absence of harm, and it is an
 25 obstacle to effective planning.

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1 As Professor Stewart-Brown reports, despite efforts
 2 to include vulnerable populations, the evidence
 3 consistently reveals a lack of sufficiently detailed or
 4 disaggregated data for many specific focus areas
 5 outlined in our research protocol. This evidence --
 6 this prevents a nuanced understanding of the pandemic's
 7 differential impacts and hinders the development of
 8 targeted policy responses.

9 Fourth, the impact on detainees, whether in prison
 10 or hospital or immigration detention, where mental
 11 illness is an all too common experience.

12 People in those settings are archetypally on the
 13 margins of society and are reliant on the state for the
 14 protection of their physical and mental wellbeing. The
 15 evidential picture is of increasing need for support,
 16 accompanied by an attenuation in its availability.

17 In prisons, for example, there was a reduction or
 18 simple cessation of access to therapy and support, at
 19 the same time as greatly increased isolation.

20 Remote support is not a panacea and, for example, is
 21 of little use if you're isolated in a cell for 23 hours
 22 a day with no private access to a phone.

23 The evidence suggests that women were especially
 24 badly impacted. 76% of women prisoners reported mental
 25 health problems in a 2021 to 2022 survey. The Chief

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1 Inspector of His Majesty's Inspectorate of Prisons
 2 reports that staff in women's prisons in particular
 3 reported having to provide care for profoundly
 4 distressed women who should have been in hospital,
 5 including women with acute mental health needs who had
 6 been sent to prison as a legal place of safety, due to a
 7 lack of hospital provision.

8 Mind agrees with the Chief Inspector that this was
 9 inappropriate, and suggests that the experiences of
 10 acutely vulnerable detainees and staff, that places that
 11 should be safe were not safe, evidences a significant,
 12 indirect effect of the pandemic.

13 The lack of safety across the nation in relation to
 14 mental health impact and people struggling with their
 15 mental health is a consistent theme in the evidence.

16 Fifth, a broader theme is again consistent across
 17 the evidence in the coincidence between a surge in
 18 people's need for mental health support alongside an
 19 experience of reduced availability and diminished
 20 quality of support. At precisely the moment demand for
 21 mental health care and treatment was escalating, the
 22 system's capacity was contracting, and was subject to
 23 rapid change.

24 The logical outcome of that coincidence is that the
 25 mental health impact on individuals, whether they

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1 fell -- wherever they fell on the continuum of need, was
 2 twofold: increased vulnerability to challenges to mental
 3 health, and reduced access to the support that was
 4 needed to mitigate the impact of that challenge.

5 Finally, Mind considers there to be great value in
 6 a recognition of the mental health impact of the
 7 pandemic, and of understanding the people it hit
 8 hardest, because it can inform planning for the next
 9 pandemic.

10 We know that a future pandemic is likely to be
 11 a question of when and not if. When it does hit, there
 12 will, again, be a mental health impact. The evidence
 13 demonstrates that the mental health impact of the Covid
 14 pandemic was profound, but that it was unequal. The
 15 shape and depth of the scars, to adopt a term from
 16 yesterday's opening, left by the pandemic and the
 17 response to it are not uniform. And it is likely to be
 18 enduring, next time, as it is this time.

19 Hindsight enables foresight. The logical purpose of
 20 examining impact is not merely to describe it, but to
 21 seek ways to mitigate it. The evidence before the
 22 Inquiry in this module permits that exercise to be
 23 undertaken.

24 Planning and preparation. Mind therefore says that
 25 planning must include first, early identification of

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1 groups that are at high risk of peril to their mental
 2 health. Second, explicit modelling of mental health
 3 consequences of disease control measures. Third,
 4 ensuring surge capacity in community and inpatient
 5 services. And fourth, addressing data gaps that obscure
 6 vulnerability.

7 My Lady, those are my submissions on behalf of Mind.

8 **LADY HALLETT:** Thank you very much for your help,
 9 Mr Pezzani.

10 Given the stenographer has had a long day so far,
 11 and my transcript needs sorting, I shall return at 3.05.

12 (2.47 pm)

13 (A short break)

14 (3.05 pm)

15 **LADY HALLETT:** Ms Stober.

16 **Submissions on behalf of the Local Government Association
 17 and the Welsh Local Government Association by MS STOBER**

18 **MS STOBER:** My Lady, I represent the interests of the Local
 19 Government Association and the Welsh Local Government
 20 Association.

21 This final module closely concerns the LGA and
 22 WLGA's member authorities. It focuses in turn on the
 23 impact of key workers, most of whom were either employed
 24 or deployed as local authority staff, and on those in
 25 need of local authority services, such as the most

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1 vulnerable, the bereaved, and those with mental health
 2 issues and wellbeing requirements.

3 The witness statement of the chief executive of
 4 the LGA, Ms Joanna Killian, and WLGA, Dr Llewelyn, cover
 5 all these points responding to the specific request for
 6 information from the Inquiry team. The team will find
 7 that, taken as a whole, their statements provide the
 8 necessary detailed evidence for the Inquiry to adopt in
 9 its description of these impacts amongst others, and to
 10 use in framing useful and practical recommendations for
 11 the future.

12 In relation to the LGA, Ms Killian explains how
 13 local authorities responded during the pandemic, noting
 14 the difficulties, issues and problems which had been
 15 overcome, and the actions that went well.

16 In this opening I can only summarise significant
 17 themes in her evidence, but, in doing so, I hope I shall
 18 be encouraging the Inquiry to see where a deeper look at
 19 the evidence is essential.

20 I must start by emphasising the importance and
 21 significance of the LGA's contribution to this module.
 22 Thus, Ms Killian notes how, during Covid, the LGA took
 23 a key role in communicating impacts to government,
 24 described in the witness statement as being the "ground
 25 truth", that enabled policy responses to be developed,

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1 and being rooted in reality experienced by local
 2 government, as the pandemic took hold.

3 In this role, the LGA captured the lived experience
 4 of member authorities on the ground, through multiple
 5 forms of engagement, fed this detailed specific
 6 knowledge to government, worked with government to do
 7 its best to ensure the policies and decisions were
 8 informed by, and reflected, local reality.

9 Her evidence contains five parts: that address the
 10 five specific areas noted in the Inquiry's request.
 11 These concerned local authority key workers and the
 12 workplace conditions, vulnerable groups, housing and
 13 homelessness, bereaved services and funerals, and
 14 community-level sports, leisure and culture.

15 To provide some focus for the module, I will add
 16 only a few comments concerning each part, starting with
 17 the impact on key workers. Ms Killian emphasised the
 18 range and burden of local government responsibilities,
 19 explaining that all local authority officers were key
 20 workers. The LGA particularly asked the Inquiry to note
 21 her evidence as to their contribution, the impact of
 22 Covid, and the significant personal cost that entailed.

23 Regarding vulnerable groups, she notes how, beyond
 24 the clinically extremely vulnerable cohorts, councils
 25 had responsibilities to address many other potentially

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1 vulnerable groups, due to several factors set out in her
 2 statement. The significant challenges around the
 3 quality and accuracy of data around the local CEV
 4 population, provided by government and the NHS to
 5 councils, significantly hampered outreach by local
 6 authorities, and which must not be repeated in future.

7 Though councils ensured emergency food supplies
 8 reached CEVs, there were numerous issues. Procedures
 9 were adapted as the definition of CEV changed,
 10 eventually leading the LGA to co-designing improved
 11 support models.

12 Social workers and support staff worked with schools
 13 and community partners to keep children safe, especially
 14 during lockdown, but regrettably, a lack of adequate
 15 national planning for non-pharmaceutical interventions
 16 led to negative impact on children's mental health and
 17 school readiness.

18 Children with disabilities and special educational
 19 needs were particularly affected with ongoing
 20 consequences for them and their families.

21 The impact on domestic abuse victims during
 22 lockdown, as you've already heard this morning, was
 23 quite significant. Government guidance led to closures
 24 of hotels and similar accommodation, impacting rough
 25 sleepers and homeless households with the LGA escalating

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1 concerns to the Ministry of Housing and Local
 2 Government.

3 Housing and homelessness. Ms Killian's statement
 4 explained in detail how Covid impacted on housing and
 5 the need to support homelessness. Briefly, the
 6 Everyone In initiative, which you've heard about this
 7 morning, which required councils to rapidly rehouse
 8 people sleeping rough or in unsuitable accommodation was
 9 very important, although guidance and funding from
 10 central government were challenging. And indeed, there
 11 were many other vulnerable groups that it did not
 12 adequately cater for, according to information from
 13 Centrepoint.

14 Thereafter, homelessness and the cost of temporary
 15 accommodation increased because of the economic impact
 16 of the pandemic, making a careful, sustained effort
 17 a clear necessity.

18 Bereaved families and funerals. The Inquiry knows
 19 well how Covid brought many sudden, unexpected deaths,
 20 and therefore the impact on bereavement was huge.
 21 Briefly, local authorities as registrars and operators
 22 of cemeteries and crematoria, witnessed the pandemic's
 23 impact on the bereaved daily. Councils faced unclear
 24 guidance on funeral attendance and had to balance
 25 supporting families with staff safety.

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1 Initial confusion arose due to lack of pre-pandemic
 2 planning and inconsistent guidance on funerals,
 3 cemeteries and crematoria operations leading to risks
 4 for council staff and families. Clarifications and
 5 amendments came later.

6 The LGA and councils pressed the government for
 7 clearer guidance and responsibilities regarding funerals
 8 and for amendments to regulations to clarify cemetery
 9 operations. Councils struggled with shortages of PPE,
 10 and concerns about staff availability due to Covid
 11 illness or self-isolation. While the Coronavirus Act
 12 granted powers for transportation, storage and disposal
 13 of bodies, no local authority areas were designated
 14 under these powers during the pandemic.

15 Impact on leisure and community services.

16 Briefly, Ms Killian also notes, for example, the
 17 role of local authorities in providing leisure and
 18 community services across England and Wales, providing
 19 over 3,000 leisure facilities and also maintaining parks
 20 and green space. The issue concerning securing access
 21 as far as possible to these important facilities during
 22 Covid were noted.

23 How the closure of cultural, sports and leisure
 24 facilities affected mental health and wellbeing and how,
 25 when alternative access was made, how the LGA worked

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1 closely with the Department of Culture Media and Sports,
 2 and how innovative steps were taken to develop online
 3 provision.

4 Her statement provides much detailed information as
 5 to the steps taken to meet new needs under lockdown, to
 6 provide innovative solutions, to maintain access and
 7 social morale.

8 My Lady, I now turn to the submission for WLGA. In
 9 his witness, Dr Llewelyn, the chief executive of WLGA,
 10 explains how the Welsh local authorities responded
 11 during the pandemic, noting both the difficulties,
 12 issues, and problems which had to be overcome and
 13 actions that went well.

14 Dr Llewelyn's witness statement also addresses the
 15 five specific areas noted in the Inquiry's Rule 9
 16 request for information. These concerns impact on local
 17 authority key workers and workplace conditions,
 18 vulnerable groups, housing and homelessness, bereaved
 19 services and funerals, community level sports, leisure
 20 and culture.

21 To provide some focus, again, I will only make a few
 22 comments concerning each part, starting with impact on
 23 work -- on key workers.

24 Impact on key workers and workplace conditions were
 25 huge. Even so, I must note that I cannot fully

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1 summarise Dr Llewelyn's important, detailed evidence
 2 about the role of local authorities enforcing workplace
 3 safety regulations, workplace interventions and safety
 4 measures, and the workload and access to support of
 5 different types of key workers.

6 What I must point out, though, in general terms is
 7 the impact Covid had on local authority officers was
 8 very significant.

9 Briefly, local authority officers, both key workers
 10 and others in important support services, worked under
 11 enormous pressures, often seven days per week, for long
 12 hours, for sustained periods, and with no breaks. Key
 13 workers in frontline and personal contact services were
 14 at great personal risk of contacting Covid-19, with
 15 higher infection rates apparent than for those key
 16 workers based in offices or working from home.

17 Many employers experienced pressures, such as
 18 managing personal mental health and wellbeing, and
 19 several had Long Covid. Some suffered abuse, where
 20 service users resented conforming to restrictions.

21 Care workers occasionally experienced verbal and
 22 physical abuse for allegedly being carriers and
 23 spreaders.

24 Key workers, particularly care workers, future
 25 emergency not initially given adequate priority for

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1 vaccination. Much of this was the result of the
 2 restructuring of new work patterns which Covid caused,
 3 because councils had to rapidly redesign services,
 4 redeploy staff, and introduce new operating models.
 5 Many of the employees were designated as key workers.
 6 Some employees volunteered to temporarily change roles.
 7 There had been no preparation for pandemic. These
 8 workforce changes had to take place at speed.

9 WLGA played a pivotal role in many workforce-related
 10 matters, providing leadership and expertise.

11 Dr Llewelyn's evidence also explains how swift
 12 action for measures to support staff were needed. They
 13 included flexible working, PPE provision, mental health
 14 support, and appropriate financial recognition. Social
 15 partnerships with trade unions and government was
 16 central to workforce planning and adaptation.

17 Impact on vulnerable groups.

18 Dr Llewelyn's statement sets out in detail the
 19 impact of Covid on vulnerable groups in Wales. He
 20 provides a detailed picture of the programmes and steps
 21 taken to meet the needs of vulnerable persons during the
 22 pandemic. He notes the challenges local authorities
 23 faced, including those arising from digital exclusion
 24 and because of the limits on access to services for
 25 those living in remote and rural areas.

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1 Housing and homelessness was a special cause of
 2 vulnerability, especially because of the impact of
 3 lockdown measures, the diminished opportunities for
 4 work, and the greatly increased workload for local
 5 government officers during the pandemic.

6 There were significant challenges in accommodating
 7 rough sleepers, managing early prisoner releases, and
 8 suspending evictions. The number of people in emergency
 9 accommodation rose sharply during the pandemic, with
 10 ongoing pressure on councils. Hotels and guest houses
 11 were opened, then closed, and later reopened, to
 12 accommodate the homeless and vulnerable groups.

13 The Inquiry team is asked to notice that councils
 14 played a critical role in securing the emergency
 15 accommodation under the No One Left Out strategy, in
 16 repurposing hotels and other facilities, while the Welsh
 17 Government provided emergency funding and guidance.

18 Bereavement services.

19 Local authorities had statutory duties for funeral
 20 provisions, cemetery and crematorium operations and
 21 death registration. Councils had a clear obligation to
 22 scale up services, adapt procedures, and provide
 23 emotional support to staff during this time.

24 Covid itself, and the restrictions imposed to defeat
 25 it, had severe effects on both local authority staff

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1 responsible for funeral and bereavement services, and
 2 the bereaved themselves. Briefly, the bereaved -- for
 3 the bereaved, there were emotional impact because many
 4 families were unable to be with loved ones at death or
 5 at funerals. There was limited accessible support from
 6 friends and the community. There had to be restrictions
 7 on mourning rituals.

8 To meet these obligations and difficulties, local
 9 authorities implemented a wide range of compassionate
 10 adaptations such as, for example, live-streamed
 11 funerals, attendance limits, outdoor ceremonies where
 12 possible, large-screen monitors and video facilities, at
 13 the crematoria.

14 Of course, those were not sufficient to meet the
 15 normal method of funerals and burials as you've heard
 16 earlier today.

17 Community-level sports and leisure. Local
 18 authorities also have a hugely important role in the
 19 provision of leisure and community services, and
 20 maintaining parks and green space. The issue concerning
 21 securing access as far as possible to these important
 22 facilities during Covid is discussed in detail in
 23 Dr Llewelyn's statement.

24 The pandemic led to widespread closure facilities,
 25 suspension of organised sports, and significant

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1 operational restrictions. The effect on mental health
 2 and wellbeing, especially for vulnerable groups,
 3 including those with disabilities and protected
 4 characteristics, was huge.

5 He also notes how councils adapted, offering virtual
 6 fitness classes, online library and museum services and
 7 resources, deliveries, though these could not fully
 8 replace the value of in-person engagement.

9 Local authorities maintained, and in some cases
 10 enhanced, funding and support for the voluntary sector,
 11 recognising its social and economic value, and that
 12 emergency funding and innovative local schemes were
 13 crucial in sustaining community support.

14 Lessons learned. My Lady, there are many lessons to
 15 be learnt from the experience of local authorities in
 16 England and Wales during the pandemic, set out in both
 17 witness statements, and I will address some of those in
 18 my closing submissions.

19 But the LGA and WLGA are grateful for the
 20 opportunity to take part in the entire Inquiry and stand
 21 ready to provide any such further assistance as may be
 22 required. Thank you.

23 **LADY HALLETT:** Thank you for your help, Ms Stober. Very
 24 grateful.

25 Mr Jacobs, again, last, but again not least.

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1 **Submissions on behalf of the Trades Union Congress by**
 2 **MR JACOBS**

3 **MR JACOBS:** My Lady, these are the opening submissions of
 4 the Trades Union Congress.

5 The members of those unions affiliated to the TUC
 6 span a range of sectors profoundly affected by the
 7 Covid-19 pandemic. They include key workers in
 8 construction and manufacturing, railways, aviation,
 9 education, food industries, retail, communications
 10 workers, Fire and Rescue Services, Civil Service, the
 11 arts, and health and social care.

12 In these opening submissions, we pay tribute to the
 13 resilience of the UK workforce. We address the impacts
 14 suffered by key workers, and we outline the context to,
 15 and drivers of, that impact.

16 First, the tribute. That the country did keep going
 17 during the pandemic stands as a great testament to the
 18 spirit and resilience of the UK workforce. There were
 19 not accounts of factories being unable to operate, of
 20 schools having to turn away the children of key workers,
 21 of parcels going undelivered, or shops not having the
 22 staff to stack shelves. Key workers turned up, and
 23 carried out their duties when so many of us were in
 24 lockdown at home. They did so despite the terrible
 25 risks and challenges, and despite, often, great concern

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1 as to the decisions being made by the government on
 2 their behalf.

3 The evidence in this module ought to reflect that
 4 admirable resilience and sense of national purpose,
 5 alongside the adverse impacts which many key workers
 6 suffered.

7 Second, impact. This Inquiry -- this module will
 8 have the benefit of four witnesses jointly giving
 9 evidence on behalf of the TUC, who will describe the
 10 impact on workers in a range of sectors.

11 My Lady, they will be more illuminating than their
 12 lawyers, and we don't seek to canvass their evidence
 13 now.

14 We do, however, emphasise that many of the most
 15 affected sectors are not often recognised as the most
 16 affected sectors. And if in the throes of the pandemic,
 17 there was a renewed appreciation for postmen, for those
 18 who stack our shelves and others, many such workers
 19 perceive that the renewed appreciation dissipated just
 20 as quickly as it appeared.

21 We also emphasise that many of the most affected
 22 sectors are those in which workers already suffer the
 23 perils of insecure work and of poverty and of health
 24 inequality. In 2020, for men, the highest rate of death
 25 involving Covid-19 was in elementary workers, which

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1 included security guards, catering assistants, refuse
 2 workers, and cleaners.

3 In construction, ONS data from April 2020 recorded
 4 that there had already been 87 Covid-19-related deaths
 5 of workers in the skilled construction and building
 6 trades, and 90 deaths among workers in the skilled
 7 metal, electrical, and electronic trades.

8 In manufacturing, there was a series of outbreaks in
 9 the Leicester garment factories which triggered Public
 10 Health England to send a team of officials to
 11 investigate the cause. An outbreak at a Bakkavor food
 12 processing factory in December 2020 was followed by
 13 100 workers testing positive for Covid and the deaths of
 14 two workers.

15 In warehousing, an outbreak occurred in May 2020 at
 16 an ASOS warehouse which employed 4,000 workers.
 17 A survey by GMB of 500 of those workers at the factory
 18 found that 98% felt unsafe at work due to Covid-19.

19 Research since the pandemic has found that those in
 20 the warehousing sector had some of the highest outbreak
 21 rates, second only to manufacturers and packers of food.

22 In transport, high rates of infection and mortality
 23 amongst London Bus drivers led to Transport for London
 24 commissioning a report to consider the causes in
 25 May 2020. The report found that black, Asian and

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1 minority ethnic bus drivers, and those living in areas
 2 characterised by deprivation, faced particularly high
 3 risk. And we heard this morning, my Lady, as to the
 4 account of a bus driver being given a shower curtain as
 5 a protective measure.

6 Of course, impact is measured beyond fatality rates.
 7 Many key workers have suffered the terrible experience
 8 of Long Covid, an experience often compounded by loss of
 9 income, by being disbelieved or misunderstood, and by
 10 a lack of workplace support.

11 This, my Lady, was the terrible correlation in the
 12 pandemic of socioeconomic disadvantage and the very
 13 worst impacts of Covid-19. These issues will be
 14 expanded upon by the TUC witnesses, and no doubt others.

15 What we can do, as the TUC's legal representatives,
 16 is set some context for the evidence as it has been
 17 revealed in this Inquiry so far. In particular, we
 18 focus on those points of context that were drivers of
 19 impact. In that sense, we take up what Ms Blackwell
 20 King's Counsel said in opening yesterday: to understand
 21 impact, you have to consider context.

22 We contract our 11 points on this in written opening
 23 to six overarching themes.

24 The first and necessary starting point is the
 25 pre-existing health inequalities with which the UK

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1 entered the pandemic, as illuminated in the Module 1
 2 report. That report described that the UK entered the
 3 pandemic with its public services depleted, health
 4 improvements stalled, health inequalities increased, and
 5 health among the poorest people in a state of decline.

6 Those circumstances shaped the experience of the
 7 pandemic for many key workers. These health
 8 inequalities are not a theoretical abstract. They are
 9 the lived experience of many who had to continue to
 10 attend work during the pandemic.

11 The second point is the lack of sector-specific
 12 planning. As the evidence in Module 1 also
 13 demonstrated, pandemic planning was focused on an
 14 influenza pandemic in healthcare settings. There was
 15 little practical planning informed by the on-the-ground
 16 knowledge of how different sectors operate for the kinds
 17 of challenges a pandemic would present across the wider
 18 economy.

19 The real world consequence was that many sectors
 20 felt they were abandoned as there was a rush to support
 21 the NHS, and they waited for months whilst colleagues
 22 fell ill or died before PPE and other resources filtered
 23 towards them too.

24 The problem with PPE was one of the issues most
 25 frequently raised with the TUC and its affiliates. The

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1 problems created by the lack of planning across sectors
 2 going into the pandemic were exacerbated by a lack of
 3 social partnership during it. Sectoral issues need both
 4 visibility and priority within government for them to be
 5 addressed. Stronger arrangements for social partnership
 6 between unions and government would have supported that,
 7 and we note the theme from the roundtable meetings as
 8 set out this morning as to the need for clarity and for
 9 consultation and coproduction in respect of guidance.

10 The third theme is structural racism. The Inquiry
 11 has heard evidence that black, Asian and minority ethnic
 12 workers are less likely to seek out risk assessments or
 13 be assertive about their needs in terms of safety at
 14 work. TUC research has found that black, Asian and
 15 minority ethnic workers report being allocated harder or
 16 less popular tasks than white counterparts, and
 17 experiencing high levels of discrimination which they do
 18 not typically feel able to report.

19 Moreover, as Professors Nazroo and Bécares said in
 20 Module 2, the employment profile of ethnic minority
 21 people is somewhat different to that of white British,
 22 as they are more likely to be employed in sectors that
 23 increase their risk of exposure to an infectious agent.
 24 So, black and minority ethnic workers are more likely to
 25 be in workplaces with increased risk, and when in those

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1 workplaces, are likely to be at higher risk than their
 2 colleagues.

3 The fourth theme is precarious work as a driver of
 4 poor outcomes. Insecure work has increased markedly in
 5 the UK with the number of workers on zero-hour contracts
 6 increasing from under 200,000 in 2010 to almost 900,000
 7 in 2018. The SAGE ethnicity group and Professors Marmot
 8 and Bambra have both highlighted the connection between
 9 precarious work and risk during a pandemic. Effective
 10 infection prevention and control relies on workers who
 11 are properly trained and empowered to follow safe
 12 systems of work, who know how, and to feel confident, to
 13 raise concerns when those systems are not operating as
 14 they should and who do not fear penalty where they are
 15 required to take proactive steps such as self-isolation.

16 Insecure employment conditions work against all of
 17 those characteristics.

18 The fifth theme is the additional challenges and
 19 vulnerabilities faced by migrant workers. Migrant
 20 workers are disproportionately represented in precarious
 21 forms of work, but additional layers of insecurity also
 22 arise from the risk of job loss impacting upon migration
 23 status.

24 As a result, they are less able to raise concerns,
 25 request risk assessments, or request PPE and infection

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1 prevention and control training, and are more likely to
 2 fall into presenteeism.

3 Migrant workers are a substantial proportion of the
 4 UK workforce. In 2020, 10% of the working population
 5 were not UK nationals, and these workers were also
 6 over-represented in many key worker roles.

7 The sixth theme is unsafe workplaces. How is it
 8 that workers in food processing plants, for example,
 9 were repeatedly suffering mass outbreaks? The Inquiry
 10 has heard some evidence as to the limitations in
 11 workplace regulation of the Health and Safety Executive
 12 and local authorities. Alarmingly few in-person
 13 inspections took place during the pandemic despite
 14 elevated risks, and it was all too easy for employers
 15 subject to Covid-19 spot check inspections to say over
 16 the phone that yes, they were following the guidance to
 17 a T.

18 As we said in our opening to Module 1, to a worker
 19 sitting on a processing plant who may already be
 20 suffering the disadvantages of low pay, in insecure
 21 work, and suffering the associated poorer health
 22 outcomes, an effective health and safety regulator may
 23 be the difference between working in an environment with
 24 or without adequate measures such as social distancing
 25 and PPE.

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1 An additional driver of unsafe workplaces was the
 2 inadequacy of the arrangements for sick pay and
 3 financial support for self-isolation.

4 My Lady, as your Module 2 report observed, a factor
 5 contributing to the risks was the ability to
 6 self-isolate without financial support. The report
 7 noted that these issues persisted throughout the
 8 pandemic, and inevitably contributed to the disparities
 9 and unequal impact.

10 Those inadequacies and financial support abandoned
 11 the most vulnerable workers who already faced the
 12 greatest risks.

13 Those, my Lady, are the points of context which the
 14 Inquiry is invited to keep in mind as it proceeds
 15 through this module.

16 Finally, it is perhaps premature to make this
 17 closing observation, given that it is the opening rather
 18 than closing of the hearings in this tenth and final
 19 module, but, my Lady, as I am unable to attend the
 20 closing submissions, perhaps you will allow me.

21 In June 2023, in the opening to Module 1, I turned
 22 to the theme of resilience, and suggested that, having
 23 then reached the foothills of the Inquiry, a reservoir
 24 of resilience upon which we would all be dependent is
 25 yours, and that we stood ready to assist.

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1 At least I intended to say that, but I accidentally
 2 said, "We stood ready to resist".

3 My Lady, an unfortunate opening.

4 I hope that as we look at this Inquiry from the
 5 perspective of its closing rather than opening module,
 6 we, on behalf of the TUC, have indeed assisted.
 7 My Lady, we are grateful for your efforts and the many
 8 who have assisted you.

9 **LADY HALLETT:** I heard what I wanted to hear, Mr Jacobs, and
 10 you have been of great assistance, so I'm sorry you
 11 can't be here on the final day, but thank you very much
 12 for all your help.

13 **MR JACOBS:** Thank you.

14 **LADY HALLETT:** Very well, that completes the opening
 15 submissions for the core participants, I think,
 16 Ms Blackwell?

17 **MS BLACKWELL:** Yes. Thank you, my Lady.

18 **LADY HALLETT:** Everyone has done some excellent timing. It
 19 bodes well for the rest of this module, so thank you,
 20 everybody, for your very helpful contributions and your
 21 excellent punctuality.

22 I shall return for 10.00 tomorrow where we start the
 23 evidence.

24 **MS BLACKWELL:** We do. Thank you very much.

25 (3.36 pm)

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

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