Tuesday, 17 February 2026

(10.00 am)

LADY HALLETT: Good morning.

Ms Rahman.

Opening statement by COUNSEL TO THE INQUIRY for MODULE 10 (continued)

MS RAHMAN: My Lady, I now turn to the roundtable events convened by the Inquiry, and I will summarise the key themes drawn from their summary reports.

As outlined yesterday, the use of roundtables is unique to this module. A total of nine events were held in 2025 as one means of gathering information about the impact of the pandemic.

These were supplementary to the considerable work done at each stage of the Inquiry, as part of Every Story Matters. While the listening exercise focuses on individual experiences of the pandemic, the roundtables were designed to facilitate discussion between a diverse range of organisations and representative groups.

What emerged from these discussions deepens our understanding of a societal impact of a pandemic, and the measures taken in response, as it was experienced across the range of sectors and organisations including by those in contact with some of the most vulnerable people in society.

Reports from each of the nine events have been prepared and provided to the Core Participants in their preparation for these hearings, and reduced by Ms Blackwell, King's Counsel, yesterday. Like each of the Every Story Matters records, the reports will be available for use with the witnesses you will hear from and in your final report.

This introduction to these reports is in three parts. First, a brief description of the methodology adopted. Second, an overview of each roundtable and some of the key messages conveyed to the Inquiry. And finally, a summary of some consistent themes across each of the discussions.

Roundtable methodology, overview.

The roundtable discussions were organised by the Inquiry and led by facilitator. They took place between February and June 2025. A range of organisations and representatives across the relevant sectors and fields were invited, though not all chose to participate. We are grateful to all those who took the time to attend and to share their insights with each other and with the Inquiry.

Each roundtable discussion was focused on the terms of reference for the Inquiry and the provisional outline of scope for Module 10. While moderated, the

substantive content of the discussion was led by the shape of the participants' contributions. This provided an opportunity for a range of views and perspectives to be shared and explored.

After the conclusion of the discussion, a summary report identified core themes and messages. Participants were given an opportunity to consider and comment on the summary report before being finalised.

The reports provide an overview. They are not a verbatim record of all the views of the participants, nor do they provide a comprehensive account of any particular issue in scope. They are part of a picture that will develop during the course of these hearings about the impact of the pandemic on society.

Finally, in each roundtable, lessons for future pandemics were identified. Whilst shaped by experiences of the Covid pandemic and the measures in response, these contributions are forward looking. They are not, of course, intended to reopen your consideration of decision making in earlier modules of the Inquiry.

I now turn to each of the nine roundtables and set out some key messages.

Business leaders, hospitality, retail, travel and tourism. At this roundtable there were two discussions, one focusing on retail and the other on hospitality,

travel and tourism. A recurring theme across both these discussions was the difficulty of implementing rules and guidance during the pandemic. Participants suggested that guidance could generate confusion and inconsistency, and that a lack of specificity resulted in uncertainty for businesses, who struggled to interpret more general guidance, and feared that their businesses were not compliant.

For example, UKHospitality said that guidance was not tailored to the specific needs of diverse hospitality subsectors, thus making it challenging to apply effectively across different types of businesses. The sector, they said, had struggled with translating broad guidelines into practical, actionable steps for the wide variety of hospitality settings, like restaurants, hotels and children's play centres.

Frequent changes to guidance meant that organisations had little time to respond appropriately and increased pressure on staff to interpret and implement guidance at pace. Hospitality Ulster stated that they learned of rules that came into effect from midnight on the same day.

In particular, the classification of businesses as essential or non-essential was said to be unclear, which led to feelings of unfairness. The Federation of Small

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

Restrictions and closures led to financial difficulties for many businesses, particularly those that did not have the financial reserves to adapt. Hospitality Ulster stated:

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

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

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

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

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

VisitBritain observed that:

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

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

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

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

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

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

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

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

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

There were also more positive impacts.

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

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

of the impact on that sector.

Community-level sport and leisure.

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

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

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

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

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

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

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

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

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

"Representatives reflected that there was more

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

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

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

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

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

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

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

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

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

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

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

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

Cultural institutions.

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

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

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

Organisations, again, struggled with guidance. Participants:

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

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

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

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

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

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

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

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

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

The Musicians' Union said:

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

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

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

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

discussions.

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

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

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

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

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

However, BECTU said changes in behaviour could not

all be attributed to the pandemic:

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

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

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

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

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

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

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

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

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

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

technology in comparison to younger members of the clergy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I turn now to key workers.

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

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

The representative from the National Association of Head Teachers said:

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

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

government guidance".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a "world of unknown" risks.

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

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

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

The GMB Union reported that they:

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

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

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

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

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

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

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

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

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

of isolation, anxiety, and burnout.

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

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

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

The National Police Chiefs' Council stated that:

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

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

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

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

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

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

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

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

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

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

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

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

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

to the negative impact on prisons during the pandemic.

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

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

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

Medical Justice said that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The representative for Bail for Immigration Detainees said:

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

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

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

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

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

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

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

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

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

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

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

However, Centrepoint explained that the initiative

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

Cymorth Cymru said to the Inquiry that:

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

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

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

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

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

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

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

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

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

The representative from St Mungo's said:

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

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

particularly the case for those in older housing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statutory services for those suffering from domestic

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mind said:

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

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

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

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

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

As Cruse Bereavement Support's representative put it:

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

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

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

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

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

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

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

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

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

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

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

Participants described how bereaved families

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

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

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

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

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

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

groups, exacerbating existing inequalities.

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

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

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

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

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

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

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

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

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

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

MS RAHMAN: Thank you, my Lady.

LADY HALLETT: Thank you.

Mr Weatherby, after the break?

MR WEATHERBY: [off microphone]

LADY HALLETT: After the break. Half past.

(11.14 am)

(A short break)

(11.30 am)

LADY HALLETT: Sorry if I caught people by surprise.

Mr Weatherby.

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

MR WEATHERBY: Thank you, my Lady.

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

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

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

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

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

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

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

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

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

Rivka went on to explain that she is:

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

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

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

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

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

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

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

too.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

restrictions.

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

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

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

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

The huge challenges of the emergency obviously

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

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

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

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

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

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

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

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

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

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

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

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

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

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

compliance with public health measures may well be less.

We urge the Inquiry to make practical and direct recommendations to promote change for the future, given that most of the impacts that will be evidenced in these hearings were foreseeable and are plainly seen now.

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

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

Thank you.

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

Mr Bindman, I think you're next.

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

MR BINDMAN: Thank you, my Lady.

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

"We can't change the past. We wish we could. We've

lived, loved, and lost during this pandemic. It's been a truly heartbreaking time for us all and we understand grief can be a very lonely journey. That is why we are channeling all our efforts to try and help to make a difference in the future."

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

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

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

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

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

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

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

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

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

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

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

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

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

incineration only".

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

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

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

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

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

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

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

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

In a similar vein, Anna Smith has reported that she

had to ultimately instruct a solicitor to get her mother's medical records after they were initially provided only partially, and the fact that she could not make a complaint to the Information Commissioner seemingly because the data she sought related to someone who was deceased. Like other group members, including Glen Grundle from whom the Inquiry will hear in person, she felt, and continues to feel, a helplessness in relation to the inability to recover information regarding her mother's death.

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

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

in any decisions on how to manage the response.

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

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

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

Thank you, my Lady.

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

Mr Stanton.

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

MR STANTON: Thank you, my Lady.

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

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

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

Health bodies gambled on bereavement modelling that

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

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

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

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

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

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

Second, visiting and funeral restrictions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

on TV with no discussion or prior warning given.

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

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

Sixth, inadequate memorials and remembrance.

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

As one group member put it:

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

The National Covid Memorial Wall in London is

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

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

Seventh, ongoing impacts on wellbeing and mental health.

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

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

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

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

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

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

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

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Mr Stanton. Ms Mitchell.

Sorry, Mr Wagner, were you expecting to go next?

MR WAGNER: I think I wasn't. I don't know. I thought I was fifth but I probably -- (overspeaking) --

LADY HALLETT: Story, you stood up. So unless anyone needs to get away?

MR WAGNER: No.

LADY HALLETT: Okay, Ms Mitchell.

Submissions on behalf of Scottish Covid Bereaved by DR MITCHELL KC

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

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

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

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

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

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

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

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

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

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

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

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

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

reference.

These are the submissions of the Scottish Covid Bereaved.

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

Now, Mr Wagner.

Submissions on behalf of Clinically Vulnerable Families by MR WAGNER KC

MR WAGNER: Thank you.

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

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

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

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

First, safety.

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

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

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

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

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

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

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

Just to give some examples which reflect the topics

being investigated in these modules -- in this module. First, in the workplace, the absence of enforceable rights to Covid-related adjustments continues to leave clinically vulnerable people exposed to danger. There's been a regular refrain during the pandemic, often repeated in this Inquiry by witnesses, that clinically vulnerable people were fearful or nervous or anxious to return to the workplace.

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

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

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

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

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

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

But they were less confident because it was unsafe.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CVF's submission is that future planning should

prioritise targeted support for clinically vulnerable people across all of the domains that Module 10 examines, which are, in essence one domain, which is the social environments which clinically vulnerable people have to operate in to live a normal life.

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

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

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

Third, intersecting vulnerabilities amplified impacts for clinically vulnerable people.

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

And, clinically vulnerable people within the

immigration and asylum system, or in prisons or other places of detention, faced acute risks from settings where they had to congregate without adequate screening or protective measures.

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

Finally, status.

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

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

Data was not collected during the pandemic to properly capture clinical vulnerability and the

experience of clinically vulnerable people. For example, surveys carried out often did not collect data on clinically vulnerable groups, and Professor Majeed has said in his statement to this module that clinically vulnerable populations relied on fragmented primary care records leading to gaps in real-time monitoring, and your systemic evidence review my Lady, also identified a lack of sufficiently detailed or disaggregated data on CV/CEV groups.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

their language or know their culture.

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

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

Third, deaths and accountability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

My Lady, DPO return to their starting point in this

Inquiry, and to what has been learned about the vulnerability of emergency systems. For systems to become resilient, there needs to be a fundamental investment in collective resilience, and for disabled people, far greater understanding of the social model and of intersectional experiences that mean that certain societal groups are far more marginalised than others.

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

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

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

(12.46 pm)

(The Short Adjournment)

(1.50 pm)

LADY HALLETT: No one caught out that time.

Ms Sergides.

Submission on behalf of the DA GROUP by MS SERGIDES

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

LADY HALLETT: I can, thank you.

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

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

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

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

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

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

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

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

Turning briefly to the evidence. The reports and

data from the violence against women and girls sector, official statistics and personal accounts all contained in the DA Group's Rule 9 witness statement, as well as those publicly available, demonstrate a clear and sustained increase in domestic abuse throughout the lockdown period.

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

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

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

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

Where there were increased reports of domestic abuse

to the police, these were almost entirely driven by third-party calls, often from neighbours who had Internet or overheard abuse through walls and gardens.

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

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

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

In the words of Pooja(?), supported by SWA, "The pandemic gave him more control because of not being able to go outside. It gave him more power to use. It inflated his ego, that he had this power and there was

no threat of calling the police or leaving".

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

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

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

In respect of children, the Women's Aid Shadow

Pandemic Report found that 53% of adult victim-survivors said their children were witnessing more domestic abuse whilst 38% said their abuser had shown increased abusive behaviour directed towards children.

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

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

Those in the LGBTQ+ community were also at greater risk of domestic abuse. As described by Professor Bécares, domestic abuse and hostile behaviour at home, including feeling uncomfortable being themselves, being neglected and harassed by family and/or housemates who did not accept them, pronouns not being respected, and a

lack of understanding and/or empathy about their experiences had a negative impact on respondents' mental health, compounding experiences of isolation and loneliness.

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

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

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

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

The DA Group will submit that having heard evidence

of the potentially large numbers of migrant victim-survivors affected by the combination of the hostile environment, the pandemic, and domestic abuse, the Inquiry must recommend that key aspects of the hostile environment, particularly healthcare charging, information sharing and restriction on access to public funds, be suspended in any future pandemic to ensure these individuals can access life-saving support and protection no matter what their status.

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

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

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

The DA Group's experience is that the pandemic led to a perfect storm of psychological distress for

victim-survivors because of intensified abuse, isolation from support networks, and reduced access to mental health services. The combination of increased scale, severity, new forms of abuse, and the difficulties in obtaining support have let to prolonged, long-term effects on survivors' mental health which continue today.

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

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

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

Listening to, and understanding the experience, of the sector, particularly those working on the front line, responding to victim-survivors' complex and

multi-faceted needs is essential in order to formulate the most effective recommendations for future pandemics. That sector must be properly funded and supported if it is to be utilised.

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

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

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

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

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

I'm grateful, my Lady.

LADY HALLETT: Thank you very much indeed for your help.

Now it's Ms Weereratne. I thought you were over there.

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

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

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

LADY HALLETT: I can, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

And this difference is significant because the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

immigration control.

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

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

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

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

There is evidence we have submitted of extensive

hands-on experience and expertise in relation to the struggles of migrants during this period.

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

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

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

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

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

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

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

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

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

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

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

Families with NRPF were at times ineligible to free school meals, leading to increased food insecurity without the safety net relied on by other families. This affects a whole family.

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

infection and migration.

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

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

Thank you, my Lady.

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

Mr Westgate, I think you're next.

Submissions on behalf of Shelter by MR WESTGATE KC

MR WESTGATE: [Inaudible - microphone not on]

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

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

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

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

UNIDENTIFIED SPEAKER: Yes, she has.

UNIDENTIFIED SPEAKER: (Inaudible - off microphone).

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

MR WESTGATE: Yes, I will.

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

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

pandemic started.

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

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

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

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

Secondly, unless this is addressed, the same pattern

will emerge in any comparable pandemic. Shelter believes that this requires a sustained programme of investment to increase the number of homes in the social rented sector, and this is a theme we see in the housing specialist evidence but also in other sources that we've referenced in our written submissions at paragraph 43.

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

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

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

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

felt less like a sanctuary and more like a prison.

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

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

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

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

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

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

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

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

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

disadvantaged groups and vital information may be missed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Those are our submissions.

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

Mr Pezzani.

Submissions on behalf of Mind by MR PEZZANI

MR PEZZANI: My Lady, am I audible?

LADY HALLETT: I'm not sure.

MR PEZZANI: The microphone says it's on.

LADY HALLETT: That's it, yeah.

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

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

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

And that diversity of impact involves its own peril.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Third, there are striking gaps in the data. Professor Osborn says, in relation to the later waves of the pandemic, that while there was evidence regarding psychosis and eating disorders, with increased referrals post-lockdown, there was no evidence regarding diagnoses such as severe OCD, severe anxiety, depression, or PTSD. No evidence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2.47 pm)

(A short break)

(3.05 pm)

LADY HALLETT: Ms Stober.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

concerns to the Ministry of Housing and Local Government.

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

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

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

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

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

Impact on leisure and community services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Impact on vulnerable groups.

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

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

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

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

Bereavement services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Submissions on behalf of the Trades Union Congress by MR JACOBS

MR JACOBS: My Lady, these are the opening submissions of the Trades Union Congress.

The members of those unions affiliated to the TUC span a range of sectors profoundly affected by the Covid-19 pandemic. They include key workers in construction and manufacturing, railways, aviation, education, food industries, retail, communications workers, Fire and Rescue Services, Civil Service, the arts, and health and social care.

In these opening submissions, we pay tribute to the resilience of the UK workforce. We address the impacts suffered by key workers, and we outline the context to, and drivers of, that impact.

First, the tribute. That the country did keep going during the pandemic stands as a great testament to the spirit and resilience of the UK workforce. There were not accounts of factories being unable to operate, of schools having to turn away the children of key workers, of parcels going undelivered, or shops not having the staff to stack shelves. Key workers turned up, and carried out their duties when so many of us were in lockdown at home. They did so despite the terrible risks and challenges, and despite, often, great concern

as to the decisions being made by the government on their behalf.

The evidence in this module ought to reflect that admirable resilience and sense of national purpose, alongside the adverse impacts which many key workers suffered.

Second, impact. This Inquiry -- this module will have the benefit of four witnesses jointly giving evidence on behalf of the TUC, who will describe the impact on workers in a range of sectors.

My Lady, they will be more illuminating than their lawyers, and we don't seek to canvass their evidence now.

We do, however, emphasise that many of the most affected sectors are not often recognised as the most affected sectors. And if in the throes of the pandemic, there was a renewed appreciation for postmen, for those who stack our shelves and others, many such workers perceive that the renewed appreciation dissipated just as quickly as it appeared.

We also emphasise that many of the most affected sectors are those in which workers already suffer the perils of insecure work and of poverty and of health inequality. In 2020, for men, the highest rate of death involving Covid-19 was in elementary workers, which

included security guards, catering assistants, refuse workers, and cleaners.

In construction, ONS data from April 2020 recorded that there had already been 87 Covid-19-related deaths of workers in the skilled construction and building trades, and 90 deaths among workers in the skilled metal, electrical, and electronic trades.

In manufacturing, there was a series of outbreaks in the Leicester garment factories which triggered Public Health England to send a team of officials to investigate the cause. An outbreak at a Bakkavor food processing factory in December 2020 was followed by 100 workers testing positive for Covid and the deaths of two workers.

In warehousing, an outbreak occurred in May 2020 at an ASOS warehouse which employed 4,000 workers. A survey by GMB of 500 of those workers at the factory found that 98% felt unsafe at work due to Covid-19.

Research since the pandemic has found that those in the warehousing sector had some of the highest outbreak rates, second only to manufacturers and packers of food.

In transport, high rates of infection and mortality amongst London Bus drivers led to Transport for London commissioning a report to consider the causes in May 2020. The report found that black, Asian and

minority ethnic bus drivers, and those living in areas characterised by deprivation, faced particularly high risk. And we heard this morning, my Lady, as to the account of a bus driver being given a shower curtain as a protective measure.

Of course, impact is measured beyond fatality rates. Many key workers have suffered the terrible experience of Long Covid, an experience often compounded by loss of income, by being disbelieved or misunderstood, and by a lack of workplace support.

This, my Lady, was the terrible correlation in the pandemic of socioeconomic disadvantage and the very worst impacts of Covid-19. These issues will be expanded upon by the TUC witnesses, and no doubt others.

What we can do, as the TUC's legal representatives, is set some context for the evidence as it has been revealed in this Inquiry so far. In particular, we focus on those points of context that were drivers of impact. In that sense, we take up what Ms Blackwell King's Counsel said in opening yesterday: to understand impact, you have to consider context.

We contract our 11 points on this in written opening to six overarching themes.

The first and necessary starting point is the pre-existing health inequalities with which the UK

entered the pandemic, as illuminated in the Module 1 report. That report described that the UK entered the pandemic with its public services depleted, health improvements stalled, health inequalities increased, and health among the poorest people in a state of decline.

Those circumstances shaped the experience of the pandemic for many key workers. These health inequalities are not a theoretical abstract. They are the lived experience of many who had to continue to attend work during the pandemic.

The second point is the lack of sector-specific planning. As the evidence in Module 1 also demonstrated, pandemic planning was focused on an influenza pandemic in healthcare settings. There was little practical planning informed by the on-the-ground knowledge of how different sectors operate for the kinds of challenges a pandemic would present across the wider economy.

The real world consequence was that many sectors felt they were abandoned as there was a rush to support the NHS, and they waited for months whilst colleagues fell ill or died before PPE and other resources filtered towards them too.

The problem with PPE was one of the issues most frequently raised with the TUC and its affiliates. The

problems created by the lack of planning across sectors going into the pandemic were exacerbated by a lack of social partnership during it. Sectoral issues need both visibility and priority within government for them to be addressed. Stronger arrangements for social partnership between unions and government would have supported that, and we note the theme from the roundtable meetings as set out this morning as to the need for clarity and for consultation and coproduction in respect of guidance.

The third theme is structural racism. The Inquiry has heard evidence that black, Asian and minority ethnic workers are less likely to seek out risk assessments or be assertive about their needs in terms of safety at work. TUC research has found that black, Asian and minority ethnic workers report being allocated harder or less popular tasks than white counterparts, and experiencing high levels of discrimination which they do not typically feel able to report.

Moreover, as Professors Nazroo and Bécares said in Module 2, the employment profile of ethnic minority people is somewhat different to that of white British, as they are more likely to be employed in sectors that increase their risk of exposure to an infectious agent. So, black and minority ethnic workers are more likely to be in workplaces with increased risk, and when in those

workplaces, are likely to be at higher risk than their colleagues.

The fourth theme is precarious work as a driver of poor outcomes. Insecure work has increased markedly in the UK with the number of workers on zero-hour contracts increasing from under 200,000 in 2010 to almost 900,000 in 2018. The SAGE ethnicity group and Professors Marmot and Bambra have both highlighted the connection between precarious work and risk during a pandemic. Effective infection prevention and control relies on workers who are properly trained and empowered to follow safe systems of work, who know how, and to feel confident, to raise concerns when those systems are not operating as they should and who do not fear penalty where they are required to take proactive steps such as self-isolation.

Insecure employment conditions work against all of those characteristics.

The fifth theme is the additional challenges and vulnerabilities faced by migrant workers. Migrant workers are disproportionately represented in precarious forms of work, but additional layers of insecurity also arise from the risk of job loss impacting upon migration status.

As a result, they are less able to raise concerns, request risk assessments, or request PPE and infection

prevention and control training, and are more likely to fall into presenteeism.

Migrant workers are a substantial proportion of the UK workforce. In 2020, 10% of the working population were not UK nationals, and these workers were also over-represented in many key worker roles.

The sixth theme is unsafe workplaces. How is it that workers in food processing plants, for example, were repeatedly suffering mass outbreaks? The Inquiry has heard some evidence as to the limitations in workplace regulation of the Health and Safety Executive and local authorities. Alarmingly few in-person inspections took place during the pandemic despite elevated risks, and it was all too easy for employers subject to Covid-19 spot check inspections to say over the phone that yes, they were following the guidance to a T.

As we said in our opening to Module 1, to a worker sitting on a processing plant who may already be suffering the disadvantages of low pay, in insecure work, and suffering the associated poorer health outcomes, an effective health and safety regulator may be the difference between working in an environment with or without adequate measures such as social distancing and PPE.

An additional driver of unsafe workplaces was the inadequacy of the arrangements for sick pay and financial support for self-isolation.

My Lady, as your Module 2 report observed, a factor contributing to the risks was the ability to self-isolate without financial support. The report noted that these issues persisted throughout the pandemic, and inevitably contributed to the disparities and unequal impact.

Those inadequacies and financial support abandoned the most vulnerable workers who already faced the greatest risks.

Those, my Lady, are the points of context which the Inquiry is invited to keep in mind as it proceeds through this module.

Finally, it is perhaps premature to make this closing observation, given that it is the opening rather than closing of the hearings in this tenth and final module, but, my Lady, as I am unable to attend the closing submissions, perhaps you will allow me.

In June 2023, in the opening to Module 1, I turned to the theme of resilience, and suggested that, having then reached the foothills of the Inquiry, a reservoir of resilience upon which we would all be dependent is yours, and that we stood ready to assist.

At least I intended to say that, but I accidentally said, "We stood ready to resist".

My Lady, an unfortunate opening.

I hope that as we look at this Inquiry from the perspective of its closing rather than opening module, we, on behalf of the TUC, have indeed assisted.

My Lady, we are grateful for your efforts and the many who have assisted you.

LADY HALLETT: I heard what I wanted to hear, Mr Jacobs, and you have been of great assistance, so I'm sorry you can't be here on the final day, but thank you very much for all your help.

MR JACOBS: Thank you.

LADY HALLETT: Very well, that completes the opening submissions for the core participants, I think, Ms Blackwell?

MS BLACKWELL: Yes. Thank you, my Lady.

LADY HALLETT: Everyone has done some excellent timing. It bodes well for the rest of this module, so thank you, everybody, for your very helpful contributions and your excellent punctuality.

I shall return for 10.00 tomorrow where we start the evidence.

MS BLACKWELL: We do. Thank you very much.

(3.36 pm)

(The hearing adjourned until 10.00 am the following day)

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