**Thursday, 19 February 2026**

**(10.00 am)**

**LADY HALLETT:** Ms Rahman.

**MS RAHMAN:** Good morning, my Lady.

My Lady, may I call the next witness, Dr Sarah Hughes.

**DR SARAH HUGHES (affirmed)**

**Questions from COUNSEL TO THE INQUIRY**

**LADY HALLETT:** Thank you for coming to help us, Dr Hughes.

**THE WITNESS:** Thank you.

**MS RAHMAN:** Doctor, could you give us your full name please.

**A.** Yes, Sarah Jane Hughes.

**Q.** Thank you. Dr Hughes, you should have in front of you a copy of a statement with a reference INQ000652569.

**A.** Yes.

**Q.** Can you confirm that is a statement that you have provided for the purposes of the Inquiry?

**A.** Yes, I can.

**Q.** And can you confirm that any facts stated within the statement are true to the best of your knowledge and belief?

**A.** Yes, I can.

**Q.** Thank you.

Dr Hughes, turning first to your professional background. In summary, and I'm taking this from



paragraph 1 of your statement, you are the chief executive officer of Mind, the mental health charity?

**A.** That's right.

**Q.** And it's right that you've been in that role since January 2023?

**A.** Indeed.

**Q.** But you also have over 30 years of experience in mental health and social care?

**A.** I have, yes.

**Q.** Although you weren't employed by Mind at the relevant time, January 2020 to June 2022, is it right that in your previous role as chief executive of the Centre for Mental Health, you were actively involved in the response to the pandemic?

**A.** Yes, that's the case.

**Q.** Now, Dr Hughes, you've set out the very many activities of Mind within your statement at paragraphs 6 to 11. In summary, it's the largest mental health charity in England and Wales.

**A.** Yes.

**Q.** And your mission is to give high-quality information and support to people experiencing mental health problems?

**A.** Absolutely.

**Q.** And you deliver that, and again, I'm summarising, through a variety of frontline services, information and



advice, policy influencing --

**A.** Yes.

**Q.** -- public campaigns, and intervening in legal cases; is that right?

**A.** That's true, yes.

**Q.** And the legal cases that you might intervene in, they're ones where there's potential to improve the law for people with mental health problems; is that correct?

**A.** It is.

**Q.** Now, that's just a summary. What I really want to ask you about is the work that Mind was doing during the pandemic. In broad terms, the demand increased substantially during the pandemic; is that correct?

**A.** It absolutely is. And thank you very much for having Mind at the Covid Inquiry, it's incredibly important to tell the mental health story.

So, absolutely, overnight, need, demand for services increased dramatically, both in terms of the community, services that our local Minds provide, but also in terms of the online provision that we provide centrally, including information services and our online peer support platform.

**Q.** Were you quite well prepared for that transition yourself at Mind? Is it something you were already doing or did you have to rapidly get on board with



providing these sorts of services?

**A.** Well, it was a mixed picture. We were able to ramp up our online services quite quickly because we already had the set-up. Our local Minds were also able to ramp up delivery quite quickly and transfer services to remote delivery. But that did take a bit of time, but I absolutely recollect a rapid turnaround in many instances, including our own ability to increase our helpline provision.

**Q.** Thank you.

Now, I don't need to take you to it but you've also been provided with parts of statements from other providers, such as the Association of Mental Health Providers. I believe Mind is a part of that association; is that correct to say that?

**A.** Yes, we are.

**Q.** And they also refer to services, crisis lines, hotlines; is that consistent with what you've been describing?

**A.** Absolutely. Every single aspect of the mental health system experienced a surge right away. So this included Shout, the services that are provided online for children and young people, they experienced significant surges right away. We experienced lots of -- our community services, people who had never used mental health services before pitching up for support and,

yeah, distress.
**Q.** That's interesting, in terms of people not having rung a hotline before, you asked -- again, I don't need to take you forward but it's at paragraph 98.1 -- you asked local Mind groups who were responsible for delivering your services across the country, you asked them for their insights about why they thought or what they remembered about this increase, and what they described is people being anxious and depressed due to lockdown, and also what they were seeing reported in the media -- does that accord --
**A.** Absolutely.
**Q.** -- with your recollection?
**A.** Absolutely. One of the most astonishing factors that we saw, especially for children and young people, the impact of the rolling news, the constant noise about what was happening, that kind of sense of crisis and emergency. So every time -- for instance, if there was an announcement by a minister, a specific kind of moment in time, all of the helplines would experience a significant spike in contact with people who were deeply anxious about what it meant for them, how long this would go on for, and indeed, Shout can reflect that quite candidly in terms of announcements made by prime ministers in relation to the pandemic.



**Q.** I think Shout, is that a young persons hotline?
**A.** It is.
**Q.** I should just remind you that Module 8 has dealt with young people, it's really interesting to hear it again, but it was --
**A.** No, it was all round --
**Q.** -- it was adults as well who were calling. Of course.

Now, what local Minds have described is the access to community mental health services being reduced, and essentially charities like Mind in some ways filling the gaps. Is that a fair sort of description of what you felt you were doing?
**A.** Yeah, absolutely. So what we understood at the time was that statutory services quickly closed down. So both services by -- run by local authorities and the NHS quickly disappeared. So we saw a rapid decline in our service users' ability to continue with any level of support. So -- and this is not an attack on the NHS or local authorities because absolutely we understand the circumstances they were in.

Nonetheless, our local Minds had to step into that gap and so instances where service users were shielding or they were unable to access support for serious mental illness, our services stepped in, either remotely or by providing kind of safely-distanced support.



**Q.** Doctor, I am reminded, and this is probably for me as well as you, that we need to speak slowly because we've got a stenographer who is trying to get down what we're saying.

What you're saying is really interesting and I think people tend to speak a bit faster when we're having conversation --
**A.** I'm north London too, so it definitely is very fast. I'll slow down.
**Q.** Yeah, let's both slow down and let's take it a little bit slower now in terms of the next few questions.

You've talked about community mental health services not being as accessible, Mind trying to fill the gap, but clearly they couldn't entirely fill the gap.
**A.** No.
**Q.** And you say at paragraph 93 of your statement that in particular, the people who had pre-existing physical and mental health conditions, they were requiring more support, but some reported despite that, feeling a sense of unsupportedness during the pandemic; is that correct?
**A.** Of course. I mean, it absolutely is correct. So local Mind services primarily are dealing with people's mental health challenges, but we do also accept that many of our service users will have co-existing conditions, mainly, you know, lung, heart, ability to get around,



et cetera. So we absolutely know that that's the cohort that we are working with, and our services usually are able to adapt and accommodate. But that wasn't the case generally across the system.

So, of course, if you were a shielding individual, it would be very difficult for you to access services. So you might be able to access some online resource, but being able to go and see your GP or being able to access a community group, et cetera, became impossible, and so for people with health conditions, physical disabilities, there was an additional layer of structural barriers that they had to experience. It wasn't just they couldn't access, but actually we couldn't get to them.
**Q.** Thank you. Now, in terms of specific types of Mind services where there was an increased demand, at paragraph 14 you say that in particular bereavement support and suicide prevention services saw unprecedented demand; is that correct?
**A.** It is.
**Q.** And just on that point, we heard some expert evidence yesterday that suggested they hadn't established any clear evidence of increased suicides, but the expert thought that that cohort, people with severe illness, would be at increased risk; does that fit with your

experience --
**A.** It does.
**Q.** -- in demand?
**A.** It does. So what we saw was an increase in people with suicidal ideation, so we expanded our emotional support helpline for that reason, because people were coming to us with ever increasing complexity, ever increasing levels of acuity in terms of their distress. So in terms of worries about suicidality at that time, everybody was very, very concerned, and so we ensured that our suicide prevention services across the piece expanded as much as they could and in fact we had some support from local authorities to do that.
**Q.** Thank you.
**A.** In terms of bereavement services, it's also the case -- obviously people started to lose individuals really quickly, and certainly from a mental health perspective this brought people who'd never accessed mental health services to us before. And so immediately we had to spring to life some quite significant surge plans to respond to that demand.
**Q.** Thank you. And I'll come back to that at the end of your evidence, specifically bereavement support.
Dr Hughes, I now want to move on to a number of reports that Mind produced during the pandemic which you



have exhibited to your statement.
Is it correct that in June 2020 you produced two reports, one for England and one for Wales, entitled "The mental health emergency -- how has the Coronavirus pandemic affected our mental health?"
**A.** Yes.
**Q.** And then a follow-up or a further report in June 2021, and that was for both England and Wales, and is it right that that then considered the ongoing impact of the pandemic on people with mental health problems?
**A.** Yes.
**MS RAHMAN:** And my Lady, could I please adduce those reports? The Inquiry numbers are INQ000471282, INQ000649007, and INQ000471299.
**LADY HALLETT:** Certainly.
**MS RAHMAN:** Dr Hughes, I will pick up just a few of the main points, but would it be right to say that, broadly speaking, the picture painted was similar between England and Wales?
**A.** Yes.
**Q.** And so if we could just get the essential learnings from the first report up on the slide, please.
INQ000471282 at page 5.
That's the front cover.
And if I could ask for page 5 to go up, with the



essential learnings.
Yeah, so we have there, in the box, the "Essential learnings" from this report, which marries with the Welsh report. Essentially, it's elsewhere in the report explained that these came from a survey that included responses from 14,421 adults aged 21-plus; is that correct?
**A.** That's right.
**Q.** And looking at the slide, it's right to say that more than half of them said that their mental health had got worse?
**A.** Absolutely.
**Q.** And the main drivers for that were the restrictions on seeing people, going outside, health worries, and loneliness.
Now, the slide also references to something we've already heard about from our expert witnesses, and that is a reduction in health seeking, because people didn't think that they deserved support, self-stigma as it is. Could you expand a little on your recollection of this feature of people's response to the pandemic?
**A.** Yes, it was quite an extraordinary response, actually. We found lots of people who just thought, you know, you know: there are people dying out there from Covid, my needs do not compare, my needs are, you know, absolutely



at the, kind of, bottom end of the scale.
So, people were not seeking help, even under the most extraordinary circumstances, even when they were in crisis, even when they felt suicidal.
So, often, they might phone a helpline, but actually, in some instances, people needed to be treated by a clinical team, they needed to go to A&E, but they wouldn't do that, and they would suffer for long, long periods of time at home on their own.
**Q.** Do you think that's part of essentially a prioritisation of physical health conditions as compared to mental health concerns? In other words, if it's something to do with feeling anxious or depressed, that's not worthy of attention because there's nothing physically wrong with you; is that part of what we've heard?
**A.** Absolutely. You know, we in the mental health field for decades have really understood a lack of parity of esteem. You know, physical and mental health are still seen as competing realities as opposed to one experience that all of us have and kind of, you know, manage on a day-to-day basis.
We very much saw during the pandemic -- if you think about all of the messaging that came out, it was all about staying physically well, it was all about, you know, the dramatic scenes at the hospital, people

waiting to get help, people on life support machines and so on and so forth. So if you can imagine having a mental health problem, you're just feeling like you can't compare -- and that there's no one there for you. So there were no mental health discussions or, you know, moments for people to say, "Look, okay, if you're in trouble, this is where you need to go." That just didn't happen.

So we were flooded with these images of very busy A&E departments and wards, and a constant conversation about the physicality of all this. Which, on one level, we understood, but equally, for our beneficiaries, it was another moment in time where the message felt like: you're less important.

**Q.** Thank you, Dr Hughes, that's very helpful.

It isn't just a case of people not wanting to seek help; a quarter of respondents said they had actually tried and failed to get support?

**A.** That's right.

**Q.** Now, we've already heard expert evidence about the disruption of health service during the pandemic and the impact of that. But, from Mind's perspective, you were also hearing what you've summarised there: the disruption of services was impacting on people's ability to get help at an early stage?



**A.** It was astonishing, actually. One of the things that we saw very, very quickly was our ability to prevent crisis disappeared overnight, and so any opportunity we had to intervene at those early stages, so when people were, at that point, coming to, you know, get help or seek support from their GP or pop along to a local Mind or another mental health service, that bit of the puzzle disappeared. And so our ability to intervene earlier slipped away. And so, in the end, people were getting into crisis. At that point, we might be able to intervene but not always.

**Q.** Yes. So, we have heard quite a bit about the adverse effect, both in terms of the individual and services, on not getting help in time --

**A.** That's right.

**Q.** -- and presenting when you're essentially in crisis?

**A.** Absolutely.

**Q.** One particular issue that has been discussed a great deal is the new remote services, and we've discussed Mind's own experience of that, getting up to speed quite quickly.

We've heard from experts about how that didn't suit anyone -- or everyone that needed care. Again, Mind did a lot of work on this, as I understand it, during the pandemic, and at paragraph 20.6 of your witness



statement you say that you, at the outset, were seeing vulnerable people struggling to book doctors' appointments and access medication; is that correct?

**A.** Yes. I mean, this was the moment that really brought the digital divide to the surface. It was something that we absolutely knew existed before the pandemic, but absolutely accelerated during. And so we saw people not in a position to book appointments, not in a position to have a remote conversation with a practitioner, either because they didn't have the resources, it could have been that they didn't have the skills -- some people didn't have the capacity. So, if you're living with a very serious mental illness, maybe psychosis, managing all of that technology during moments of stress and crisis would be incredibly difficult and fraught. And indeed, people often were in vulnerable scenarios. So, seeking -- you know, if you're living in a home with, you know, three other people, finding a confidential space to have a remote consultation became very challenging as well.

Equally, it made it very difficult for practitioners to, kind of, really discern what was going on for the individual because you're only seeing them in a snapshot in time, you can't really understand what's going on for them, and so many tells, if you like, were missed and



lost.

**Q.** The tells don't come through the screen; is that what you're saying?

**A.** Yes.

**Q.** I can quite understand that.

You've said in your statement that your concern was really about choice, you've got a report, I'm not going to take you to it, trying to connect the importance of choice in remote health services. Is that what you really saw during the pandemic, that people weren't being given a choice and it was impacting upon them?

**A.** Oh yes, there wasn't a choice and there wasn't an opportunity to really think about what could be done as an alternative to remote consultations. So for a very long time people had: either they could do that or they couldn't. They might be able to access, you know, kind of community support via local Minds or other mental health organisations, that was a light touch, but in terms of, you know, support for clinical needs there wasn't a choice.

And actually, we heard from practitioners, too, that they found not being able to offer choices to their patients who they knew were incredibly vulnerable created some moral injury in the long term.

So actually, it had a -- the impact was felt all

round. It wasn't just on people receiving the services but also delivering them.

**Q.** Yes, Dr Hughes, I will come back to that term you've used there in a moment, "moral injury", it's an interesting term that you've used in your statement and I will ask you about it.

Finally on this topic of remote health services, you do say, for instance at paragraph 169.4 of your statement, you did see positives, older service users becoming more engaged with technology by necessity, I take it?

**A.** Absolutely. And of course we supported, across our local Minds, we supported the education of digital skills, so we supported lots of groups who were vulnerable in different ways to develop some understanding about how they could use technology in their care. We continue to do that across the piece because, as we know, remote consultations and the way in which we deliver services hasn't gone back to pre-pandemic times. So this is still an ongoing legacy of the pandemic.

**Q.** Yes, and a positive one?

**A.** And a positive one, yes.

**Q.** Looking back to the slide on coping mechanisms, what you've said there is "Connecting with family and friends



online is the most popular way to cope" -- again, this is from 2020 -- "amongst both young people and adults."

No surprise particularly there, but just to flag the remainder of coping strategies, when you look at the detail of what you're describing there, are essentially harmful behaviours, it seems?

**A.** Absolutely, yes.

**Q.** So within the report it's highlighted that there are vulnerable groups, tying in with that first bullet point there, with eating disorders who are over- or under-eating to cope, perhaps not even people with diagnoses of eating disorders. That seems to be a feature?

**A.** **(Witness nodded)**

**Q.** Obsessive compulsive disorder is flagged in the report?

**A.** Mm.

**Q.** And those experiencing social deprivation were particularly impacted; is that correct?

**A.** Absolutely. Again, one of the things that was very clear -- again, very, very quickly -- is that coping mechanisms varied and some were positive, and so we had the, you know, people used physical activity, they used their hour a day to really kind of support their wellbeing. But equally, we also saw an increase in the use of alcohol, drugs, self-harm, for people with eating



distress, it became almost impossible to be in a kind of confined space, often, you know, with parents or with loved ones, and, you know, kind of that pressure around eating. So it became like a sort of, you know, it was like a nuclear, you know, just, you know, waiting to happen. It was such a tinder spike. It was, you know, if you can imagine somebody at home with eating distress or feelings of, you know, mental illness, being surrounded by individuals, often we don't always understand what's going on for people. So the pressure was extraordinary and so, sadly, people did retreat to coping mechanisms that were incredibly unhealthy, and of course people who already used alcohol or drugs for instance to support, you know, or to manage their mental health or their difficult feelings also couldn't access AA support or any of those sorts of things that they might have been done before the pandemic because they also disappeared until they re-emerged online, and again, some of those worked and some of those didn't.

So for all of the coping mechanisms that were very negative, all of the mitigants disappeared. So sadly, again, we couldn't intervene early enough in some of those situations.

**Q.** Thank you. Doctor, you do come back to those three reports that I have adduced, and their findings in more



detail at the end of your statement. And that's there, obviously, for everybody to read. But briefly on the second report, from July 2021, is it correct that that confirmed many of the same issues still pertained at that point?

**A.** Yes, absolutely. I mean, we continued to see a decline in people's mental health. We also see, continued to see, a surge in demand that we couldn't meet. We also saw a continuation of behaviours, kind of coping mechanisms, that again, specifically around self-harm, that deepened, and still remains today.

**Q.** Yes. And it's right that at that point in July 2021, you identified, from the people who responded, a decline from the previous years with nearly 30% of adults saying that their mental health had actually got worse?

**A.** Yes.

**Q.** Thank you.

Dr Hughes, I want to ask you now about some specific aspects of Mind's work that may illustrate the impact on some of the people that you were helping. First, in relation to sport and physical activity -- we'll hear shortly about the Inquiry's systematic evidence review on mental health and wellbeing, and I think, Doctor, that you've been sent some sections from that?

**A.** Yes.

**Q.** And that described several studies showing that a lack of physical activity is associated with worsening mental health. And Doctor, at paragraphs 28 to 42 of your statement, you talk a lot about the work you did about encouraging activity; does that chime with what we've seen in our systematic review about worsening mental health being associated with lack of activity?
**A.** Absolutely. We have a firm belief that physical activity supports good mental health and so again, when we could see the immediate decline, we were very clear that we needed to ramp up our physical activity across the piece.
**Q.** Thank you. And it's right to say that this sort of work had been ongoing for some time prior to the pandemic?
**A.** Yes.
**Q.** But as the pandemic hit, you saw increased demand, particularly when sports facilities closed?
**A.** Yes.
**Q.** And, at paragraph 36, I want to ask you about some specific points about physical activity, and it touches on what we've just been discussing. Some people didn't find it very easy to use physical activity to cope; is that correct?
**A.** Yes, I mean many of the people who have serious mental illness have other co-existing physical issues too, and



so the assumption that they could just go on a walk or -- and actually, quite often they were shielding, so, indeed, all of these things conspired to make it very, very difficult for people to do all of the things that they might have done before. You know, they couldn't go swimming, for instance, for people with, you know, really significant skeletal issues.

So, you know, we found at that moment of when we were thinking through all of the support that we could provide, we wondered how we could meet that gap that we saw. But, ultimately, we couldn't fill it entirely because those health centres, those physical activity environments, et cetera, are incredibly important, and we absolutely couldn't replicate that. But what we did -- what we were able to do, is provide peer support, provide encouragement, provide guidance. In fact, we had lots of walking groups across local Minds, appropriately distanced of course, all sorts of things --

**Q.** Yes, I'm going to come back to that point in a moment. One individual told you that they were exercising for up to 10 hours a day. You mention that. I just wanted to ask you about that. That physical activity wasn't an easy thing to give advice about, was it?
**A.** No, you're quite right. And indeed, for certain groups,



physical activity -- if you're living with eating distress, for instance, physical activity can be incredibly problematic.
**Q.** Yes.
**A.** And excessive exercise is absolutely not great for your mental health either. So we had to be really cautious and thoughtful because we did not want to feed into that, those messages, but equally, we really wanted to hold on to the value that physical activity could place. So, again, those trauma-informed -- and I'll, kind of, be really clear about that: our physical activity services are trauma informed.
**Q.** Yes.
**A.** And so, from that perspective, being able to manage that distinction between harm and, you know, kind of, positive impact, will -- (overspeaking) --
**Q.** Yes, it's a balance, essentially?
**A.** It's a balance, yes.
**Q.** And you -- during the pandemic, you, created -- I think you've exhibited it to your witness statement, I don't need to take you to it, but a specific resource was on your website about healthy relationships with physical activity?
**A.** Yes.
**Q.** And that was because of this, this need for --



**A.** Absolutely, yes.
**Q.** -- sort of quite nuanced and carefully balanced advice?
**A.** Yes.
**Q.** Thank you.

I'm just going to take you through a couple of the other things that you mention that you developed in light of this concern about inactivity. You mention the delivery of 20,000 Get Active at Home leaflets and activity packs, and you delivered those because you were concerned about the digitally excluded, as I understand it?
**A.** Mm.
**Q.** I will turn now to the walking groups that you mentioned. So this is at paragraph 39 of your statement, and you described these groups being set up, as well as the online peer support, to really keep people who were particularly isolated on track; is that correct?
**A.** Yes, absolutely. Primarily because we know that people with particularly serious mental illness have, you know, a mortality rate of 15 to 20 years before the rest of the population, and so our desire to maintain healthy coping mechanisms, including physical exercise, was a priority. We felt deeply concerned that the deterioration in all of the physical activity would

contribute even more so to that incredibly painful stat.
**Q.** Yes. I'm just going to touch on that, because we heard evidence yesterday about that striking statistic. It's a pre-existing feature --
**A.** Yes.
**Q.** -- severe mental illnesses and mortality rates being 15 to 20 years lower. But what you describe in your statement is something that was ongoing to try to address that statistic; is that correct?
**A.** Yes.
**Q.** But during the pandemic, is it right to say that efforts to focus on that group were redoubled in terms of the mortality risk from not doing any physical exercise?
**A.** Indeed. So we know that people with serious mental illness were five times more likely to die during the pandemic, and physical health challenges were absolutely key and core to that. And so we knew that this would happen during the pandemic, and so our response was not just about supporting people's emotional health but we needed to attack the physical health piece too.
And providing walking groups, et cetera, was not the only intervention we took; we also assisted people with accessing vaccines and, you know, doing all of those things too, because we were really concerned about that, the impact of that overall.



**Q.** It would be right to say that this is a very hard to reach part of society?
**A.** Incredibly.
**Q.** And you described in your statement, paragraph 42.2, a lot has gone into that initiative. You described Oxfordshire Mind, Active Oxford, Oxford Mental Health Partnership and funding from Sport England's Tackling Inactivity and Economic Disadvantage fund?
**A.** Yes.
**Q.** So a lot goes into trying to devise something to shift that statistic?
**A.** Absolutely. You know, this has been the reality for people with serious mental illness for some time, so this is a known quantity, this has been something that we in the mental health community have been trying to attack, and physical activity is one way of doing it. And so we have been working with Sport England, and in fact our sports and physical activity work has been ongoing for about 15 years.
**Q.** I'm just going to touch, before we move to another section of your statement, on a couple of other specifics that you have noted about the pandemic, again related to physical of the group we've been talking about. You say at paragraph 20 of your statement you became aware of some people with those severe illnesses



being unable to access food because they weren't on the shielding list.
Was that a feature you noted in terms of physical health of people with mental illnesses?
**A.** Absolutely. So it was extraordinary that we found that people with serious mental illness were not immediately on the shielding registers. You know, even with SMI, serious mental illness, registers across primary care, for some reason that was a largely excluded group. Not in every part of the country but there --
**Q.** There were some instances of that?
**A.** Yeah, quite a lot, actually. I would probably say it was kind of 50/50 in terms of whether you were on the shielding list or not. And so the other part of that, though, is that in those instances, you would hope that mental health services then could step in and advocate for somebody, but that often lagged. That took some time to realise, well, who's missing? Who actually needs this support? And it demanded mental health services to reach out, which was right, because actually, whilst we'd call it a hard-to-reach group, it's actually the fact that we don't reach them. So for us it was really thinking through, how do we get to them, how do we identify these individuals? And that took time.



**Q.** One last specific insight that you've offered, telephone hearings for mental health review tribunals for the justice system were devised, but you highlighted that that could cause issues for patients for instance with paranoia or hallucinations. Was that a specific impact of the pandemic measures that you recall that Mind advocated for?
**A.** Yes, we found that -- I mean, far too many instances where those systems absolutely created impenetrable realities for these people who were very, very poorly. They couldn't access advocates in the same way, and so all of that, that whole system, became -- there was a lack of integrity to it for those reasons.
**Q.** Thank you.
I'm going to move on to another topic. Dr Hughes, your statement covers pretty much every aspect of Module 10's scope and we've heard a lot about mental health in general terms, but you talk in your statement also about the impact on workers and your staff that I just want to ask you about, because you raise a few points about your staff that have a broader resonance in some of the evidence that we've already heard and will hear.
At paragraph 45 of your statement a particular feature of the pandemic you describe, and that is a rise

in verbal and physical abuse of shop workers with heightened levels of mental distress. So you've mentioned that in your statement.

Dr Hughes, one of the documents that we sent to you was from our Roundtable for Business Leaders, and I wonder if that could be put up on screen just to remind you of that.

Essentially what we found from others who discussed this issue was this: representatives discussed how staff across their sectors faced increased workloads during the pandemic because of staff shortages and changes to having interacted with customers. This increased their responsibilities at work and contributed to work-based stress. And, for example, in the retail sector, staff had to enforce regulations like mask wearing, which increased verbal and physical abuse from customers who did not want to comply, and it had a negative impact on staff mental health and wellbeing.

So it seems that this resonates with what you've described.

**A.** Oh, completely. And sadly, we still see this, there is a legacy to that. So we still see an increase in verbal and physical attacks on retail and hospitality staff. I doubt there's many of us in this room that wouldn't have seen an incident during the pandemic where a member



of staff had to intervene or ask somebody to be compliant, et cetera, with regulations. And far too often, there was a negative response. And I -- and whilst we -- I think we can reflect, and high levels of stress and high levels of worry and anxiety, but it was absolutely disproportionate. The impact on hospitality and retail staff's mental health has been quite astonishing too, and I think the fear has increased and remained, sadly.

We saw -- and again, we can explain some of that behaviour because of the lack of support elsewhere, you know, the lack of community, the lack of being able to kind of maintain those social contacts and so on. So, you know, we were all a little bit of a powder keg in many respects, but this really extended beyond anything I think most of us anticipated.

**Q.** We heard somebody, I think, from the theatre industry in one of the roundtables describing almost a sense of people having forgotten how to behave. Is that something you might think might be behind some of these incidents that you've described?

**A.** Yeah, I mean, I think when you're in isolation for long periods of time, all of our normal or ordinary conventions disappeared overnight. So again, going to the shop or going to Tesco's, or any other supermarket,



you know, these huge, huge queues outside, all of these kind of psychological images of the pandemic that all of the -- everybody -- we were all kind of consumed by. We can still hold them in mind, right?

And so -- but we forgot, we literally forgot how to hold conversations, and, you know, many people didn't see another person for days and days and days, and so of course we lost skills, we lost skills around compassion, actually. We kind of forgot that shop workers were also experiencing the pandemic, as well. And so all of these things are still part of the legacy of the pandemic and we are still seeing and feeling the effects of that today.

**Q.** Back to the issue of what workers were going through. Mind compiled a workplace wellbeing index. You mention that from paragraph 42 of your statement, and that considers the experiences of over 42,000 staff over a range of industries during the pandemic; is that correct?

**A.** Yes.

**Q.** And you say it confirmed some expected outcomes, such as furloughed workers reporting greater job satisfaction; is that correct?

**A.** Yes.

**Q.** And you also noted that onsite workers who felt



supported by employers were the least likely to report worse mental health; is that correct?

**A.** Yes.

**Q.** So Dr Hughes again, trying to get your insights about what worked, what could a supportive employer do to support the mental health in the particularly stressful circumstances that you've described in your statement, and we've seen from the roundtable report? How do you support staff or how did you support staff, having to experience that level of abuse and sort of a new normal for behaviour?

**A.** I mean, it's incredibly difficult and I think what's important is to first and foremost acknowledge the stress and the pressure that people are under. I think that kind of approach of denial is never going to be helpful. So, you know, we very much acknowledged the pressure and stress, and of course we also furloughed individuals. Our shops were closed, so an entire workforce were furloughed overnight. And I think what we found is the distinction was people who were furloughed, you know, they had higher levels of wellbeing. However, those people who were remote working, for instance, they had a drop in their wellbeing and that was often because they were experiencing increased pressure and demand because there

were less people. So, you know, concentrated areas of work.

So I think that one of the things that had been helpful in environments, and certainly is about managing workload. So it's not just about creating the environment for good mental health, we can have conversations, we've got good policies, we've got a framework, et cetera and we've got these resources you can access, but also tackling the fundamentals about how people work, how much they've got to work, and I think you can't do those two things separately. They need to be considered together.

**Q.** Thank you.

Dr Hughes, you next turn in your statement specifically to the mental health on -- the impact of mental health of key workers. And you restarted, you say at paragraph 51, something called the Blue Light Programme that I'm going to ask you about, and that was to support emergency responders, including staff and volunteers working in the police, fire, ambulance, search and rescue services; is that correct?

**A.** Yes.

**Q.** And it's right to say, again, that the scheme had run in previous years but it wasn't active at the start of the pandemic?



**A.** That's right. We recognised for a long time the mental health impacts on blue light workers and had an extensive programme which was why, when we went into the pandemic, we again immediately recognised this is going to hit the fan. So we really need to kind of work out what we're going to do to support our frontline staff.

**Q.** Thank you. And you surveyed almost 4,000 of these workers and you published again a report on their experiences and deteriorating mental health, and you've exhibited that to your statement, as well?

**A.** Yes.

**Q.** And you give a quote from one of these workers -- that's at paragraph 59 of your statement.

Please can we bring it up -- in fact it's already happened -- INQ000652569 at page 21. And this is an emergency responder, who says:

"You drop them off, have I done the best for them? I might worry that I didn't do the right thing or, did I do the right thing leaving someone at home when we should have taken them in? But I try not to think about it because that's a recipe for disaster."

So I just want to ask you a little bit about the mental health of some of these emergency responders.

You've referred earlier, and also at paragraph 59, to the concept of moral injury.



**A.** Mm.

**Q.** And the footnote to your statement says that's the psychological effects of witnessing human suffering or failing to prevent outcomes which go against deeply-held beliefs. So, for the emergency responders, is the deeply-held belief in this context that you should be able to help people?

**A.** Indeed. And, you know, it kind of fills me with great sadness when I think and reflect back on what happened to our emergency workers. And I think about that paramedic who would go out to a family with a very ill individual, could be a grandparent, parent, whatever, and seeing children, not really being able to have the resources to do very much other than maybe provide some oxygen, knowing that if they'd brought them to A&E that they may not survive.

And I think that that -- you know, that always had existed, but during the pandemic the threshold of that absolutely went through the roof. So people were not, kind of -- paramedics, as an example, were not going to a very difficult situation once a day or twice a day; this was every contact they were having was incredibly problematic, high stakes, incredibly worrying, with complex clinical realities that needed, really, unpicking, knowing that they didn't entirely have the



resources to respond. And that was happening day in, day out, time and time again.

And that is corrosive. It is corrosive on all of our health and care workers. And again, has left a residue. I know personally many individuals who worked during the pandemic very closely with very sick individuals, and I don't know that they will ever recover from the decisions that they had to make during that time.

**Q.** Dr Hughes, you're talking, for obvious reasons, about health and social home workers, but it's right to say as well that we are talking -- we've heard from police, fire and rescue, and is the issue that they were also having to step in to provide services that they wouldn't normally do as part of their work as, for instance, police?

**A.** Oh, my goodness, absolutely. And of course the police and fire also had very late PPE, et cetera, so they were at high risk in those -- certainly in the early days. And of course they were also having to enforce new laws very, very quickly. The pressure and the stress and the scrutiny, which again continues today, but also made it feel, again, incredibly scary, an incredibly unsafe role to play in your local community, for instance.

If you're talking to families, "No, you can't sit

that closely together in the park", or, you know, actually they're responding to a home where somebody is incredibly suicidal. All of these factors absolutely are ongoing for the police, but during the pandemic I think that one of the things we kind of did is we divided our frontline workers into almost the "good" and "bad", and I think the police were in the, sort of, "bad" box. And, you know, we did a lot of clapping, didn't we, for our NHS workers? We didn't really acknowledge that for any other part of the system that really, kind of, came out in force.

**Q.** Dr Hughes, you've described something that was a key feature of what various key workers explained about their experience during the pandemic.

**A.** Mm.

**Q.** So thank you very much for that.

In terms of one other feature for key workers in particular, paragraphs 63-66, you're talking about, there, the very real concern about spreading the virus, which we've already heard a lot of evidence about, and you've described, in summary, widespread fear about an anxiety about PPE, access to vaccines, testing, and the media coverage that you've described. Is that a fair summary of some of the concerns for these key workers?

**A.** Absolutely. So, I'm going to share a bit of a personal



example. My mother was a key worker during that time and, as a result, we -- and me and my family were shielding because I have a child with a serious medical condition. And my mum actually lives across the road from me, but we couldn't see each other for three, four months, for the reasons that you've described: she was terrified of bringing the condition -- she worked in an old people's home, very high-risk environment. She was incredibly worried, so she was incredibly isolated. So, not only was she worried about passing the virus on to us, she was alone, she was alone dealing with very, very poorly individuals, with a very highly stressed workforce, and an incredibly worried family.

So, all round, people felt incredibly worried all of the time. That fear about spreading the virus, and of course even worse if you had older people in your family. And so we found emergency workers and key workers making the very difficult decision to leave family homes, to --

**Q.** Yes.

**A.** -- you know, be apart from their loved ones for this very reason. And, again, the impact on families, the legacy still remains.

**Q.** Yes. We have heard, again, teachers as well deciding to leave the family home.



**A.** Yes, yes.

**Q.** Touching, lastly, on a point you make arising from the blue light research, and that is about respondents from BAME backgrounds being less likely to report their mental health getting worse, which you, I think in your statement at paragraph 72, express a bit of surprise about, considering the higher risk of infection and mortality risks in some of those groups.

And you say you think maybe there was a need for the research to be a bit more culturally competent. Can you briefly summarise what you mean by that in that context?

**A.** Yes, so generally research comes from a very, kind of, normative model and therefore isn't often very culturally appropriate or thoughtful about what's going on in different communities. What we do know now is that actually in some of the black and minority ethnic groups that they have some protected factors, protective factors because of family connections and community. So we do know that there are some protective factors as well as some high risk.

So what we'd really like to see is some culturally appropriate research that is kind of -- that can elaborate, really, on those protective factors to help us really unpick what happened during those really difficult moments, especially when we realise that



people from black and minority ethnic communities were at high risk of dying.

So, all in all, it is quite a peculiar outcome, particularly, again, when we couldn't have funerals in the way that we would normally have. So all in all, it is a bit of a surprising outcome, but we also know that this particular cohort have extraordinary mitigating factors as well.

**Q.** Thank you.

Dr Hughes, I'm going to now ask you about some of the more vulnerable groups in society and I'm going to pick up on a few questions that some of the other core participants have suggested we explore.

Firstly, in relation to the clinically vulnerable and clinically extremely vulnerable, you've said that those who were shielding, Mind found were some of the most impacted by poor mental health; is that correct?

**A.** Yes.

**Q.** You describe loneliness and isolation of course, but also some particular accounts experiencing resentment from colleagues because they were permitted to work from home; is that correct?

**A.** Yeah, a really complicated picture. I think during the pandemic, obviously many of us experience that kind of sense of survival and looking at everybody else, what is

everybody else doing? So those dynamics absolutely were tricky, you know -- however, nonetheless I think generally, for people who were shielding, the risks around, or the perceived risk of being infected was very, very high. So even, you know, people would describe shopping being delivered and having to literally kind of bleach all of the packaging, et cetera, the kind of high levels of paranoia and worry which was based on the, you know, the very powerful messages that we were getting at the time around safety and infection control.

And so for shielding families, and again I can talk from experience, you know, you were not able to have access to all of the things that others were doing in terms of physical activity, you know, you couldn't have the hour a day. You know, even safe distancing wasn't often an option. And so the layering of isolation, fear, exclusion, and of course for many of those groups who were shielding, they also had comorbidities which meant that they also would be digitally excluded.

**Q.** Yes.

**A.** So, you know, it's not just a perfect storm, this is a perfect hurricane of factors.

**Q.** Just finally on that, you've described confusion about guidance and anxiety about getting Covid when the



in-person services resumed. So that's essentially a legitimate safety concern, as well, but it was impacting on mental health?

**A.** Oh absolutely. The fear of infection and the lack of infection control in mental health services conspired together to create a very, very poor picture.

**Q.** Thank you.

Moving on to briefly deal with what you say at paragraphs 99 to 105 about housing and homelessness. You point to another report from 2021, I don't need to take you to it but it's focusing on poverty. And you say that homelessness, social deprivation, domestic abuse and substance abuse problems, you describe that in your statement. And in terms of the report on poverty, you called this a confluence -- a spiral of adversity.

**A.** Yes. You would have heard from Professor Marmot yesterday.

**Q.** Yes, we did.

**A.** And I would absolutely concur with everything that he would have outlined.

**Q.** Thank you. And of course you've described specific initiatives such as the Everyone In initiative, and the eviction ban, and you've mentioned one group that benefited from the policies that were brought in were migrant groups with no recourse to public funds. Just



a couple of questions I'm asked to ask you about that group, please.

Later in your statement you note a disproportionate effect or impact on people from racialised communities in terms of poor mental health, primarily related to housing problems. Would you agree that many migrants without recourse to public funds would also be amongst that particular group?

**A.** Yes.

**Q.** And you've also been referred, I think, to part of a witness statement on behalf of the migrants' rights commission, and that noted a high prevalence of mental health, in particular amongst asylum seekers who have experienced prior trauma?

**A.** **(Witness nodded)**

**Q.** Is that consistent with your understanding of mental health in migrant groups?

**A.** Absolutely, because it's no surprise to many of us that often people who are seeking asylum, migrant groups, have already come from a place of trauma, already very, very vulnerable. And so again, what we saw in the pandemic -- and I don't use this word lightly -- but people were being triggered time and time again, either because of fear, isolation, exclusion, and this kind of idea of not belonging anywhere or to anyone.



**Q.** Thank you.

Turning now to paragraph 106 of your statement, you've said there's a strong link between exposure to intimate partner abuse and the incidents of mental illness, and also that women with mental health problems are more likely to be domestically abused. A few questions on this group, please.

A number of Mind reports note that speaking to family and friends online, spending time outside, were the most common coping strategies, and we've seen that. Did you encounter such strategies being restricted by perpetrators exercising greater control over victim-survivors during lockdown?

**A.** Yes, I'm so utterly sad to talk and think about this, but absolutely, that's true. I think where there were instances of domestic violence or coercion in homes, absolutely created an increased layer of isolation for victims. Often we heard stories about people not able to have the hour a day, not being able to retain any contact with friends or family, experiencing extreme levels of violence and not being get the care to attend to those injuries. So absolutely, it created a terribly, terribly vulnerable group with children.

**Q.** So you've got perpetrators controlling movements, access to technology and social connections; is that correct?

**A.** Yes.
**Q.** And lack of access to mental health services during lockdown in that environment would have a particular impact on this group?
**A.** Absolutely. And our ability as workers really compromised in terms of being able to know what's going on. So I come back to that point around, you know, if we're doing remote consultations, you know, we are limited in what we can see and know about the individual. Injuries can be, you know, hidden. What's going on in the environment can be hidden. And so our ability to intervene was deeply compromised.
**Q.** And services going online clearly presented particular challenges --
**A.** Yes.
**Q.** -- that you've described for that group?
**A.** Yes.
**Q.** Thank you.

Turning to people detained in prisons and detention centres. I think you say that Mind hasn't conducted any specific research on that.
**A.** No, but I worked at the Centre for Mental Health at the time when we were commissioned by NHS to do a review of mental health in the prison service.
**Q.** So I think you've said at paragraph 109, there was



significant concern about that population during the pandemic, and understanding that there was a considerable deterioration in the mental health of detained people?
**A.** Absolutely. So this is already an incredibly vulnerable cohort. This is, you know, a group often that has anything between 75 and 90% of people going into prison have some sort of mental health or learning disability, you know, or some vulnerability of some kind. So this is already a very vulnerable group of people.

What we saw during the pandemic is that mental health support flatlined again overnight. We also so saw a massively -- a massive increase in the amount of time people were held in cells, for instance that often didn't meet human rights regulations.

So, you know, exercise wasn't really an option. There were massive delays in accessing education. There were massive delays in staff accessing PPE so distance, you know, therefore they had to keep huge distances between officers and prisoners.

We saw, you know, a lack of contact with family and friends, so any of those protective factors disappeared overnight and for people with serious mental illness, not being able to access medication, for instance, is life threatening.



**Q.** Thank you.

I'm going to turn finally to your experience of the bereaved, at paragraph 116 of your statement. Again, the Inquiry has received and will be hearing more evidence about this from other witnesses. I just want to ask you about one of the many case studies you present from a bereaved individual who has spoken to Mind, and it was mentioned in your opening statement, as well, on behalf of Mind.

You cover the experience earlier in the statement, at paragraphs 93 to 97, the experience of disrupted mental health services, essentially. And what the account involves is a very negative experience during the pandemic in terms of the healthcare provided to a loved one before they died.

And in summary, she says that her father was admitted to hospitals under the Mental Health Act, was not allowed visitors, she was very concerned about the adverse affect of that on him, and that sadly he died from complications of Covid. So that's what happened.

In terms of what she's been left with, and you describe it in your statement, she's left with many concerns about his care, ventilation, and testing.

And then moving on to his death, she wasn't able to see his body, there were only ten mourners allowed at



his funeral, and she explains, and you set this out in your statement, a huge amount of resentment about what happened and a lack of closure.

So, just taking that one example that you have cited quite a lot in your statement, can I ask you, do you think that having multiple layers of distress at each stage of the loss and bereavement process, does that have a particularly bad impact in terms of closure in the bereavement process, in your view?
**A.** Absolutely. And first and foremost, I think -- I just want to say that Mind stands in heart and solidarity with all of those families that lost loved ones during those terrible days.

I think that it absolutely does, and we, again, are seeing the legacy of that today. We are seeing complex grief, for the reasons that you describe, at every point of the story that you've highlighted. All of the ordinary things that you would expect a family to be able to do were taken away. And so not only did the individual die alone, effectively, the family also were unable to provide the support that they wanted to, and that they could have provided if they were allowed to.

So, all of these aspects I think have, again, conspired to create a legacy of grief that we still, as a nation, are not really understanding. The 10,000

children who lost their primary caregiver, all of those funerals that were not done in the way that we would have wanted to. We can see in racialised communities, particularly where the ritual of funerals that we couldn't deliver on, the legacy and the pain of that still remains with -- deeply within families.

I think that we're seeing complex grief but we're also seeing post-traumatic stress disorder as well as a result of that, and I certainly, again, you know, can use many personal examples where, you know -- you know, we had to speak to a dying loved one over an iPad or, you know, a funeral online. And all of these things, again, do not create the ending or the natural process that you undertake when you're grieving.

**Q.** Do you see this, which has affected so many people, as a driver for persistent symptoms of poor mental health?

**A.** Absolutely. And the government are obviously undertaking a prevalence review of mental health at the moment, and certainly bereavement is, you know, a core factor for exploration and inquiry. The reality is that the entire fabric of how we support people who are dying, the families, and what happens afterwards, completely disappeared. And so all of the things that we would usually do were unavailable to us.

And if, you know, we can cast our minds to those



moments when a loved one is in those last moments and you're having to be online, you can't hold them, touch them, kiss them, the legacy of that is forever. That doesn't disappear.

**Q.** Thank you so much, Dr Hughes.

I'm going to, finally, touch on the lessons learned from the pandemic in terms of the impact on mental health, as you've described it.

You set that out in a series of recommendations that are at different points, three points, in your statement. The first set I don't need to take you to, I'll just draw out some of the main points, that was at paragraph 49, relating to the general population. And it's fair to say that some of those are essentially calls for action on issues that already existed during the pandemic, for instance inequalities, but it's right to say that the pandemic brought into sharp focus some of those priorities; would that be a fair way of describing it?

**A.** Oh, my goodness. I mean, all of the things that those of us who have been in the sector for a long already knew sadly came home to roost in the pandemic in very glaring and catastrophic ways. And I think that our primary recommendation alongside the demand for a recognition of mental health surge planning in the



overall pandemic planning approach is really that we must tackle the inequality that people are experiencing. We saw far too many people die; we saw far too many people develop, you know, mental health challenges but also deepen their mental illness.

So all around, what we can see from an inequality perspective, it's a key driver, it is catastrophically harming the nation still today and sadly the pandemic accelerated the deepening of inequalities for far too many families, particularly those with comorbidities, mental and physical challenges.

**Q.** Thank you. Thank you so much for that summary.

Can I just draw out a couple of the lessons that seem to be the most specific to everything you've explained about the Covid pandemic. You mention normalising workplace conversations and embedding mental health considerations in workplace practices; is that correct?

**A.** Yes.

**Q.** And we saw that in particular as part of what you described as the learnings from the Blue Light Programme and the workplace wellbeing index?

**A.** Yes, we have to create the conditions in all aspects of society for mental health conversations to happen, but also mental health literacy, and also the ability to



access help when you need it. So it's not just good enough to talk, workplaces need to be able to do that. They also need to be able to provide resources and they also need to be able to signpost people to help when they need it.

And I think, all around, during the pandemic that did emerge over time, and we saw that -- some brilliant work across many industries and sectors, but again, we're seeing a decline in that approach now. And so if another pandemic were to happen tomorrow, I'm not entirely sure those lessons have been really deeply embedded in the fabric of the way that we think about work.

**Q.** That is what you'd like to see?

**A.** A hundred per cent.

**Q.** Secondly, you've talked about, again, the importance of physical activity and use of social prescribing, and all of that is borne out of what you've described about the activities and initiatives that you provided during the pandemic?

**A.** Yes.

**Q.** And the second set of key points, at paragraph 86, are specific to key workers. Again, it's the importance of prioritising mental health. We don't need to touch on that again. But in terms of that specific issue about

key workers being public facing and needing to enforce research -- restrictions and the abuse they might face, you've essentially suggested that some quite tailored support is needed for that; is that correct?

**A.** Indeed, because it rests on so many factors. I mean, especially if you think about small communities, where, you know, somebody might be aggressive or violent in a shop, but that affects the entire community, right? So all relationships get damaged. So, in terms of the impact, the kind of halo effect of all of these things, it's not just on shop workers, it'll be on their families too. So, we do need to be able to think about a tailored intervention, we do need to be able to support individuals, but we also need to manage the risk of that. So it's not just about giving them the tools, maybe, to de-escalate or to understand a mental health crisis, but also to be able to keep themselves safe, and how do we do that, you know, in terms of alarms, making sure they do have relationships with the police locally and regionally, and I think all of those things, both practically and, kind of, philosophically, in terms of how we should be thinking about these things, need to come to bear.

**Q.** Finally, I'll just run through four specific points that come from your statement shortly. Specific issues about



challenging self stigma, particularly emergency workers, as you've described. In terms of vulnerable people, the importance of access to PPE, for both mental health wards and others, like charities such as yourself. And finally, you note the need for expanded suicide and bereavement support services. They seem to me to be the most pandemic-specific learnings?

**A.** Yes.

**Q.** Is there anything else that I've missed?

**A.** No, I think that the only thing I'd probably add is that as we plan the next decade of mental health interventions, I would urge the government to make sure that they take on the learnings of what happened in the pandemic and create mental health services that attend to the legacy of that.

**MS RAHMAN:** Thank you very much, Dr Hughes. There may be some other questions for you.

**THE WITNESS:** Thank you.

**LADY HALLETT:** There are. Mr Weatherby.

Mr Weatherby is just there.

**Questions from MR WEATHERBY KC**

**MR WEATHERBY:** Thank you.

Dr Hughes, I represent Covid Bereaved Families for Justice UK, and in fact the family member whose case you highlighted with respect to her father who was under



a section. So I thank you for that.

Just a very short point from us, and it goes back to some evidence you gave at the start of this session. In your statement at paragraph 9, you say that:

"There has been a marked increase in the level of distress displayed by our beneficiaries during contact, with many citing that they're unable to access services."

And that's at the beginning of the pandemic and that's the evidence you were giving.

Did that include the inability of bereaved people to seek access to bereavement support as well as more general mental health access?

**A.** Yes, I'm afraid it did in the early days, yes.

**Q.** Yes, and that leads to your recommendation that that needs to be ramped up in future?

**A.** Absolutely. It has to be a core part of mental health services going forward. I mean, obviously, grief is not a mental health issue per se.

**Q.** No.

**A.** But pandemic-related grief becomes a mental health issue.

**Q.** Yes.

**A.** And so our very clear recommendation is that that must be taken into consideration in the future, especially



around the impact on families, but also in terms of the type of services that we support. So this is not just kind of, you know, ordinarily grief support would be very kind of gentle and low key.

**Q.** Yes.

**A.** We're talking about complex PTSD or complex grief which demands a clinical intervention.

**MR WEATHERBY:** Yes, thank you very much, thank you.

**LADY HALLETT:** Thank you, Mr Weatherby.

Ms Douglas, who is that way.

**Questions from MS DOUGLAS**

**MS DOUGLAS:** Thank you, Dr Hughes. I act for Clinically Vulnerable Families.

In your statement at 98.2 and it's where you're describing some of the insights provided by local Minds, you reported that the anxiety of avoiding catching Covid-19 and spreading it to vulnerable relatives was felt more acutely prior to lockdown when clinically vulnerable people felt helpless to protect themselves from getting infected.

**A.** **(Witness nodded)**

**Q.** And then you go on to note that after lockdown, restrictions started to ease, a top concern was about members of the public refusing to adhere to social distancing and other infection control measures.

Would you agree that for clinically vulnerable people and those living with clinically vulnerable relatives, the mental health impact increased as restrictions eased because they were left to manage their elevated risk from infection alone without society-wide protective measures?

**A.** Oh absolutely. We heard from individuals that it felt like a cliff edge, that all of the protective factors had disappeared. That they suddenly become almost like a polarised group of people who often were not just kind of frightened, but in some instances kind of humiliated and mocked for that anxiety in the long term, and all of those factors impacted mental health in the long term.

So this group were incredibly vulnerable, and continued to be vulnerable for quite some time after the pandemic. And even now, the legacy of the pandemic has been when you hear -- so, for instance, before Christmas we had that kind of flu, "We're in crisis with flu", for those individuals, it immediately brought back to that sense of fear, risk, isolation, worry, and so again, the legacy of that has continued, sadly.

And certainly, again, I can use our own experience as a shielding family, when the restrictions came to an end, we did feel that sense of abandoned because, you know, not knowing how we would be able to survive in



this world where individuals were not maintaining safe distance, et cetera, et cetera, and that took some time to kind of get over.

**LADY HALLETT:** Thank you, Ms Douglas.

Ms Sergides. Over that way.

**Questions from MS SERGIDES**

**MS SERGIDES:** Grateful, my Lady.

Dr Hughes, my name is Ms Sergides. I represent the Domestic Abuse Group. I'm just going to start with the first topic which is housing and homelessness.

At paragraph 100 of your statement, you probably have it in front of you, you describe the spiral of adversity experienced by people with mental health problems who are more likely to experience homelessness, social deprivation, domestic abuse and substance abuse.

During the pandemic, women fleeing domestic abuse struggled to access mental health services, health services more generally, and housing support simultaneously, for example in the DA Group's evidence, the second largest reason women were refused emergency accommodation at specialist services was that their mental health needs were too great to be managed safely. That's in the DA Group's evidence.

Would you agree that this intersection of mental health needs and domestic abuse created a particularly



acute service gap during the pandemic?

**A.** Yes. And, again, I think that the legacy of that continues on children and families, and victims of domestic abuse.

Absolutely, it was a significant gap, and one that increased every day. And again, our ability to really discern what was happening for individuals was compromised, our usual safeguarding mechanisms, again, disappeared overnight. And so, absolutely, this group was incredibly vulnerable. We know that the figures, in some instances, up 300% in terms of the violence and abuse particularly women were experiencing, and, again, that creates a legacy of PTSD, complex needs. And, again, the legacy on children and young people was significant.

**Q.** Yes, I think you've spoken in evidence about workers being compromised, that they didn't -- couldn't quite access what was going on?

**A.** Yes, yes.

**Q.** Turning to the second topic, which relates to key workers -- and again, you've given very clear evidence to that this morning -- refuge workers were working on the frontline, potentially exposing themselves to the virus, whilst simultaneously assisting in dealing with victim-survivors and their trauma at the most intense



periods during the pandemic. And I think you deal with this -- you dealt with this in your oral evidence. And I think you also deal with it, of course, in your statement, at page 17.

Do you agree that the poor rates of mental health amongst those working or volunteering on the frontline, and the examples you've given, such as the police, fire, ambulance, retail and education, frontline workers, also applies to workers in the violence against women and girls sector?

**A.** Absolutely, and I think -- I just want to acknowledge that many workers who work in the violence against women or domestic violence sector will also have lived experience, so either past lived experience, which is why they work in the sector -- and, of course, all of us who work in the system generally are also part of this world and, so, many of us also experience domestic abuse during that time. So, again, the combination of dealing with incredibly -- the most vulnerable women under the most incredibly painful and frightening circumstances, perhaps with your own experiences too, understanding that you couldn't help -- so not only have you got lived experience, you're seeing somebody in terrible distress and you know that you can't provide the support, ie, moral injury, the combination of those factors is,

again, catastrophic. So, yes, I would agree.
**Q.** And just to follow on from that, Dr Hughes, the evidence from the DA Group is that whilst their workers worked incredibly hard and were dedicated during this period -- and of course, more broadly, the sector has since experienced high rates of staff turnover and burnout.
**A.** Yes.
**Q.** And I think you've briefly touched on that as well.
**A.** Mm.
**Q.** Would you say that that account is on par with your observations about blue light staff and some of the other frontline workers you've referred to?
**A.** I absolutely agree, and I can see that, across the board, we have seen an increase in burnout, sick days, I think 9.4 or 10 -- nearly 10 -- sick days have increased, you know, across the board because of the impact of the pandemic, in my view.
And I think that of particular concern is that we were unable to intervene in terms of understanding the particular trauma on staff because the business carried on.
**Q.** Yes.
**A.** So there has been no opportunity to stop, and of course there isn't, because people still need us. People still need us to be there. The reality is that this work is



incredibly painful, and during the pandemic particularly painful, and the legacy of that continues, and I think that the issue of burnout is one that we must attend to as a matter of urgency.
**LADY HALLETT:** Thank you very much, Ms Sergides.
Dr Hughes, you said that one of the roles of Mind is to advocate for those who suffer from mental health problems and issues of illness. If I may say so, you are an extraordinary advocate for Mind. You have been a very, very powerful witness and I'm extremely grateful to you for the help that Mind has given to the Inquiry, and obviously excellently represented by Mr Pezzani, but also for the help you've given. It's been a very interesting morning.
**THE WITNESS:** Thank you, my Lady. I really appreciate that.
**LADY HALLETT:** Very well, I shall return at 11.35.
**(11.22 am)**
**(A short break)**
**(11.35 am)**
**LADY HALLETT:** Ms Rahman.
**MS RAHMAN:** My Lady, may I call the next witness, Professor Sarah Stewart-Brown.
**PROFESSOR SARAH STEWART-BROWN (affirmed)**
**LADY HALLETT:** Professor Stewart-Brown, thank you for coming to help us and for the work you've done for us so far.



I think you know what's going to happen. I think you've been following the proceedings for the last few minutes.
Ms Rahman.
**Questions from COUNSEL TO THE INQUIRY**
**MS RAHMAN:** Professor, could you give your full name, please?
**A.** Yes, I'm Sarah Stewart-Brown.
**Q.** Thank you. And Professor, you should have in front of you a copy of a report which is entitled "Systematic Evidence Review: The impact of the Covid-19 pandemic on the mental health and wellbeing of the UK adult population". Reference INQ000659787.
**A.** Yes.
**Q.** And you've also, Professor, provided us with a brief statement, INQ000549365, and in that you confirm that you were the senior academic consultant for the Centre for Strategy and Evaluation Services, and they were appointed by the Inquiry to prepare the review; is that correct?
**A.** It is.
**Q.** Thank you. Professor, can you confirm that any facts stated within the review are true to the best of your knowledge and belief?
**A.** Yes.
**Q.** And can you also confirm that any opinions you've stated



represent your true and complete professional opinion?
**A.** I can, yes.
**Q.** Thank you.
Now, Professor, turning first to your professional background, in summary you are the emeritus professor of public health at the University of Warwick?
**A.** Yes.
**Q.** And you're also an expert adviser to several research projects and programmes?
**A.** Yes.
**Q.** And you've also advised the English, Scottish and Welsh governments on public health mental health in a variety of contexts?
**A.** Yes, public health mental health was my specialist area within public health.
**Q.** Thank you very much.
Now, Professor, turning to page 7 of the review, and can I have that up on screen, please, it's INQ000659787, page 7. And this sets out the review's research questions, and just so we all know what this document is doing, it is looking at how did the general UK adult population's mental health and wellbeing change during the pandemic? And the period was approximately March 2020 to June 2022; is that correct?
**A.** It is, yes.

**Q.** But I think we see at some point some of the research goes a little bit further than that, and you touch on that during the course of the review occasionally.
**A.** Yes, it's important that this was focused on the general population, so people like you and me, you know, people who didn't necessarily have any defining factors before it, but that population includes, you know, 20% of that population do have a mental illness.
**Q.** Right, yes.
**A.** And a lot will be parents or -- there are particular groups within the population and so when -- the general population studies may well also look at the sizeable groups within the general population and make a comment on them.
**Q.** Yes, thank you. So you're talking there about what we mean by the general UK adult population; it does in fact include some people with severe conditions, and we'll come back to definitions of mental health in a moment.
**A.** Yes.
**Q.** Let me move to the second question: what were the risk and protective factors for changes in mental health and wellbeing relative to pre-pandemic trends? And I don't need to take you to it, but there's a glossary to the review that explains what is meant by a risk or protective factor and in summary it says a risk factor



increases the chance of a negative outcome whilst a protective factor reduces that chance or helps improve outcomes.

Can you give us an example?

**A.** Yes. So, for example, smoking might increase your risk of getting cancer but it doesn't dictate that you will get cancer.
**Q.** So it's just a risk factor?
**A.** Just a risk factor.
**Q.** And, for instance, a protective factor might be, for instance, wealth or something like that in terms of mental health?
**A.** Indeed, indeed.
**Q.** Thank you. And then on that second question again on page 7, it says that where data allows a range of specific focus areas, risk factors, protective factors, demographic characteristics or geographic location, have been examined and you did that to understand how different specific groups or populations were affected?
**A.** Yes, indeed. And I think we're going to come on to a little bit about the methodology.
**Q.** Yes.
**A.** But the point about systematic reviews is you try and find every possible study that could be relevant to your topic and then you weed them down further from there,



but you are constrained by what research has been published.
**Q.** Yes, indeed. We are going to come up to that now.

Can I bring up the review INQ000659787, page 8, please, and that talks about the methodology. And just to understand the scale of what was involved that you and your team were looking at, there were over 5,700 sources, studies, essentially, on mental health in the pandemic, of which 2,700 were unique. Does that mean there were a lot of references to the same study or does that mean -- (overspeaking) -- duplication.
**A.** There were lots of duplicates and this research might be published in the same way in different -- (overspeaking) --
**Q.** And then you -- there's a lot to the report. There's also a technical report attached to it explaining how you identified what was a study that was robust. We'll come back to that. You included 118 studies, and ultimately, you excluded some of those because of quality checks, and we've ended up with a list and it's still 98 high-quality studies, essentially?
**A.** Yes, that's true.
**Q.** And can I just ask you, the fact that you've got so many studies and sources all looking at the issue of the pandemic and the impact on the population's mental



health, does that tell you anything about the extent of the impact -- or why was it, do you think, that so many of these studies had looked at this particular issue?
**A.** Because I think people in the research community were extremely concerned to document and find out what was going on in the pandemic.

And I think one of the other things about this is that some of the rules which would usually be there for research studies and would enable you to get grant funding were relaxed a bit during the pandemic, because there was this real big concern to try to find out what was going on, so there were more studies published, for example, on -- invitations for people to take part in them, rather than selecting a random sample of the population.

So you just need to be a bit more careful about who was part of that study and who wasn't.
**Q.** So, what you've done, you and your team have done, is gone through many, many different studies and resources, all of which were devised with the very laudable aim of trying to work out what happened, but you have fine-tuned the selection to something that we can really draw some conclusions on?
**A.** And I suppose the large number is just evidence of the fact that if you look at the technical report you can

see all the search terms, and so the review did aim to specifically identify any studies that were relevant to any of the risk or protective factors. And then you have to weed out which of those are actually just commentaries, there's no data in them, or, you know, there are people there talking about other people's studies, and hone down on the ones that have got useful data that they're presenting.

**Q.** Thank you so much.

Can I ask again, same INQ reference but page 13, which you have essentially stressed some limitations, which I'll just take you through very quickly.

Essentially, the quality of the studies varied, the measures used weren't always consistent, so in terms of definition of mental health, we'll come back to that. Data availability. And certain groups -- again, we've heard about this and we'll come back to it -- such as people from minority ethnic groups, disabled people, those in institutionalised settings, people without Internet access, were often underrepresented.

So we'll come back to those at the end but those were the sorts of limitations that still apply, notwithstanding this rigorous filtering process.

**A.** Yes, indeed.

**Q.** Thank you.



Then, if I could ask you to look, same INQ reference, page 14, this is the traffic light system that anyone reading the review will recognise. It's a visual way of explaining some of the points that you've just explained, and I'll just ask you about the right hand column essentially.

If you see a traffic light with the red traffic light, it essentially means low confidence in the findings. So, notwithstanding the filtering process, it sounds as if you've still got a few in the mix, as it were, where there are, in fact, some major flaws that you identify; is that correct?

**A.** Yes, but I think that's taking into account the fact that there were some populations that were seriously difficult to study.

**Q.** Yes.

**A.** I mean, the homeless don't feature in any of these studies because you can't involve them in these sort of studies. So where people have made an effort to study a difficult-to-reach population, even though the method is not quite up to the scratch with the others, we would want to have it included there because it gave the best evidence that was available.

**Q.** Thank you. That's a really helpful explanation for why we still do see some of the studies there.



And then more easy to understand, the amber light: reasonable confidence but some issues around size, generalisability.

And then, finally, the high confidence: well-designed, high-quality studies.

**A.** (No audible answer)

**Q.** Thank you very much.

Can I just bring up page 14 again, under 1.4 on that at page. This is about defining mental health, and I just want to ask you about that, what you've said or the review says there is that there is quite a lot of confusion about the terms "mental health" because it's used to synonymously mean mental illness. Do you mean by that, sometimes people say something has affected their mental health and what they mean by that is adversely?

**A.** That's how it's very often used, that term, yes.

**Q.** And you use the term differently, as a continuum, so spanning from the presence of a really severe mental condition at one end and a really positive wellbeing at the other; is that correct?

**A.** Yes. I think this is a really important point throughout, because we're talking about the population's mental health and that does span from serious mental illness or common mental disorders, psychological



distress, right through to the mental wellbeing at the other end. And it is -- "mental wellbeing" in many texts is defined as feeling good and functioning well, and every psychiatric diagnosis is made on the basis of feeling bad or functioning poorly. So there is a continuum there. But I think the point to recognise there is that most of us muddle along somewhere in the middle of this continuum and up to 50% of us will drop into the category of clinical mental health problems, mental illness, at some stage or another.

So, there's a lot to be covered in this, but I -- if I can go on from there, these studies use slightly different definitions of mental health or mental illness, and many of them divided the population. So they would use a scale, but they would decide on a particular cut point in the scale, and this side of that cut point you would be in the psychologically distressed or depressed or anxious category, and the other side, you'd be fine. And those studies produce information which is very easy to understand. So we had 20% of the population were psychologically distressed before, and afterwards there's 30%, and that's easy to grasp. But it misses a lot of data.

So if you then turn to an approach where you're looking at a mean, an average, and some confidence

intervals around that in the general population, and how that shifted, you get a much more nuanced and statistically robust result. But it's more difficult for people to understand.

**Q.** Yes.

**A.** So both have their value, and I think most of the studies on mental health problems of one sort or another, analyse data in that way, whereas the studies of mental wellbeing and the various different ways of measuring that, like life satisfaction or happiness or engagement with life, they'd much more look at a continuum.

**Q.** That's really interesting. Thank you very much. You've done a really good job of explaining something that's quite complicated.

We heard yesterday from another witness, an expert witness, who was saying that, you know, simply ticking boxes -- meets a threshold for a diagnosis, doesn't meet it -- it means that you missed some of the nuanced data that can be quite helpful to understand in part?

**A.** Well, I think another important fact is that the -- in the non-clinical range, I -- you know, the range of mental health that is not of interest to psychiatrists, your level of mental health within that continuum has huge implications for future physical health, health



service usage, productivity, sickness absence, all those things.

**Q.** Yes.

**A.** So it matters.

**Q.** Yes.

**A.** And you cut that out of studies where you've gone for a what's called a dichotomy. You've cut the population in two.

**Q.** Thank you, Professor.

Now, in terms of the review's period of analysis, I would like to now just take you to page 15, again it's the review, INQ000659787. And you touch here on the broad periods of time that the review has taken in terms of analysing the impact on mental health and wellbeing.

So first, the description there of the pre-pandemic period which you've taken from 2017 to 2020, and in describing that period, it's essentially said that it was characterised by uncertainty, and you refer to Brexit, austerity, public service cuts, housing, insecurity, and unaffordability, and you're flagging this, I take it, that because in the context of mental health, those sorts of factors could affect people's mental health and wellbeing?

**A.** Yes, and during the -- you know, up until the pandemic there was evidence that mental health problems were on



the rise.

**Q.** And then looking at the next period, the post-pandemic period that you're looking at, you have highlighted March to June 2020, which is broadly characterised as the first lockdown period, because that's the sort of time when you'd expect to see, I take it, some sort of impact or it would be worthwhile looking at that sort of time period because of the lockdown and people's mental health suffering?

**A.** Yes, but I think it's also important to point out in terms of methodology, the particular study may not have started in March, or may not have started -- there were different time periods depending on the datasets that people could access and the questions that were being asked of them at the particular time.

**Q.** Yes.

**A.** So we were putting together an overview of data from many different studies.

**Q.** So you've done the best you can despite the fact that all of these studies are taken at slightly different times, to try to work out what you can say in a robust analysis about that particular period, what happened to people in the first lockdown?

**A.** Yeah.

**Q.** Thank you. And then just to touch on some of these



other time periods on the next page, easing and summer, that is July to October 2020, and we remember and you remind us, it was characterised by hospitality and leisure venues reopening, the Eat Out to Help Out scheme, further easing, but then towards the end of the period we have increasing case numbers and, of course, the rule of six and things like this.

So that's another sort of description of what the country was, in colloquial terms, going through during that period of time.

**A.** And I think a certain amount of uncertainty about whether what the recommendations that were coming out the best option for that period. So there was a lot of uncertainty then, wasn't there? And a lot of relief.

**Q.** Of course. And then the penultimate time period for the review, the second and third lockdowns, and you've pointed out that one of the, sort of, main events of that period of time was the Covid-19 vaccine being administered and the gradual reopening of services and public spaces.

And the final period you look at, and again, time periods may vary, but from April 2021, the stepwise restriction lifting by mid-2022. That was the time at which you've taken the lifting of most restrictions.

**A.** Yes.

**Q.** And you do say there that you then see in that last period, presumably from the studies, an overlap with other societal pressures such as the cost of living crisis?
**A.** Yes, indeed.
**Q.** Thank you.
**A.** And I think it's worth pointing out that the searches were done in October 2025, so we'd hoped to pick up any studies that were reporting on information up to that, but it takes quite a long time to do these studies and to publish them, so actually, the last data we have is from 2023.
**Q.** Thank you very much, Professor. That's a very helpful time for us to now come to the findings of the review.

So if I can bring up the review again, INQ000659787 at page 17. And that, filtering all of the evidence that you've reviewed, is what the pattern over those periods of time tends to suggest.

So if I could just ask you, please, Professor, just explain these findings, with the benefit of that slide in front of you, to us.
**A.** Yes, well, I don't think it'll be any surprise to anybody to discover that the pandemic had a pretty dramatic effect on population mental health and, you know, from the first lockdown on, rates of mental health



problems, psychological distress and, in fact, mental illness rose. And whilst it eased during the lockdown periods and then went up again when more restrictions came on, it didn't fall back to where it had started from, and by 2023, we're still seeing quite a significant rise in the levels of mental health problems relative to pre-pandemic levels.
**Q.** And the pre-pandemic levels perhaps worth commenting upon. Even before the pandemic, nearly one in five, 19.4% of adults -- women -- of adults -- did report psychological distress, that was before the pandemic, with certain groups more affected. But that has gone up during lockdown, unsurprisingly, and then you've got a partial rebound.

Could I just ask you about that. In terms of the partial rebound, are there things such as employment that are particularly relevant to why some people rebound and some people do not after lockdown?
**A.** Well, I think we'll probably go to that in looking at the more specific factors. So these were just, really, looking at the general trends.

I think that what might be more important to add is that overall picture that we've painted hides different trajectories. So, for a proportion of the population you can see their mental health going -- getting worse



as soon as the lockdowns come in, and never really recovering. And then there are other groups where the population's mental health went up and then recovered a bit during the pandemic, and then went down during lockdowns, and then the easing and then came up again afterwards. And there were some people who were in between that group.

But if you look at a purely binary cut point between psychological distress and not, you could suggest that maybe 50% of the population were resilient and 50% dropped into that category of mental health problems during the pandemic. But amongst those in the 50% who were apparently resilient, you can see that the changes in mental wellbeing happen even in that group.
**Q.** Thank you.

Earlier on in your evidence you were explaining to us about this area of mental health, which is perhaps not as striking as some of the very severe impacts that we have heard about, but which nonetheless have a real impact in terms of time off work, ability to function.

I just want to ask a bit more about that which we can get most easily from your summary of what happened in the first lockdown.

So, again, review INQ000659787, page 19.

In the initial lockdown, towards the bottom of the



page, just to remind us what we're talking about in terms of impact on mental health during this period: concentration difficulties, sleep problems --
**A.** Yes.
**Q.** -- feeling a lack of role and purpose, and just an inability to enjoy daily activities.

Can I just ask you for a few key points arising out of those sorts of factors that are set out?
**A.** Yes, these are the sort of things that people might use to get a handle on mental wellbeing that wasn't at the level of being ill.
**Q.** Yes.
**A.** And these are things that commonly go wrong when people aren't doing so well. And we're looking here particularly at the negative aspects of them, but it would have been more appropriate, possibly, to measure the people who were still sleeping well rather than those who weren't.
**Q.** Yes. And what seems to be quite a striking statistic towards the end, inability to enjoy daily activities, that was the most significant deterioration.
**A.** Yes.
**Q.** And you go from 16.8% of people saying that in 2019 to 46.2% in April 2020?
**A.** Yes, exactly.

**Q.** So we're not -- these aren't people who are reporting severe mental health conditions but an inability to actually enjoy life, very significantly --

**A.** Well, these are people like you and me.

**Q.** Well, you make a lot of assumptions, but yes, indeed.

So, moving on to the impact not being experienced equally. Professor, we've heard a lot of evidence about this and pre-existing inequalities. I don't need you to delve into it in a lot of detail, but, in summary, you have pointed out in the review on a number of occasions that pre-existing inequalities have clearly played a huge amount of significance in how people have been impacted by the pandemic.

Just in a few sentences, could you explain why you have stressed that so many times during the course of the review?

**A.** Yes. I mean, there's -- we'll go into this I think in more detail, but there's no doubt that there were pre-existing groups in the population who were vulnerable, suffered worse, and there's some -- a few anomalies in that we can look at.

But I don't think this is of any surprise. I mean, if you take a group of people who are vulnerable and you lob something enormous at them like the pandemic, they will be less resilient to the effects of it than people



who start off from a resilient perspective.

**Q.** Of course.

**A.** And I think that covers pretty much all the groups we were able to look at, because there was data available.

**Q.** Thank you very much, Professor.

So, the review has drawn these large conclusions about how people have reacted across the course of those five time periods. The final time period, you've identified that, in the longer term, there are still very elevated levels of distress despite the lifting of restrictions, and one question I've been asked to explore with you is whether or not you think that that could be related in some way to the number of people experiencing bereavement. Given the scale of bereavement that was experienced by the population, and perhaps the long-term nature of it, which the Inquiry has heard some evidence of, was that any part of the reviews that you looked at, a specific focus on bereavement?

**A.** There was nothing in the review evidence to be able to say one way or the other. I mean, I am sure that there were very few people in the pandemic who experienced a good death, and a bad death has huge implications for the bereaved. But they still are -- they still, whilst there was -- a huge number of people died in the



pandemic, the bereaved families still represent a relatively small proportion of the population in total.

**Q.** Yes.

**A.** And so the effect on their mental health is unlikely to be a result -- be the cause of the statistics that we've seen.

**Q.** Because what you're looking at is very broad population-wide type statistics so some of these groups aren't represented in high numbers -- (overspeaking) --

**A.** There's not enough of them statistically --

**Q.** Statistically.

**A.** -- to create the effect that we saw in the data.

**Q.** Thank you, that's very clear.

So the next part of your report is part of you looking at the review at very specific demographic groups, and that is from pages 27, my Lady, to 63 of the review.

And is it right, Professor, that what you've attempted to do there is take some specific groups or factors, and I'll list them in a minute, and what you've done is look at the evidence base and try and summarise, again over those five periods, exactly what each group was doing in terms of their reaction and the mental health during the pandemic?



**A.** Yes, we've done the best job we can but you're short of studies in lots of places and the evidence isn't so robust.

In fact, could I please just go back to --

**Q.** Please do, yes.

**A.** -- there were a couple of points that came out of the general population studies we've referred to already, and one was a study that attempted to look at the stringency of lockdown measures and see whether they could predict what was happening to mental health at the time. And this study did find that the stringency of lockdown predicted how much impact there was on mental health, which I think is important because one of the things about the pandemic and all this data is it's very difficult to tease out the effect of this very frightening virus from the effect of the control measures. And some control measures were inevitable, but there was choice around which control measures.

And so it's important to know, it's important to be able to find out, to the extent you can, which was the driving force. So that's one point.

And I think the other point which is relevant is quite a lot of these studies suggested that people whose mental health was more compromised to begin with, or at the lower level of the wellbeing spectrum, were more

likely to get infected.
**Q.** Physically affected?
**A.** By the -- the virus was more likely to infect them and more likely to affect them severely and there was higher mortality rates.
**Q.** Thank you. That's very interesting.
I'm going to move back to the specific factors -- unless there's anything else, Professor. It's a huge report so if there's anything that we've missed then -- (overspeaking) --
**A.** No, no, those were the two areas I just wanted to --
**Q.** Thank you.
Yes, so what the next bit of the report does is it does, I think you've said that you've done the best that you can, but leading back to the point about data gaps, you've gone through and you've said at each stage, well, at this stage of the pandemic there's less evidence, and is it right that comparing all of those different factors that I will list in a moment, it helps you identify where you're really short of data but just that exercise in itself would assist you to do that?
**A.** Yes, yes.
**Q.** And the factors that you have covered are by reference to the following 14 areas: age, gender, ethnicity and race, sexual orientation, socioeconomic status,



occupation, housing and residential status, geographical differences, parents, pregnancy and maternity, caring status, disabled people and individuals with chronic illnesses, clinically vulnerable and clinically extremely vulnerable individuals, and finally, health status. So it's a huge endeavour, Professor.
**A.** Yes, and what we're doing is presenting whatever studies we could find in those particular groups.
**Q.** Thank you.
Now, Professor, obviously I'm not going to go through each and every part of the pandemic by reference to that, but we have, through various core participants, had some assistance with identifying some key questions about just the last few of those groups and the way that the review has approached it. So if I can ask you just a few questions about that.
The last three were, firstly, disabled people and individuals with chronic illnesses, and the last one was health status.
So just in relation to that, it's been pointed out that both of those sections, the disability in individuals with chronic illnesses and, secondly, health status, both of those sections will include conditions and impairments that have a substantial or long-term adverse effect on the ability to carry out day-to-day



activities.
**A.** Yes.
**Q.** And so, for instance, we see, if you delve into that section, you've got chronic illnesses in both things like chronic pain, long-standing illness, is that correct? You've got that occurring in both those sections?
**A.** Yes, because there's a huge overlap, and you're just, you're limited to the definitions people have made in the particular paper you're looking at. So you then have to extrapolate from that that there's some people with chronic illness in this group so the data might be relevant.
**Q.** Would you say, then, that you should take those two sections together to get the full picture about the impact on people with disabilities?
**A.** Yes.
**Q.** Thank you.
The -- just again, a very specific point that's been asked about this, please help us if you're able to -- I appreciate that it's a very long report, but the review says that at paragraph 3.2.12, whilst there was overall mental distress, the increase in people with disabilities or those with pre-existing health conditions was smaller or not statistically significant



compared to non-disabled or those without the pre-existing health conditions. And the question is this: are you able to say whether that's against a sort of significantly higher baseline amongst those groups?
**A.** Yes, and I think we're going to see this in another group, and particularly one of those papers -- I mean, the focus of the paper was something else but you find this little nugget in the last couple of paragraphs of the results, and it is clearly pertinent to people with chronic illnesses -- I mean, health conditions can just be physical health problems or it can include all mental health problems. Disability can be defined very differently in these different surveys.
So, yes, there seemed to be in those studies something that was of relevance, and the overall marker was that people with chronic illness or disability on average have poorer mental health to start with --
**Q.** In the first place?
**A.** But in the actual rise. So, you know, from -- it didn't go from here to here, it went from there to there [indicates].
**Q.** Yes.
**A.** There was a lesser rise on the higher baseline in these groups.
**Q.** Professor, because you've done something visually with

your hands, I'm going to try to attempt to describe what it is you did, but I might --

**A.** -- (overspeaking) --

**Q.** Could you just explain what you just did with your hands, in terms of the effect?

**A.** Yes, so if you have the general population going from this level to this level [indicates], that's a baseline, but your people with disability or longstanding illness might have started there -- (overspeaking) --

**Q.** Closer to the top line, yes.

**A.** So the rise has been less. The difference is less.

**Q.** I think everyone understands. I'm just attempting, for the stenographer, to try to sum that up.

But the important point is that you might look at a statistic like that in a report and, you know, misread it to say that disabled individuals, you know, weren't that affected. That's not the case. They were already very affected by mental health, mental distress, and so the point at 3.2.12 isn't to be read like that.

**A.** And also that those individuals where the general population's health came down quite significantly when the restrictions were eased, this group [indicates] didn't drop so much.

**Q.** Yes. I see, so they stayed at a higher level?

**A.** So it's complex to put an overall --



**Q.** Again, it's been very helpful to ask about this particular part of the review, and what you've explained is that you're looking at a lot of studies. It may not be that the study is particularly signposted as being about disabled people, but you have managed to find something that you think is worth footnoting or referring to, and that's the next question, in fact.

Footnote 289 covers sex and ethnicity or adults over the age of 50, on the face of it, and that is got from the description of the studies, 86, 20, and 16. I won't take you to the detailed description, but indeed it does seem to describe sex and ethnicity, the first paper. Refers to Covid-19 as an at-risk group as opposed to something specific on disabled people, that's the second one. And finally something about loneliness, physical activity and mental health. Again, it's a geriatric paper.

So the points being made is, you know, are these studies that are footnoted there actually focused on disabled people?

**A.** They have comments or issues that they're reporting which are relevant to that group, but that wasn't their main purpose when they set out.

**Q.** And did they disaggregate for disability? It sounds not, from what you're saying. You're just saying that



they were mentioned?

**A.** We've been able to pull up a couple of the papers and have a look. I mean, I would need to spend a little time working out exactly, but certainly one of them had this little nugget about people with disabilities and chronic illness towards the end, which was very specific to them.

**Q.** Thank you. I'm going to leave that section of the report now, whilst again thanking you for the detailed consideration against all of those groups in society. Really important to look at that, with that level of detail.

Can I now take you to the concluding sections of the review.

Again, the reference is INQ000659787.

And if we could go to page 63, these are your concluding reflections.

Again, we can all read it, but could you, as the senior academic consultant, sort of sum it up for us. Where did you get to in terms of the patterns and the reflections, having looked at all of that evidence?

**A.** Well, there's a couple of patterns that were really robust and strong that we haven't actually touched on yet, and these were where there's very large groups of the population. So with both age and gender, there were



really important findings within the most robust studies, and particularly with age, the -- there was a clear evidence that the younger age groups, the younger adults whose mental health started a bit poorer, there, the rise in mental health problems amongst that group was really importantly more than in the other age groups, and that actually across the population it was the elderly whose mental health deteriorated less during the pandemic.

And that's particularly important because the young were those who were least at risk from the virus, and whose mental health seems to have been impacted more adversely, and has come back -- not come back to the level where it was before. So this is --I think this is one of the really key things that came out of this report.

And the other thing was the impact on women, where again we've got a disparity in the starting point in that women's mental health is less good, but the effect on women was clearly very dramatically more so than on men, in terms of the reporting of their mental health. And whilst you can still see the same patterns of easing when the restrictions came off and then getting worse when they went on again, this is a finding of -- an extremely robust and very important finding.

**Q.** Thank you. Could we just go to the next page, if possible. Yes, just there.

It's going back to recovery, and we've touched on this when we were looking at the broad periods earlier on, and also protective factors, as well. So if I could just ask you to just take us through those two points which are in bold on the screen there.

**A.** Yes. So the -- obviously the risk factors, socioeconomic risk factors were a big thing that we focused on and looked to find data on, and there was an interesting paradoxical finding in the first lockdown that it seemed to be the people with the highest levels of education and the greatest wealth whose mental health was impacted more, which was very much a surprise finding because we'd expect the reverse. But that didn't carry on as -- and we found the classic things that we might have looked for, like people who lost their jobs or were suffering financial insecurity during the pandemic, their mental health was affected more.

But there's couple of things that came out of this particularly, maybe with the occupational group rather than the socioeconomic factors, but maybe we can deal with it here, in terms of working conditions and what was going on, was initially, again, people who were in employment and particularly people who were working from



home at the beginning, their mental health was protected to begin with. But that didn't carry on as the pandemic went through, and it became -- home working then became more of an issue, and did reduce people's levels of mental health.

Otherwise, people who started off the pandemic unemployed or with high levels of poverty, a bit like we've already spoken of with other groups, their mental distress started high and it didn't go up as much, because -- so the increase wasn't as great as with the other population groups, but that was because of the high level, and then there was less recovery amongst that group.

So there's some important -- there's some important detail here. The data on ethnic minority groups was also really, you know, it was one we looked at in some detail, and there weren't -- the studies weren't very clear, but the suggestion was that both men and women of black and minority ethnic groups, their mental health dropped to the same level as white women. So the white men seemed to fare better.

So there was evidence that that wasn't -- black and minority ethnic communities were affected disproportionately.

**Q.** Thank you.



Professor, I will be moving towards some closing parts of your report now. I'm just conscious again, huge coverage of many points. Again, as we get to the end of this section, is there anything that we haven't covered that you'd like to before I move on to things such as data gaps and other conclusions?

**A.** Clearly, furloughing did protect people against the drop in mental health problems, so that was a good thing. Interestingly, people who were in unions, their mental health fared better.

So, we haven't really talked about the protective factors. And there, one -- another interesting finding was -- and particularly in terms of Sarah Hughes's evidence, previously Dr Hughes's evidence --

**Q.** Yes.

**A.** -- that there was a physical activity effect. So we know that physical activity is protective of mental health. But what happened at the beginning of the pandemic, it seemed that people who relied on physical activity to maintain their good mental health, their mental health was severely affected because they couldn't go to their gyms any more, and possibly more so, because that was their main protective factor, that they weren't using other methods.

And the other clear protective factor that came out



was to do with access to green spaces. So urban populations tended to fare worse than rural ones. But in London people who had access to green spaces, for example, fared better than those who didn't. So people who were able to get out of their houses and go for a walk in nature had less severe deterioration.

So those were important protective factors that we identified.

**Q.** Thank you, Professor.

I think you've covered there all of the key highlighted issues in that section of the concluding remarks. Again, if there's anything else that you think is worthy of a bit more attention, please just say, we have the time to hear you on anything else that hasn't been covered.

**A.** Were we going to be looking at gaps?

**Q.** Yes, that's next. Yes.

**A.** Yes.

**Q.** That's good --

**A.** So -- oh, the other thing, which is all tied up with many of the things we talked about, but people who -- so loneliness was a big thing that came out in many of the reports, and loneliness is an important predictor of mental health problems. And so the corollary of that was that people who had access to social connectedness

and social support of some sort were protected.
**Q.** Thank you.
Ultimately, that statistic, looking at multiple lockdowns and the pandemic as an experience as a whole, what you've provided is the statistic of 40% of people kept feeling high levels of stress or distress during lockdowns, and I take it that you feel that conclusion is pretty robust?
**A.** Absolutely. Absolutely. And certainly, you know, 50% of people at some stage dipped into what we might call a clinical level of mental health problems.
**Q.** Thank you.
Now, I would now like to, before we do get to data gaps, just look at a conclusion that you've reached at page 68. So, same INQ reference, but page 68.
And drawing it all together, whether or not all of these impacts that you've described were actually caused by the pandemic, and what you've said there is that most of the studies reviewed clearly cannot provide a direct cause and effect, but they show associations between the pandemic and these changes. It's not absolute proof.
But then you go on to essentially conclude that it's very likely that the pandemic played a major role and you've given these three features there. Could I ask you just to explain those to us: timing, inconsistency,



exposure and impact.
**A.** Yes, epidemiologists are very often focused with this issue because they'll observe an association between one thing and another thing, and did it, did one cause the other? And so a lot of effort has gone in this discipline to saying: so what are the factors that we might consider which would really end up with us believing that A does cause B? And they're not a single thing; they are a cumulative number of things. And when you get to the end of the list, you're a hundred per cent sure, but when you're halfway through the list, you might be 70% sure, for example.
And so one of the key things is that all these studies looked at mental health at one point in time and then they looked at mental health at another point in time, and related that to what was going on in the pandemic at that time. So you're seeing shifts in mental health which are related to what was going on in terms of the virus, the lockdowns, and the vaccines. So that's an important -- that the trajectories follow each other.
**Q.** Yes.
**A.** The other thing is that you -- and this is where the systematic reviews come in as really important -- if you get the same findings or similar findings, in a lot of



different studies, you're going to go: mm, this is something that is really robust and that we need to take into account.
And then the other thing that these studies gave us was that the greater -- if you've got the greater exposure to whatever you're considering to be the risk, like the pandemic or the lockdown effects, the greater effect on the outcomes.
So these are pretty strong evidence, and whilst other factors may well have come in and played a part, and they may have played a part disproportionately on different populations, there is absolutely no doubt in my mind, having looked at all this data, that the pandemic had a profound and I think not really anticipated effect on the mental health of the population in the UK that has not gone back to where it was before.
So we've seen a resetting of the population's health at a level which is very detrimental to lots of things that we might care a lot about.
**Q.** Thank you so much, Professor.
Can I ask you now to -- let's go to page 73, same INQ reference. And this is this issue of gaps. So you've looked at all of these studies, and you have noted some key gaps, and when we go to individual groups



you'll see the odd use of the red traffic light, or amber, to try and investigate and get what you described as nuggets of information about groups, and I'm not going to ask you about the ones that you've listed. What I'm going to ask you about is some others that others in the room today have asked me to clarify with you whether or not there's more to say about that.
But the list that you've given there, just taking it in turn, ethnic minorities, sexual and gender minorities, caregivers, individuals with pre-existing conditions, specific occupational groups, survivors of gender-based violence and abuse, parents, especially single parents, pregnant women and maternity, and I think finally -- no, penultimate, no, not finally -- older adults, individuals with Long Covid, individuals in specific settings which are set out there, and finally, clinically vulnerable and clinically extremely vulnerable groups.
So you've set out there specific population groups where you felt that there are -- there's just a lack of data in the various ways described.
**A.** Yes. Just to add to that. It would have been wonderful to have found studies relevant to these populations, but we can't go back and get that data so no further research can tell what happened to those particular

populations in the pandemic. And I also think there is a lack of realism in thinking that we could have had this data, because the sort of studies that were done, and these big population surveys, rely on people having addresses, having Internet addresses, and being able to complete forms themselves, complete questionnaires themselves. And you cannot, for example, get good data from people who are homeless in that sort of methodology. You have to go -- have a completely different, much, much more expensive methodology where people go and sit with and find people in the parks who are homeless and have conversations with them, and help them fill in these forms.

And the same is true of a lot of these marginalised groups, is that you don't expect to find great things, in research terms, from those populations in these sort of large-scale population studies. You have to do something special to find those.

**Q.** Thank you.

So, leading on, then, we had some earlier questions about the section on disabled people. I'm asked to clarify with you, do you consider there's a significant data gap in relation to disabled people specifically?

**A.** Well, in these terms, yes. I do. But I don't know that more could have been done.



**Q.** Yes. I mean, we're not going to focus on -- well, we may ask you some questions about why there are these gaps later, but in relation to disabled people, there is a gap, and would you agree there's a need for disaggregated data on disabled people?

**A.** Yes, it would be very good to have that.

**Q.** I'm also asked to clarify or ask you to consider whether there's a data gap, and whether there are dedicated studies needed on the mental health and wellbeing of clinically vulnerable or clinically extremely vulnerable people. So they are there at the end of the list, we've got it up on the screen, but I think the question is, do you consider there should be dedicated studies? Because you've mentioned that elsewhere.

**A.** I think one of the issues is the definition of clinically vulnerable is it changes, and did change during the pandemic. So, initially, that term was used to describe people who were on chemotherapy or who had illnesses that compromised their immune systems. It was a very limited definition, and they were advised to shield, and that was a good thing for them to do. But actually, people with severe mental illness were a clinically vulnerable population because their immune systems were compromised, and the shielding -- they weren't part of that definition to begin with --



**Q.** We've heard that this morning, yes.

**A.** -- the shielding would have been -- the shielding would have been really not a good idea, because that would have been further damaging their mental health and then their infection risk.

So I think this whole idea of what is a clinically vulnerable population is one that's not really been possible to tease out much in this review, and clearly is important.

But what this review has done is highlighted that when we're talking about -- "clinically vulnerable" was only thought about as: are you at risk of this virus? There were a lot of people in this population who were clinically vulnerable to severe mental health problems, and that was not considered in the definition, and thought wasn't given to how we optimise pandemic control measures to support that group in a way that doesn't really severely impact on their mental health.

**Q.** Thank you.

Is there a gap in the evidence relating to people in prison and immigration removal centres?

**A.** Yes. But, once again, immigration -- you know, it was not simple to get data, and particularly on immigrants many of whom's first language is not English. You need a different type of study and you need a different type



of study to engage the prison population in something like this, who are, you know, a disaffected group.

**Q.** Yes. And I think some of these questions that I'm coming to our dealing more with the issues that we're touching on.

What are the barriers that have led to the underrepresentation of these groups and how could they be addressed?

**A.** Well, I think we've just covered that.

**Q.** Indeed, yes.

**A.** And how can they be addressed? We did need this data, on population-level data, and no other approach would have given us the information that we've been able to present today, which is what we were asked to do, that this pandemic had a huge effect on the general population's mental health.

Those studies are valuable and necessary, but it is also important to consider more vulnerable populations and what happened with them.

But my sense is this Inquiry has actually covered those groups quite well through qualitative descriptions and through groups who are in touch with those groups, and has brought the mental health impact on those groups into the Inquiry, and tends to be the -- all the rest are okay, and they weren't.

**Q.** Thank you.

I do, I'm afraid, have just quite a few more questions of a similar vein, so if you could just bear with me, we'll probably take it, it's very fair to ask if a particular group has or hasn't been covered even though it's maybe not mentioned.

So one thing that you have said in the review is you've mentioned long-term studies with pre-pandemic data to enable comparisons, and also about international comparisons. This is in order to understand the impact.

**A.** That's on the research that --

**Q.** Yes, it was later on.

**A.** It would be great if I could have them up.

**Q.** Ah, well, I tell you what, we'll come back to that --

**A.** Okay.

**Q.** -- because that will be the last slide. So we'll come back to that, that's kind of recommendations for specific sorts of research and you're going to be asked about whether or not there are any barriers to that happening.

So I'll come back to those two questions.

A more specific one: was there any evidence that access to public services was a critical determinant of overall mental wellbeing, and if not, do you consider further research would be beneficial in that area?



**A.** I mean, I think the research did not give us that information. You know, it would be astonishing if it wasn't important, but I can't say anything on the basis of the data we looked at.

**Q.** Just three more questions, I think, on this, on the data gaps. Four.

You were asked -- well, you're asked about the data gaps being in relation to groups that appear to be vulnerable. So what's being pointed out is that during the course of the review you've identified various vulnerable groups and it's the self-same groups, in many cases, where we don't have the data. What's the consequence for understanding the full-scale and the distribution of mental health harms during the pandemic of that?

**A.** Um ...

**LADY HALLETT:** Doesn't that take us back to the answer you gave us just now, that you've gathered the evidence in other ways?

**A.** Yes.

**LADY HALLETT:** The qualitative evidence and the evidence from representative groups?

**A.** Yes, and it's quite hard to weight qualitative evidence against quantitative, you know, putting those two together. But there is no other way of getting at this,



I think.

**MS RAHMAN:** Yes, I can probably take these three last questions together. They are one, were the vulnerabilities understood before the pandemic? Do you understand why the gaps exist? And finally, do the gaps hinder planning for these same groups, and mitigating harms for any future pandemic or civil emergency?

**A.** So I think from what I said I understand the gaps.

**Q.** Yes.

**A.** They're very understandable and, I think, probably unavoidable in the context. But it just means that you don't rely on a systematic review like this to consider all the possible harms. You have other mechanisms, such as you've put in play.

**Q.** Thank you. Can I get then, finally, the slide that has your recommendations, and these are recommendations about the types of research. And you may have some points of your own, but the two remaining questions were about the use or the need for long-term studies with pre-pandemic data to enable comparisons and also international comparisons, and you're being asked, are there any barriers to such studies being prepared?

**A.** Yes, so I think of these ones which are actually quite easy to put into place. The longer-term trend is really, really important. The last data point was 2023.



We're now in 2026. Has this dropped? Has our population mental health gone back to where it was pre-pandemic, or is the trend in that direction, or is it stable, or is it continuing to go on?

We need that to understand the impact of the pandemic, because those mental -- that resetting of the level of mental health has implications for all sorts of aspects of human functioning in the future. You know, not least health service usage but also chronic illness, and productivity, sickness, all those kind of things. So a reduction in mental wellbeing of one point has a measurable effect on health service usage for physical health problems in the years to come.

So --

**LADY HALLETT:** That reminds -- I'm sorry, I interrupted you. You finish your thought.

**A.** That was the end of that thought. I've got another one, but we can stop.

**LADY HALLETT:** Keep that thought in your head, the second thought. Can I go back to, you said that mental health problems, however we're going to call them, they were on the rise before the pandemic.

**A.** Yes.

**LADY HALLETT:** And you said that the levels have not returned to pre-pandemic levels.

**A.** Yes.
**LADY HALLETT:** Let's take the pandemic out of the equation.
**A.** Yes.
**LADY HALLETT:** If they were on the rise before --
**A.** I -- (overspeaking) --
**LADY HALLETT:** -- which we should have expected to see -- (overspeaking) --
**A.** Yes, they would have gone on rising, but the trajectory is completely different.
**LADY HALLETT:** That's the key.
**A.** And we're not at a point now where you would have expected the trends, the gradual trends, to end up. So we're not there yet.
**LADY HALLETT:** Okay, your second thought now.
**A.** I might need to go back. What it was -- we need to just -- I mean I think that's the end of that. We must carry on looking at population mental health in this way, and to particularly look at age and gender, the big groups that you really can tell something about.

So those studies must be commissioned, I imagine they will be being commissioned, but ... there may be a tendency to sort of forget about it. Everybody, all the academics, were rushing into Covid when it happened, and doing studies that contributed to their credibility, and value. And now it's gone away, there's



a possibility that we'll sort of forget what happened.

So I think it is important that's remembered.

**MS RAHMAN:** Well, Professor, you and your team made a massive contribution to recording what happened. Thank you very much for all of that work, to the whole of your team, and also for explaining it to us so engagingly today.
**A.** There was just the one more point from this, which was not about the trends, but that we -- there is a little bit of evidence in this that it was -- there were two things. There was the virus, which was terrifying and had huge impacts, and there was the control measures. Different countries had different levels of control measures, and we know those different levels of control measures had an impact on the virus and its spread.

We could commission studies that looked at different approaches to control measures and the mental health studies that were done in those populations, and make a comparison with mental health as an outcome on a par with all the illness and disability that went on with Covid, many of which, most of which, people have recovered from.

So I think that's a very doable study that could be put in place, but probably would need to be commissioned.



**MS RAHMAN:** Thank you very much. There may be some more questions for you.
**LADY HALLETT:** There are.

It's Mr Weatherby to start, who sits just there.

**Questions from MR WEATHERBY KC**

**MR WEATHERBY:** Thank you very much.

Professor, I represent the Covid Bereaved Families for Justice UK group. And I have just one point, and it's about data gap, I'm afraid. You've given a lot of evidence about that, but this is a specific point about bereavement, so I think it may be slightly different.

At page 13 of the report, or the study, you refer to data availability as a limitation on your findings, and noting in particular, and I quote:

"... although data extraction on bereavement using validated grief measures was attempted, none of the included studies reported bereavement outcomes, consequently, no quantitative analysis was possible for this domain."

And my question is, are you, first of all, able to help us as to why there is this dataset deficit with respect to that? And having noted the lack of available research data on bereavement and mental health outcomes, is this an area where further research is required, both now and in a future emergency?



**A.** I think there is room for a lot more research on bereavement and its impact, and I think particularly I've referred to good death and a bad death, and what went on in the pandemic could not be described as a good death under any circumstances, and the effect that those have on the mental health of the bereaved ongoing, but I don't know that that needs to be linked to a pandemic. And I think it's unlikely to be able to be -- I mean, it -- you have to prioritise what is going on in terms of research in the context of a pandemic, where everybody's frantically trying to do things. And I think those questions could be answered outside a pandemic and possibly a little more reflectively.
**MR WEATHERBY:** Right. Thank you.
**LADY HALLETT:** Thank you, Mr Weatherby.

Mr Wagner.

Mr Wagner sits at the back there.

**Questions from MR WAGNER KC**

**MR WAGNER:** Thank you.

Good afternoon, Professor. I act for Clinically Vulnerable Families.
**A.** I'm having a little trouble hearing you.
**Q.** Can you hear me now?
**A.** A bit better.
**Q.** Okay, I'll speak a bit closer to the microphone.

I act for Clinically Vulnerable Families. I want to ask you about the definition of clinically vulnerable and clinically extremely vulnerable which you have referred to in your evidence, and you say in the report that evidence on clinically vulnerable and clinically extremely vulnerable groups was hampered by inconsistent definitions and classifications across studies. And you also say that in many studies, the CV or CEV group was defined using the government's official shielding list while others included individuals with chronic conditions or self-reported vulnerability more broadly.

First question on this is this: would it be easier to conduct the dedicated study that you have recommended if there was a consistent measure of clinical vulnerability?

**A.** Yes, but I think we're unlikely to get it just like that, because it depends what factors you're considering in that definition, and the point that I've made is that having a severe mental illness makes you clinically vulnerable, but I don't think it's in any of the definitions that people are thinking about because they are thinking about particular physical health problems. So I think there's a much longer conversation to be had before we could get to that point.

**Q.** I suppose you're answering a slightly different question



about what that category would include, and of course, that would be a longer conversation. But do you see, in principle, the value of attempting to find some sort of category where you could include clinical vulnerability because it has an analytical benefit for mental health -- for studying people's mental health?

**A.** Yes, I'm sure it would be valuable.

**Q.** Yes. And do you think it would assist, in that respect also, if clinical vulnerability to disease in general was recognised as a distinct characteristic or a population group?

**A.** I think the danger there would be turning something that's a spectrum or a continuum into a dichotomy or a binary thing, because we've all got varying levels of susceptibility or vulnerability to illness, and it's not a-- you couldn't ever make a cut point that says, "You're vulnerable and you're not."

So I don't know that what you're looking for could be achieved. I think there will always be different cut points that are necessary to include in the studies.

**Q.** But doesn't that apply to lots of vulnerabilities that you -- an individual may fluctuate from one to the -- on a spectrum, but we do look at, for example, disability as an overall category, even though individuals might fluctuate and conditions may -- may be less or more of



a disability in general?

**A.** Yes.

**Q.** But do you see, there is a value in looking at that generally?

**A.** But the studies with different definitions have a contribution to make.

**Q.** Yes.

**A.** I think is what I'd say.

**MR WAGNER:** Thank you.

**LADY HALLETT:** Thank you, Mr Wagner.

Ms Moffatt who I think is over there.

**Questions from MS MOFFATT**

**MS MOFFATT:** Good afternoon, Professor.

**A.** I'm challenged on the hearing.

**Q.** I represent the MRC, a group of nine organisations who represents the rights and interests of migrant people.

You may have in part answered my question when you spoke about people in immigration detention. It relates again to data gaps.

You cover immigration status on page 63 of your report, I don't propose that you turn it up, but in summary what you say is that there is very limited evidence directly on immigration status and that most studies either do not mention it or say that results for this population group were not reported or analysed.



And so my simple question is, do you consider that the lack of research on migrants' mental health during the pandemic may be explained by insufficient or inadequate data collection on this population? Was this, in effect, an additional data gap?

**A.** Yes, it is a data gap. But I think I have answered the question in that what were the priorities for this research, and that doesn't mean to say the health of migrants is not incredibly important, but it was -- the focus of the research was on the general population.

**MS MOFFATT:** Thank you.

**LADY HALLETT:** Thank you.

Now I have Ms Davies, who is that way.

**Questions from MS DAVIES KC**

**MS DAVIES:** Can you see and hear me, Professor?

**A.** I can.

**Q.** Jolly good. And I think I am your last set of questions you'll be pleased to hear.

**LADY HALLETT:** We've got one more.

**MS DAVIES:** One more, I apologise.

I am asking questions on behalf of the Domestic Abuse Group, which is three organisations from the violence against women and girls sector.

And you've just been asked about the data gap in relation to immigration status, which you deal with in

your report at page 62, and immediately preceding that, another group of people for whom there's a data gap is survivors of gender-based violence, and I want to ask you about the intersection between those two, because there is a certain amount of evidence, we've provided accounts in the statement from the Domestic Abuse Group's -- the Domestic Abuse Group's statement, which I think you've been asked to read some of. There's also a comment in the expert witness evidence from Dr Wenham, who is the expert to this Inquiry on gender, and indeed, there have been reports from the Domestic Abuse Commissioner, and so forth, to the effect that migrant women with insecure immigration status, those with no recourse to public funds, are especially vulnerable, often lacking access to public funds, excluded from what was the destitution domestic violence concession, fearing enforcement if they seek help, and specifically help with domestic abuse, and therefore women in that situation with insecure immigration status, and subject to domestic abuse, faced compounded mental health challenges.

So on that, first of all, are you able to say that corroborates some of the research that is available, and secondly, do you agree that there is a data gap into this issue of immigration status and domestic abuse that



warrants further research?

**A.** So I would not in any way question your fundamental premise, but the review wasn't able to offer any additional information on that, because of the various factors that we've talked about already.

And I'm sure this would be a valuable research endeavour. It's quite a difficult one, because gender-based violence offers a lot of shame and people don't come forward to talk about it a lot. And particularly with the migrant population, it's a very -- needs to be a very thought-out, reflective piece of work as to how you would find the truth in that population. And that's not compatible with the, sort of, types of research that can contribute to the main question we were answering in this part of the Inquiry.

**Q.** Thank you.

And that leads me on to, moving away from the connection with immigration abuse and, more broadly, domestic abuse, survivors of gender-based violence. You say that whilst domestic and sexual violence are recognised as major factors affecting mental health, the large UK studies review did not collect direct data from survivors, and so you put up an exclamation mark and you say that the conclusions need to be treated with caution.



I wonder if we could have the Domestic Abuse Group's statement INQ000652188, at page 78, please, up on the screen. And specifically paragraph 272.

Paragraph 272, which contains a case study in the names of Tracey. All our names are anonymised. And she sets out, she was a client of Solace Women's Aid, she came to a refuge after fleeing from her ex-husband. On arriving she was very emotional and distressed, struggled to maintain focus due to high anxiety levels. It later emerged that she was experiencing her first psychotic episode and was supported to attend hospital to be seen by the crisis team. So that comes from Solace Women's Aid.

Is that the sort of direct evidence and testimony that researchers would need in order to corroborate the 'Interpret with caution' findings?

**A.** Well, I think this sort of case study approach and the qualitative interviews make a really valuable contribution. You need both methods to try to get to truth in this.

**Q.** Thank you.

And my final question, in your opinion, does the violence against women and girls sector, that consists of women's aides, refuges, a number of what's called by and for organisations and so forth, would they have an



important role to play in helping to bridge those evidence gaps and producing some efficient methods in order to collect and gather that type of qualitative evidence from victim-survivors, would the sector help?

**A.** I can't imagine trying to embark on a study like that without the sector's help.

**MS DAVIES:** That's very helpful. Thank you very much.

Thank you, my Lady.

**LADY HALLETT:** Thank you, Ms Davies.

And Mr Pezzani who is behind you, but don't worry, if you speak into the microphone, he's used to people's backs, aren't you, Mr Pezzani?

**MR PEZZANI:** I am, my Lady.

**THE WITNESS:** -- (overspeaking) -- hearing him.

**MR PEZZANI:** Also, there's no need to turn around because my question has been asked and answered already. So I'm grateful.

**LADY HALLETT:** All right. Thank you very much indeed. Well, that completes the questions we have for you, Professor. Thank you so much for all your help and the help of your team. I really don't envy the task that you all had, I hope you had a really supportive and excellent team around you.

**THE WITNESS:** Yes.

**LADY HALLETT:** It's been extremely helpful and there's

sometimes a temptation for those of us who don't understand more about these studies to say: well, that report says X. And it's only when you find out the caveats from an expert like you that you can put that report into context. So I am extremely grateful to you and your team.

**THE WITNESS:** Thank you.

**LADY HALLETT:** Please convey my thanks to them as well.

Very well, I shall return at 1.55.

**(12.55 pm)**

**(The Short Adjournment)**

**(1.56 pm)**

**LADY HALLETT:** Ms Blackwell.

**MS BLACKWELL:** My Lady, may I call the next witnesses, please, Professor Tom Shakespeare and Professor Nick Watson.

**PROFESSOR TOM SHAKESPEARE (affirmed)**

**PROFESSOR NICK WATSON (affirmed)**

**LADY HALLETT:** Welcome back, Professors, thank you for coming to help us again.

**Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 10**

**MS BLACKWELL:** Thank you very much, Professors.

In front of you, you should have copies of your joint report with the reference number INQ000588216.

Please can you both confirm that that is the expert



report that you have jointly provided for the purposes of the Inquiry.

**PROFESSOR SHAKESPEARE:** It is, yes.

**PROFESSOR WATSON:** I confirm.

**Q.** Thank you. And that the facts stated within the report are true to the best of your knowledge and belief?

**PROFESSOR SHAKESPEARE:** Yes.

**Q.** And that any opinions that you have stated in them, in the report, represent your true and complete professional opinions?

**PROFESSOR SHAKESPEARE:** Yes, they do.

**PROFESSOR WATSON:** They do.

**Q.** Thank you very much.

May I also thank you for returning to the Inquiry. For those who don't know you, I'm going to introduce you again.

Professor Tom Shakespeare, you are a professor of disability research at the London School of Hygiene and Tropical Medicine, and you have written extensively on disability, development and bioethics.

And Professor Nick Watson, you are chair of disability studies and director of the Centre for Disability Research at the School of Social and Political Sciences at the University of Glasgow.

**PROFESSOR WATSON:** I was. I retired in January, at the end



of Jan --

**Q.** Congratulations.

**PROFESSOR WATSON:** Thank you. It's magnificent. I recommend it.

**Q.** And you have also written extensively on a range of disability issues, including disability in childhood?

**PROFESSOR WATSON:** Yeah.

**Q.** Social care and social support for disabled people, for disabled young people in transition to adulthood, and from public service reform and poverty?

**PROFESSOR WATSON:** Yeah.

**Q.** Thank you very much.

In introducing your report, it starts from a point of fact that the potential for disabled people and those with underlying health conditions were at a higher risk of harm from Covid-19, and that was well understood before the pandemic took full effect; is that right?

**PROFESSOR SHAKESPEARE:** Yes, correct.

**PROFESSOR WATSON:** Correct.

**Q.** Your report for this module explores the impact of the Covid-19 pandemic on inequalities experienced by disabled, clinically vulnerable and clinically extremely vulnerable people across the United Kingdom.

**PROFESSOR WATSON:** Yes.

**PROFESSOR SHAKESPEARE:** Yes, it does.



**Q.** And it builds upon your previous report that was commissioned for Module 2?

**PROFESSOR SHAKESPEARE:** Yes.

**PROFESSOR WATSON:** Yes.

**Q.** Professor Shakespeare, you have told us that not only were disabled and clinically vulnerable people often more susceptible to the Covid-19 virus, but both their pre-existing inequities and the social impact of pandemic control measures put them at an increased risk of harm?

**PROFESSOR SHAKESPEARE:** Yes, it did. Yes, it did. Because our approach to disability is very much that people have conditions, maybe underlying conditions, but it's the social relations which render them very vulnerable. So it's a combination of both the intrinsic, as it were, vulnerability, and the way that society is structured.

**Q.** And that was known before the pandemic hit?

**PROFESSOR SHAKESPEARE:** It was widely known, yes.

**Q.** Right. Before we turn to the detail of your report I just want to pause for a moment and acknowledge that both of you have indicated that in certain aspects of your expertise, areas, there is data missing, that there is poor quality data and insufficient data.

And I'd just like to ask you, please, Professor Watson, if you can help us with the areas in

particular that are lacking.
**PROFESSOR WATSON:** I think that one area that's been particularly lacking is what's happened after the pandemic. So how did the -- I mean, there is some research on what happened to disabled people and clinically extremely vulnerable people during the pandemic, but what the impact of the measures that were taken during the pandemic have had in the long term around wellbeing and mental health, around employment, poverty and so on. So there's that.

And then I think the other area where there's a big shortage of data is around the intersection between disability and other protected characteristics, around, for example -- for people from black and ethnic minorities or poverty or gender or other, sort of, social characteristics.
**Q.** Thank you. You tell us your report that there are evidence gaps, for example around violence and hate crime, gender-based violence --
**PROFESSOR WATSON:** Yes.
**Q.** -- leisure activities and also housing.
**PROFESSOR WATSON:** Yes, those were -- we couldn't find anything on that, yeah.
**Q.** And is there also data lacking in terms of those who were delineated as clinically vulnerable and clinically



extremely vulnerable?
**PROFESSOR WATSON:** I think, yes, there is a shortage of data and -- I mean, the issue around definitions of clinically vulnerable and clinically extremely vulnerable is a moving feast because it was a new category that emerged during the pandemic, and so that there aren't -- there definitely aren't the well-established sort of markers that policy analysts could look to that there might be in disability.

So, for example, there are easy markers around, say, people who are immunocompromised or so on, so there is that that becomes very difficult and there is a shortage of data specifically looking at clinically extremely vulnerable people.
**Q.** Thank you. Well, staying with definitions for the moment, at paragraph 15 of your report you use the term "disability" as that defined by the Equality Act of 2010?
**PROFESSOR WATSON:** Yes.
**Q.** Which says that a disabled person is defined as someone with a physical or mental impairment which has a substantial or long-term adverse effect on their ability to carry out normal day-to-day activities.
**PROFESSOR WATSON:** Yes.
**PROFESSOR SHAKESPEARE:** Yes.



**Q.** And we heard yesterday from Professors Herrick and Majeed about the definitions of clinically vulnerable and clinically extremely vulnerable people, and particularly from Professor Herrick that those definitions changed over the course of the pandemic, and indeed, were different at times between all four nations of the UK, and different across the world.
**PROFESSOR WATSON:** Mm-hm.
**Q.** Did that cause confusion for those that it affected?
**PROFESSOR WATSON:** Definitely because there was a lot of -- people didn't know whether they were clinically vulnerable or not or whether they were vulnerable to the pandemic or more vulnerable than others and we had in Scotland different criteria used to England and it did create that -- that did create problems.
**PROFESSOR SHAKESPEARE:** And certainly that would be a problem for anybody, particularly if they had a learning disability, because they would not understand. And so lots of folk who were maybe clinically extremely vulnerable or clinically vulnerable or disabled people would not know if they were at risk if they went out of their homes. So yes, it was a concern. A lot of uncertainty.
**PROFESSOR WATSON:** And I think also made worse by the digital exclusion that disabled people experienced that



we touched on in our last report.
**Q.** Yes.
**PROFESSOR WATSON:** So there was a lack of ability to access the detailed information that certain people who had ability to use the digital media.
**Q.** Thank you. The definition of disabled people is wide-ranging.
**PROFESSOR WATSON:** Mm-hm, yes.
**Q.** It encapsulates a lot of people, doesn't it? And lots of those people will also have other difficulties. I want to ask you about the tailored response which local authorities should be perhaps considering in terms of, let's say, disabled women who need to relocate because of domestic abuse. Does there need to be consideration given to a flexible, portable package, really, for people who for instance fall into that category, and how should that be done?
**PROFESSOR SHAKESPEARE:** Well, I think definitely and particularly -- we know that rates of violence are higher for disabled people, we know that they're higher for women than men and things, and things like Women's Aid or any provision made by a local authority needs to be accessible and understand that they may well have women and girls, men and women, men and boys, who need their facilities. So they need to be accessible

and that's not just physical access, it's also understanding that there are groups of people who might use them.

**Q.** Thank you. Of course, not all disabled people are clinically vulnerable and not all clinically vulnerable people are disabled. There is a wide spectrum of different types of issues which people have to grapple with in daily life.

Professor Watson, are people with learning disabilities more likely to have underlying health conditions that lead to more serious outcomes for pandemics such as Covid-19?

**PROFESSOR WATSON:** Yes, definitely, I think there's evidence from the Scottish Learning Disability Observatory that people with a learning disability at age 20 have the same number of comorbidities as somebody without a learning disability at age 50. So there's definite evidence that people with learning -- whether those comorbidities are the result of -- are intrinsic to the individual's impairment or some of them will be the result of social pressures, social barriers, poverty, and so on, and so it varies between them. But I think it's undoubtedly the case that, you know, people -- people -- according to MENCAP, 90% of people with a learning disability regularly experience a hate crime.



So it's no wonder that creates comorbidities within people with a learning disability.

So it's well established that people with a learning disability have more underlying conditions than without.

**Q.** Thank you. And drawing this together, your recommendation is that a better way of identifying people who are vulnerable, and extremely vulnerable, is a marker on GP records.

**PROFESSOR WATSON:** Yes.

**PROFESSOR SHAKESPEARE:** Well, certainly people with learning disabilities, many of them would have markers on GP records so we should see, our colleagues can see immediately whether they were disproportionately affected by any of these measures or indeed the underlying pandemic, whereas lots of folk would not -- did not have markers, and therefore how can you find out? There's no either NHS, social care or government statistics that you can draw on. So it's more difficult.

**Q.** Thank you.

Let's turn, please, to look at the ultimate impact of Covid-19 and morbidity and mortality amongst disabled and clinically extremely vulnerable people. You tell us at paragraph 6 in your report that across each wave of the pandemic both disabled women and disabled men had



a higher rate of mortality than their non-disabled peers and you rely on the Office for National Statistics data for that.

So let's look, please, at the tables that you have included in your report, the first table, which is at page 5, is the age-standardised mortality rates for deaths involving Covid-19 for men.

What are we looking at here?

**PROFESSOR WATSON:** Well, I think if you can see here, so the age standardised mortality rates are the rates where it would be standardised to what the mortality rates should be without a disability.

**Q.** Yes.

**PROFESSOR WATSON:** And so the more disabled an individual is, the higher their mortality ratio was. So -- and ONS created different categories, limited a lot, limited a little, and limited less, and --

**Q.** And sorry to interrupt, we can see that down the left-hand column --

**PROFESSOR WATSON:** Yes.

**Q.** -- the disability status levels, yes.

**PROFESSOR WATSON:** Yes, the disability and at every -- obviously at every level throughout the pandemic disabled people across the range there they're limited a little or a lot, experienced higher mortality rates



compared to non-disabled people.

**Q.** Yes.

**PROFESSOR WATSON:** So there's three waves there, and I think ONS have wave 1, which was between the middle of January and to September in 2020. Wave 2 was September to June. And then wave 3 was the final stages. And all the way across, and you can see that, standardised mortality ratio went up.

**Q.** Yes.

**PROFESSOR WATSON:** And it went up for non-disabled people as well, but it went significantly up for disabled people. As you can see in the second wave, for example, it went up to 942 compared to 304 for non-disabled. It's three times the --

**PROFESSOR SHAKESPEARE:** And remembering that this is not people who think they're disabled; it's people who have limitations, as under the Act.

**Q.** Thank you.

We can take that down, please, and replace it with the table relating to women, please, which is at page 6. Thank you.

And do we see a similar pattern there?

**PROFESSOR WATSON:** Yes.

**Q.** I think the highest figure there is 670.

**PROFESSOR WATSON:** 70, yeah.

**Q.** As opposed to the non-disabled relevant figure for wave 2, which is 175.

**PROFESSOR WATSON:** Yes. So, again, it's roughly a tripling.

**Q.** Yes, thank you very much.

We can take that down, please.

The impact of the pandemic on disabled and clinically extremely vulnerable health and wellbeing.

During the pandemic, you tell us at paragraph 22, disabled people were more likely than their non-disabled peers to experience high levels of loneliness, anxiety, and depression, poor wellbeing, and their access to communication needs were neglected.

**PROFESSOR WATSON:** Mm-hm.

**Q.** And there was a survey you refer to carried out by the Glasgow Disability Alliance reporting that 90% of the respondents were worried about their physical and mental health during the pandemic and that similar findings were reported by Inclusion London, the Welsh Government, and Disability Action Northern Ireland?

**PROFESSOR WATSON:** Yes.

**Q.** So similar patterns across the UK?

**PROFESSOR WATSON:** Yes.

**Q.** Why was that? Why were these issues being felt so keenly?

**PROFESSOR WATSON:** I think there were a number of reasons.



You know, because disabled people felt that they were more vulnerable, with good reason, that they were more vulnerable to the pandemic, but there was also issues that occurred. So, for example, things like the Coronavirus Act, and the do not attempt cardiopulmonary resuscitation --

**Q.** Yes, we'll come to those in a moment.

**PROFESSOR WATSON:** We'll come on to it. But those all helped to create that atmosphere of fear, and I think that there was -- social care -- overnight, social care disappeared. So daycare centres and day activities and so on just closed overnight, and so, suddenly, people were left feeling alone, and there was a -- social care didn't get the support that it needed, and I think that people were left in a vacuum, so there was that fear that emerged, and that came through at the time.

**Q.** Thank you.

Well, you've mentioned it, so I'll deal with that now, if I may, the introduction of the Coronavirus Act.

**PROFESSOR WATSON:** Mm-hm.

**Q.** And that reduced many of the duties for local authorities to provide care and support for disabled people, didn't it? Allowing, for instance, temporary reductions or withdrawals of care and support, and suspension of assessments?



**PROFESSOR SHAKESPEARE:** Yeah, and that allowed easements of the Care Act. So obviously people feared -- rightly, as Nicholas has stated -- that their care would be withdrawn and they would not be able to get, for example, daycare or day centres or whatever.

**PROFESSOR WATSON:** Yes. And it goes to fear -- very few of the easements were actually used, as we could find it, but it was the fact that it could happen that made people worried. And it was -- you know, I was involved with Glasgow Disability Alliance, it was a major talking point amongst disabled people, was the fear of what was going to happen, rather than what happened and -- to their social care.

**PROFESSOR SHAKESPEARE:** And sorry to interrupt, but the Coronavirus Act was actually better known than most pieces of legislation. My partner at the time was a doctor, and she carried a copy of the Coronavirus Act with her when she visited me, so that she could say, "I'm in his bubble, I'm allowed under the Act to visit him."

**Q.** I suppose thereby demonstrating how people were really concerned not to break the provisions of the Act but at the same time it was really invading their lives in a practical way.

**PROFESSOR WATSON:** Yeah. And I think at the time of the



passing, there was a lot of concern expressed across the disabled people's organisations and organisations for disabled people, who started to express concern around the Coronavirus Act, and this became -- I mean, quite rightly expressed concern, which again created that sort of -- which represented their concern that their communities were telling them.

**Q.** Yes. In terms of social care and domiciliary social care, was there also a fear that the reductions that happened during the course of the pandemic were going to continue after the pandemic had lifted? I mean, were people in fear of not being able to socialise and really being left in limbo and in isolation?

**PROFESSOR SHAKESPEARE:** Yeah, I think that what -- across the pandemic, and the response to the virus, there was a focus on health but a neglect of the care sector. And when it was thought of, it was only thought of as people in care homes, older people in care homes, and not well thought of then. But actually most older people and disabled people live in the community, and many of them do receive care workers, but they might be the same care workers who go on to work with lots of other people. And they -- the provision of, for example, protective masking or whatever was less for people like that.

We did a survey of people who received domiciliary

care and their workers, and found that they were neglected.

**Q.** I think, Professor Watson, you also told, us about a single mother living in Scotland who explained to you her fears and her isolation and how that affected her?

**PROFESSOR WATSON:** I think -- I mean, when we were doing -- the research we did during the pandemic, we interviewed, I mean, several parents of older disabled children, whose young people went to a day service or a day centre of some form or another, and those were closed overnight, and care and support for their older child became their responsibility. Many of them had to furlough because they couldn't carry on working and manage the care of their child. And, I mean, one of them told me she'd heard nothing from social services for over a year and she was just left looking after her child. And I think that people felt this unsupported, they felt -- and we found things like -- some of the work, we found that care workers who were normally being working with people with learning disabilities was shifted to work in a more health-focused thing.

So the emphasis was, in the early stages of the pandemic, was about saving the NHS and not about ensuring that social care was -- or some form of -- level of social care continued.



And I think, as Tom said, you know, twice -- there was some discussion of the care home sector but twice as many disabled people receive care in the domiciliary care setting than in the care home setting.

**Q.** And as for the levels of anxiety and depression that you found, there were similar findings, weren't there, for those defined at clinically extremely vulnerable people?

**PROFESSOR WATSON:** Yes.

**Q.** And I'd like to have a look, please, at the witness statement of Lara Wong from Clinically Vulnerable Families, who tells us about this, and it's INQ000657970, at page 10 and paragraph 20.

This relates to impact on mental health and wellbeing, as we've been discussing, and she says:

"The pandemic created sustained psychological pressures for Clinically Vulnerable people that went beyond the immediate threat of infection. Extended shielding ([both] formal or informal), repeated disruption to healthcare access, and prolonged exclusion from everyday activities meant that risk management became a constant feature of daily life. Many experienced the erosion of protective measures as a signal that their safety was no longer a public priority, amplifying feelings of isolation and abandonment. Their challenges were often compounded by



pre-existing health conditions which created new barriers to social connections, and disrupted access to sources of emotional support."

And does that accord with what you found in your research?

**PROFESSOR WATSON:** Yes, yes.

**Q.** Thank you.

I'd just like to remain with Ms Wong's statement for a moment and scroll down to paragraph 23.

Yesterday, during the evidence of Professors Herrick and Majeed, we looked at the survey findings -- the Clinically Vulnerable Families group conducted a survey of their members, and they have provided us with the results of that, entitled 'Impact on Society Survey', and we'll look at that document in a moment, but their responses showed social isolation, increased infection risks, particularly in healthcare environments, depression and a sense of hopelessness, particularly so -- I just pause to confirm -- that when mitigations were lifted for some, that didn't necessarily accord with the lives that were being led by those who were clinically extremely vulnerable. And the so-called Freedom Day was anything but for those who were designated as suffering from those sorts of issues?

**PROFESSOR WATSON:** And their families.



**Q.** And their families, yes, of course.

**PROFESSOR WATSON:** And, I mean, I spoke to one parent -- one family where the family had essentially split up, where the mother went to live with their disabled offspring and the father stayed with their two other non-disabled children, so that they could keep them safe. You know, it created real trauma and real tension across the family.

**Q.** Yes. And just to complete the list, grief and trauma were compounded by the circumstances, such as being unable to visit dying relatives, and there were reports of loneliness.

**PROFESSOR WATSON:** Uh-huh.

**Q.** If we scroll down, please, to the following paragraph, paragraph 24, one thing we didn't look at yesterday was the patterns over time. And we can see here that in the early shielding period, respondents to the survey cited extreme isolation, anxiety about the unknown risks of Covid-19, and distress over being unable to access routine medical care.

The results of the survey also showed that in mid-2020 and early 2021, anxiety remained high, despite some easing of restrictions, due to continued vulnerability and concerns about inconsistent public compliance with safety measures.

"There was a slight decrease in anxiety following vaccinations ... where the proportion reporting high anxiety decreased from 86.4% to 82.4% ... [and] A further decrease was observed between [July and October of 2021], and [November of 2021 and January of 2022] ... [although] Loneliness rose from 38.4% during the first lockdown to 54.4% by June of 2022, following the introduction of the 'Living with Covid' policy.

And does that pattern accord with what you found in your research?

**PROFESSOR SHAKESPEARE:** Yes, it certainly does. I mean, we found people were very frightened of going out, they were frightened of non-masked people infecting them, they were frightened of going to healthcare facilities. And we need to remember that people who are clinically extremely vulnerable or disabled people may need healthcare facilities a lot more than non-disabled people. So in the normal course of events they'd be more likely to go to hospital or rehabilitation or whatever, or GP, but now they felt that those very places were places they would get ill, so, not surprisingly, they didn't go for needed support.

**Q.** Did all of this lead to some disabled people and those designated as clinically extremely vulnerable feeling that their lives were being undervalued?



**PROFESSOR SHAKESPEARE:** I think that, for example -- I know this isn't relevant to this particular module, but I think when people see messages that "There are deaths, but it's okay, they had underlying conditions", they feel devalued.

**Q.** Thank you.

Please could we display the article from the Office for National Statistics entitled 'Coronavirus and the social impacts on disabled people in Great Britain'.

It's at INQ000417407.

We can see this is the front page, this is the document compiled by the Office for National Statistics.

Please could we go to page 2, and display the "Main points" of this document and what the main findings were.

We can see:

"In February 2021, among people aged 16 years and over in Great Britain:

"A larger proportion of disabled people (78%) than non-disabled people (69%), said they were worried (very or somewhat) about the effect that the coronavirus (COVID-19) was having on their life; for disabled people this proportion was lower than in September 2020 (83%).

"Disabled people more often indicated coronavirus had affected their life than non-disabled people in ways



such as their health [the figures are given there], access to healthcare for non-coronavirus related issues ... wellbeing ... and access to groceries, medication and essentials ..."

Just pausing there, did you come across a difficulty for those who were shielding, either under direction or self-shielding, being able to access medical supplies, food, and such like?

**PROFESSOR SHAKESPEARE:** Very much so. I think I've talked also about healthcare and people's greater reliance on healthcare, and their fear of being in a healthcare environment. But also everybody at that stage, for example, if they had access to the Internet, bought their shopping online, and they, people who always had to -- so, for example, to take a personal case, I would always buy my shopping online because I cannot carry heavy bags, and I suddenly couldn't get any delivery for weeks because, of course, everybody wanted their shopping online. I personally contacted my usual shop and said, you know, "I'm not included in extra vulnerable or extremely vulnerable, but I need this", and they put me on the list. But that was -- I had a sort of middle-class -- I felt this was outrageous, I couldn't get it and therefore I complained, and therefore I got it. Many people would



not and they would be excluded and have no remedy because they are not included in those categories.

**Q.** Thank you.

Reading on:

"Feeling stressed or anxious, feeling bored and feeling worried about the future were the well-being concerns most frequently cited by both disabled ... and non-disabled people ... feeling bored has increasingly been reported by both disabled ... and non-disabled ... people with wellbeing concern since September 2020.

"Among people who indicated coronavirus affected their well-being, disabled people more frequently than non-disabled people specified that the coronavirus was making their mental health worse ..."

Again, is that something that accords with your decision?

**PROFESSOR WATSON:** Yeah, definitely.

**PROFESSOR SHAKESPEARE:** Absolutely. People who already have -- who are disabled people, or who have underlying conditions, were more isolated -- were very isolated, and as a result, we think, of that, their mental health was worse. They were less likely to see family, let alone friends.

**Q.** Yes.

**PROFESSOR WATSON:** And I think, you know, having, again,

those people with -- the withdrawal of social care, having to rely more on family members, it increased the idea that they were -- they felt more of a burden because they were having to ask family members to provide care that previously they had been able to get through social care.

**Q.** Yes, thank you.

And just moving briefly through the remaining bullet points, poorer wellbeing ratings, life satisfaction and happiness ratings were poorer, and they were less -- disabled people were less optimistic than non-disabled people about life returning to normal.

[Witnesses both nodded]

But at the bottom of this page and the final bullet point we see:

"Positive sentiment towards the vaccine was high among both disabled and non-disabled people ..."

Tell us about whether or not there was a change in the pattern of health and wellbeing once the vaccination system was up and running.

**PROFESSOR SHAKESPEARE:** If people could get access to vaccination, and often disabled people would not get any priority about access to vaccination. And it took substantial evidential lobbying of the authorities before, for example, people with intellectual learning



disability were placed a higher priority, and it was the evidence that they're more likely to die from the virus, or more likely to contract the virus in the first place, was part of enabling them to get access to the vaccine, that they knew -- it was a matter of life and death for them.

**Q.** Because -- I'm so sorry to stop you.

**PROFESSOR SHAKESPEARE:** No, it's okay, I've stopped.

**Q.** The vaccination programme when it was first introduced was initially prioritised by age, wasn't it?

**PROFESSOR SHAKESPEARE:** Yes.

**Q.** And those with a learning disability were particularly affect if they hadn't qualified to be on that list.

But did the joint committee on vaccination and immunisation listen and did they change the prioritisation -- (overspeaking) --

**PROFESSOR SHAKESPEARE:** Yes, eventually.

**PROFESSOR WATSON:** Eventually. It took a long -- it took a lot of evidence -- a lot of shouting to get them -- (overspeaking) --

**PROFESSOR SHAKESPEARE:** And evidence because, of course, they're public health people and they need evidence and there wasn't any evidence except anecdotal or self-report, and people needed to gather the evidence, and the evidence of intellectual learning disability is,



because there's a marker on the records, was higher, was there, whereas the evidence for other people is not there, because you just couldn't get the data. Of course they are, rightly, following the science.

**Q.** Yes, which I suppose is another argument for keeping those markers on GP records --

**PROFESSOR WATSON:** Yes.

**PROFESSOR SHAKESPEARE:** Yes.

**Q.** -- for every sort of disability?

**PROFESSOR WATSON:** Yes.

**PROFESSOR SHAKESPEARE:** Yes, it is.

**Q.** Thank you. Can we take that down now and have a look at our Every Story Matters record for mental health and wellbeing, which is at INQ000659895 and please could we go to page 23. Thank you.

And I'm just going to read the stories from Skegness which appears in the pink box here:

"At a listening event in Skegness, we visited a supported accommodation facility for disabled adults. We heard from those living in the facility which provides residents with 24-hour care and support. They told us how the pandemic led to feelings of loneliness and despair which were made worse by not being able to see their loved ones due to visiting restrictions.

"The way that Covid-19 cases were managed within the



facility meant that if there was an outbreak, residents would have to stay in their rooms for days on end. This isolation from visitors, support staff and other residents often made their mental health much worse."

A contributor told Every Story Matters:

"The main thing was I couldn't see my family. My mum lives 20 minutes down the road but I couldn't keep in touch with family and that was horrible. I like company but when you can't see anyone, it's hard."

And another contributor said:

"You couldn't see anyone so you were on your own -- never saw a soul in isolation. There was nothing good about it at all. It had a devastating effect on everyone's health. You couldn't mix with anybody, no friendships, that's hard, isn't it? In the army I had friends but now on your own, all of a sudden, it was very hard to be on my own."

And I suppose it's worthy of note that even those who were living in a 24-hour care facility often were in isolation in their own rooms for long periods of time.

**PROFESSOR SHAKESPEARE:** I remember being very struck by when we did our survey, our reports, qualitative reports from people, somebody saying there's only so much sleep you can have, because you can't sleep all day for 24 hours. And they were very, very bored. They were very

isolated, and, as a result, bored.
**Q.** Thank you. Now we've talked about the Coronavirus Act, I also want to talk, please, about do not attempt cardiopulmonary resuscitation notices. The Inquiry has already heard evidence about these notices, but from your point of view, Professor Watson, could you just explain to my Lady what the effect of those was when they were first brought into force and how, perhaps, it changed over time?
**PROFESSOR WATSON:** Well, I think initially they -- NICE published a report, as I think we say in our report here, NICE published a report about frailty score and DNACPRs, and this created a fear. There was talk of sort of GPs sending out blanket letters to all their participants. My own wife got phoned up by the GP, she has asthma, to ask if she wanted this to be put on her records. And I think that this just -- again, coupled with the Coronavirus Act, it created this fear and then, as Tom said, the "Don't worry, the only people who are dying are disabled people" and then you get told your social care is going to be withdrawn and then you're told "Actually, if you do get sick we're not going to attempt to make you better."
So this created a feeling of -- and added to that, you've got that social isolation that you pointed to in



the last document you showed. This whole feeling of we're not important, we're not part of the mainstream, they don't really care about us. So that added to the feelings of -- the, you know, all of the -- it's no wonder people felt anxious and felt lonely, and had levels of depression, and so on, when those sorts of things were going on.
And there was just a real fear about "If I get sick, they're not going to make me better."
**PROFESSOR SHAKESPEARE:** That NICE guideline which says that people who have complete dependence on personal care from whatever cause were the maximum score. You know, many, many disabled people, and clinically extremely vulnerable people, are completely dependent on care, but that doesn't mean anything for their ability to enjoy life or to participate in life. Many people work, like Lady Campbell, she was -- I know she was very -- or -- I know she was very concerned, and rightly. Because when you apply a DNACPR order to somebody, lots of people reported that their normal healthcare needs were also deprioritised. So it's not just if they were dying or in need of CPR, but also their general healthcare needs.
**Q.** And the Care Quality Commission reviewed the DNACPR policies, did they not, and found that there had been,



in their words, unacceptable and inappropriate DNACPRs being made at the start of the pandemic?
**PROFESSOR WATSON:** Yeah.
**Q.** Strong words.
**PROFESSOR WATSON:** Unusually strong for the Care Quality Commission to make and I think it -- those words make the point, very clearly, that it was -- the move inappropriate. Not just inappropriate. Beyond inappropriate.
**LADY HALLETT:** I'm sorry to interrupt, it's a perfectly valid point, I'm not attempting to undermine the point that you made, but it's just that what I have heard in other modules about the use of these notices was there was a belief and a fear that there were blanket policies.
**MS BLACKWELL:** Yes.
**PROFESSOR WATSON:** Yes, yeah.
**LADY HALLETT:** But in fact the evidence doesn't show that there was a blanket policy.
**MS BLACKWELL:** No.
**LADY HALLETT:** But it does show that there were instances of people like a GP not understanding that this shouldn't happen.
**PROFESSOR WATSON:** Yes.
**MS BLACKWELL:** Yes, thank you my Lady.



**PROFESSOR SHAKESPEARE:** Thank you for the correction. In the initial stages it was not -- it was felt to be a blanket policy. There's no -- not necessary evidence it was. So for example, Professor Watson, his wife just has asthma, she's not disabled in any way that I can see, she's a wonderful woman, and she does not need support but she was sent a DNACPR letter by her GP.
**PROFESSOR WATSON:** Not a letter, a phone call.
**PROFESSOR SHAKESPEARE:** A phone call, I beg your pardon.
**Q.** On that point, my Lady, Professor Watson, at paragraph 60 in your report you talk about discovering a GP in Wales who had sent out blanket communications to disabled and other patients so it would appear that even if the intention was not to use it in that way, there was a misunderstanding --
**PROFESSOR WATSON:** Yes.
**Q.** -- at that level and that's what was taking place.
And I think you say that that is but one example of --
**PROFESSOR WATSON:** Mm-hm, yes.
**Q.** -- of many.
**PROFESSOR WATSON:** Yes.
**Q.** We've touched on social care, and you've told us that there was a real fear of social care duties being removed and a lack of understanding, perhaps, of

domiciliary social care, and what that entailed and what that needed to include going through the pandemic. Was that a misunderstanding and a lack of consideration, really, across the United Kingdom, or was that just in one particular area?

**PROFESSOR WATSON:** I think it was across the United Kingdom, and I think -- I mean we make the point in the report that I point to the lack of involvement of either service users or their organisations, and the stages of the planning for the pandemic and for understanding how social care worked and the importance of social care to people's lives, and I think, for example, the early models on the spread of coronavirus didn't understand that a care worker would work with several disabled people in domiciliary.

**Q.** Yes.

**PROFESSOR WATSON:** And that would have been pointed out -- SAGE had no representation from service users or their organisations in the early stages, and I think that was -- and so planning was being made. It was very top-down, it was very "This is what we're going to do", there was no discussing with people "What would be the implications if we did this?"

**Q.** Yes.

**PROFESSOR WATSON:** And I think if there'd been much better,



much greater involvement, we would have resolved a lot of these problems earlier on.

**Q.** Thank you. And dealing with this issue in relation to those who were clinically vulnerable and clinically extremely vulnerable, please could we put on screen again the statement of Ms Wong.

It's at INQ000657970 at page 39. And let's look at paragraph 119, please.

"Many respondents to CVF survey described substantial disruption in accessing social care services, often during critical periods when such support was most urgently needed. Across the UK, CVF members reported that services such as in-home care, personal assistance, respite, and other social support were significantly reduced or withdrawn altogether, frequently without replacement or meaningful communication."

And if we move down to look at the quote that's included there from Alex, 45, in England:

"All support for my relative with severe mental illness disappeared overnight. And support had been very limited to start with. I was left with 24/7 unpaid caring responsibilities on top of my job, on top of my own health conditions. It was unmanageable and unbearable and has had a long-term impact on my health."



I suppose that also goes back, Professor Watson, to what you were telling us about families and people having to choose who was going to look after the person that needed the most care and that effectively splitting up the family.

**PROFESSOR WATSON:** Yes, and I think, you know, that those comments accord with our research, and the work we've done down here. And, you know, things like short breaks -- and understandably, congregate support was -- had to be rethought but what happened was it wasn't just rethought, it was just withdrawn altogether and there was no attempt to sort of say, well, families who needed, who benefited from short breaks, we won't give them short breaks, but there was no attempt to say, well, what can we do? Because the short breaks were there for a reason, to help the families.

**Q.** Yes.

**PROFESSOR WATSON:** And there was no attempt to think, well, what can we do or how can we help people? And I think it affected both the families but also very much the disabled people, and talking to people with learning disabilities, for example, these were their main social interaction, and then you withdraw that, and there was nothing there and, you know, a lot of us were able to move on to Zoom to keep our family things, but where you



had digital exclusion and so on, people didn't have that to draw back on, so people became very isolated.

And it goes back to thinking about the anxiety, I mean, I remember talking to a young woman with learning disability as part of our research, and she'd become so anxious that she was washing herself every day with bleach and ended up in hospital with scars from the bleach. And these are -- with skin damage from the bleaching. And this is just a result of high anxiety building up and nobody to talk to and nobody to say, "Actually, it's not a good idea to use bleach as a soap or" -- and so it became a real -- I think -- and again, like I said, we were missing these long-term effects of how Covid -- how that period of time anxiety has played out post-pandemic for people -- disabled people.

**Q.** The Inquiry has heard that there was a lot of confusion in terms of which health services might be accessible and which weren't, confusion with policy announcements and guidance, which were not always in accessible format.

**PROFESSOR WATSON:** Mm.

**Q.** You speak about those with learning difficulties, but also British Sign Language, that they had to step up, I think, as one of the organisations to help the government, didn't they?

**PROFESSOR WATSON:** Mm-hm.
**PROFESSOR SHAKESPEARE:** Nick can talk about the organisations, but the communication changed and obviously sciences was gradually expanding its understanding but the communications were not always clear so, for example, lack of sign language in the main British UK announcements, but also we found that people with learning difficulties or disabilities would often say, "What did that mean?" You know, ringing up their families and say, "What should I do now?" They just didn't know. It wasn't clear, and they changed.
**Q.** The Inquiry heard a significant amount of evidence yesterday about shielding. So I'm not going to take you to that except to ask you about the information you provide at paragraph 54 of your report where you say:
"One of the key problems with shielding appears to be the lack of consultation with those deemed vulnerable or the organisations that represent them. The response was not what was wanted and the problem could have been avoided with more involvement of disabled people and their organisations. In the early stages of the pandemic, the category was based solely on clinical judgement which, given the circumstances, was undesirable, but as the pandemic progressed, the communities became aware of the challenges that they



faced, and there was, thereafter, little engagement with them."
So as a general point, has your research disclosed that there was very little negotiation, consultations, involvement, really, with those representing disabled people and clinically vulnerable people?
**PROFESSOR WATSON:** Yes, I think that would be the case. And I think -- I assume we'll come on to it later, but this was where the third sector stepped up and provided that support in shielding and I think that --
**Q.** Yes, well, let's move on to that, please, Professor Watson because I know you both want to pay tribute to the great supporting institutions who are the third sector, who stepped in, filled the gaps, gave advice, and really assisted during the course of the pandemic.
**PROFESSOR WATSON:** I think, you know, without the third sector, and the way they stepped up, the way -- they are much fleeter of foot than the statutory agencies, they were much more able to change the way things -- and also, much closer to the communities. So they were able to know what was going on and, you know, in the early stages of the pandemic it was organisations like Glasgow Disability Alliance, Inclusion Scotland, Inclusion London --



**PROFESSOR SHAKESPEARE:** Equal Lives.
**PROFESSOR WATSON:** Equal Lives, yes, who ran surveys of their members and brought the needs of disabled -- how disabled people had been treated to the public attention. And I think this created a -- they showed the plight of disabled people, but they were also -- they changed the way they worked, you know, things like the Centre for Inclusive Living in Glasgow became a major provider of PPE because they recognised, so they went out and they sourced their own because they saw that people living in their own homes weren't getting access to PPE so they stepped in and provided this service where others -- where it wasn't being provided.
They challenged the digital exclusion of disabled people, they, you know -- and part of it was because their funding streams were made, you know, they were just told by the local authorities "Spend the money as you want". And so money that might have been used for running theatre groups or so on, they bought computers in. They ran -- sent laptops or pads to -- or tablets to people. They ran classes to show people how to use them. They set up things, you know, that -- organisations for people with learning disability set up chatrooms for disabled people, ran regular evenings, discos and so on, for people to come together. And it



was them that were -- they were the groups who held things together during this pandemic.
**PROFESSOR SHAKESPEARE:** Both the existing groups and people coming together to provide those facilities, which they lacked in the public, where they were not offered so they provided them themselves.
**Q.** Thank you.
At paragraph 66 of your report, you do say there were regional differences in the way that governments worked with the third sector. You say that there's some evidence that governments in Scotland, Wales and Northern Ireland were more likely to work with disabled people's organisations than was the case in England.
**PROFESSOR WATSON:** Mm.
**Q.** You give the example of the Minister for Health and Social Care in Scotland setting up a group and meeting regularly with the major disability organisations. But you also talk of there being a complaint, really, about how far that went, whether or not it was really effective. Because Jim Elder-Woodward from Inclusion Scotland has told you that a recurring theme was that Inclusion Scotland was increasingly presented with a near final draft policy and plan at meetings, and therefore, although there was an indication that there had been inclusion and consultation, in fact, in

practical terms, it mattered very little?
**PROFESSOR WATSON:** It wasn't really what you'd call co-production. It was telling people "This is what we're going to do, what do you think?" rather than "How shall we solve this problem?"
**Q.** Thank you.
Now, before I turn to ask you about reflections on lessons learned and recommendations, there is one additional point, and I suppose it reflects upon a lack of data and a need for further research, but it's into black and ethnic minority disabled people and those who were clinically extremely vulnerable. And you deal with this at paragraphs 73-75 in the report.
Is it right that there is a paucity of data and there needs to be more reach into this area?
**PROFESSOR WATSON:** Yes, I think there's a lack of data -- there's a general lack of data around ethnicity and disability, I'd say, and this was demonstrated during the pandemic.
**PROFESSOR SHAKESPEARE:** For example, when we did a survey, we talked to -- interviews, rather -- we talked to lots of organisations, lots of individuals. We tried very hard to get organisations of black and ethnic minority people, and we failed. So that is partly our fault but it is also partly that there weren't those to consult



with.
**Q.** Yes, thank you very much.
I'm going to summarise, I hope accurately, and, please, you will tell me if there's anything you would like to add to this, your reflections on lessons learned. You say at paragraph 77:
"The best outcomes were achieved when those affected by decisions were included in the planning process."
And we've just confirmed that now.
"... there was a lack of co-ordination between the various sectors and this affected service delivery."
There was:
"The failure to take into account the needs of those who received domiciliary social care and poor acknowledgement of the importance of the sector created significant problems ..."
There was communication to disabled people and those who were clinically extremely vulnerable being of a poor level, and "both groups were left feeling ignored and unsupported".
You say:
"The key role played by the Third Sector in helping disabled people and those who were clinically vulnerable and extremely vulnerable has to be acknowledged."
And I hope that you've been given the opportunity to



do just that.
**PROFESSOR WATSON: (Witness nodded)**
**Q.** And as far as recommendations are concerned, you go on, starting at paragraph 82, to say this:
"Further research is needed to explore the intersection between disability and other protected characteristics, geographical location and socioeconomic status."
But:
"Social care needs to be seen as an equal partner to health care and the importance of domiciliary care needs to be recognised.
"Better coordination [is needed] between statutory services and ... local and national governments and the third sector.
"Greater consultation with the third sector organisations [is needed, together with] ... coproduction of services."
There needs to be:
"Better communication and dialogue with disabled people and those who are clinically extremely vulnerable."
There needs to be:
"A better way of identifying people who are extremely vulnerable, for example [as we've discussed]



a marker on GP records."
And finally, there needs to be:
"More secure funding for the Third Sector."
**PROFESSOR SHAKESPEARE:** Yes.
**PROFESSOR WATSON:** Yes.
**Q.** Is there anything that I've left out or anything that either of you would like to add?
**PROFESSOR WATSON:** No.
**MS BLACKWELL:** Professor Shakespeare, Professor Watson, thank you very much. I think there may be a couple of additional questions.
**LADY HALLETT:** There are couple of questions and I think the first one is from Mr Wagner, who is over that way.

**Questions from MR WAGNER KC**

**MR WAGNER:** Can you hear me?
**LADY HALLETT:** I can now.
**MR WAGNER:** You've spoken quite a bit about the crossover between clinical vulnerability and disability and other factors. Would it be fair to say that the impact of the pandemic and the UK's response to it may have been quite different for disabled people and clinically vulnerable people, as in obviously there's obviously some crossover between the categories, but there are also some quite significant differences?
**PROFESSOR SHAKESPEARE:** I would have thought, as our

evidence suggests, both groups would have been exposed to obviously the easements, both would have been exposed to the Coronavirus Act and the guidelines in terms of social activity and so forth. So there is difference, but there's also a -- they're all vulnerable. They felt they were vulnerable. Whether truly or not, they felt they were vulnerable. And care was limited for definitely disabled people, but some clinically extremely vulnerable people, but it would also have depended on certainly health but social services, and they would not have had access to those.

**PROFESSOR WATSON:** And I think that the evidence from Lucy Wong's (sic) report, that counsel reported on, where they talked about withdrawal of services, closure of respite centres and so on, those are not terms that are just applied to people who are clinically extremely vulnerable, those are the experiences of what we would define as disabled people. And I think there's a -- of course, there's a problem that some -- there was different experiences for different disabled people, and there's a danger -- you know, disabled people are not a homogeneous group. There's lots of different needs. And some disabled people were more vulnerable than other disabled people and -- depending on the particular health needs and their particular health challenges they



faced.

So I think it's wrong to talk about these groups as if they're a homogeneous group, there's differences that were created within it, and those experiences were different. And then the experiences of those people who relied heavily on social care, who may not have been extremely vulnerable to the virus but were extremely vulnerable to changes in the delivery of social care, greatly impacted their lives and greatly impacted their wellbeing. So it's not -- I think that you can look at differences and similarities, but the vulnerabilities that they faced were either vulnerabilities that were intrinsic to their condition or they were vulnerabilities that were created by the response to the pandemic and the way that social care and healthcare and other things were organised, so I think you should be looking at specific contexts for these.

**Q.** May I just follow up with one question, my Lady?

I entirely understood the definitional issues, and there's lots of crossover. Would you also agree there is a value in having a separate clinical vulnerability definition or category, because it highlights particular groups of people? For example, the immunocompromised, for whom there are very specific challenges, and I think you spoke quite a bit about the challenges of going to



health care, and facing dangerous environments because of poor air quality or spreading the virus, or whatever it would be, but would you agree that there is a value analytically in maintaining some kind of category of clinical vulnerability?

**PROFESSOR SHAKESPEARE:** Certainly analytically, but it needs to be communicated extremely clearly who we're talking about, because even if people who weren't clinically extremely vulnerable, they felt they might be, they felt they were in that group, even if they were not listed. So that risk of fear of, say, public environments or healthcare environments, or whatever, was common to all, even though perhaps not everybody was equally vulnerable.

**Q.** And I think that's something that clinically vulnerable families and Lara Wong, who you referred to, would agree with.

Thank you.

**LADY HALLETT:** Thank you, Mr Wagner.

And now I think it's Ms Sergides, who is over that way.

**Questions from MS SERGIDES**

**MS SERGIDES:** I'm grateful, my Lady.

Professors, can you hear me?

**PROFESSOR WATSON:** Yes.



**MS SERGIDES:** Grateful. My name is Marina Sergides and I represent the Domestic Abuse Group and I will be asking a few questions. I want to start by addressing the impact on disabled people and those who are clinically vulnerable who experience domestic abuse.

So your report recognises that the removal and disruption of social care during the pandemic had a disproportionate impact on disabled people, and those who were clinically extremely vulnerable. That's at paragraph 30. And you further state in some cases disabled people were forced to return to their parents' homes and that there also appeared to be an expectation by social services that families resumed caring responsibilities for adult disabled relatives.

For victim-survivors of domestic abuse, this withdrawal of social care support increased their dependence on partners or family members for care, which in turn increased the potential for exploitation or abuse by perpetrators and created fewer opportunities to escape abuse.

I wonder if in that context I can turn to Disabled People's Organisations' witness statement, if I can perhaps have it on screen that would be most helpful, and in particular paragraph 140.

On screen? I'm grateful.

And in particular the sort of -- halfway down that paragraph which starts "What is particularly alarming", do you see that, Professors?

**PROFESSOR SHAKESPEARE:** Yes.

**PROFESSOR WATSON:** Yes.

**Q.** "What is particularly alarming about the increased domestic abuse rates during the pandemic was that often abuse partners were not leaving the home due to lockdown policies and therefore the opportunities for survivors to report abuse was severely limited. Instead, domestic abuse survivors were often trapped for long periods of time in the same house as the perpetrator."

With that in mind, do you agree that this was a very real risk of reducing -- that the very real risk of reducing social care and placing care on -- caring obligations on family members was this? Would you agree with this statement?

**PROFESSOR SHAKESPEARE:** Yes.

**PROFESSOR WATSON:** Yes. And I think that -- you know, it's well known that disabled victims of domestic abuse, even outside a pandemic, have real problems reporting that domestic abuse, especially where it's a so-called "mate crime" that's going on. So I think the pandemic increased the possibility of -- or increased the possibility of mate crime, but also it made it much



harder to report, as it says here, so I think I wouldn't disagree with that at all.

**MS SERGIDES:** I'm grateful.

**LADY HALLETT:** Thank you very much indeed. That completes our questions for you, and in fact completes the witness for this week. Thank you both very much indeed, I'm very grateful. You were very helpful and clear last time again, and have been so again, as I expected.

I am sorry we had to call on you more than once, but it's been really useful, so thank you very much.

**PROFESSOR SHAKESPEARE:** Thank you for your work.

**PROFESSOR WATSON:** Thank you very much.

**LADY HALLETT:** And enjoy your retirement. Don't tell me what it's like!

**PROFESSOR WATSON:** One day, one day.

**LADY HALLETT:** That completes the evidence for this week.

**MS BLACKWELL:** It does.

**LADY HALLETT:** Thank you very much indeed. I shall return -- I shall be chairing the hearings remotely next week and I shall return to start sitting again at 10.30 on Monday, the 23rd.

**MS BLACKWELL:** Thank you.

**LADY HALLETT:** Thank you very much.

**(3.01 pm)**

**(The hearing adjourned until 10.30 am on**



**Monday, 23rd February 2026)**



**I N D E X**