

1 yeah, distress.
 2 Q. That's interesting, in terms of people not having rung
 3 a hotline before, you asked -- again, I don't need to
 4 take you forward but it's at paragraph 98.1 -- you asked
 5 local Mind groups who were responsible for delivering
 6 your services across the country, you asked them for
 7 their insights about why they thought or what they
 8 remembered about this increase, and what they described
 9 is people being anxious and depressed due to lockdown,
 10 and also what they were seeing reported in the media --
 11 does that accord --

12 A. Absolutely.

13 Q. -- with your recollection?

14 A. Absolutely. One of the most astonishing factors that we
 15 saw, especially for children and young people, the
 16 impact of the rolling news, the constant noise about
 17 what was happening, that kind of sense of crisis and
 18 emergency. So every time -- for instance, if there was
 19 an announcement by a minister, a specific kind of moment
 20 in time, all of the helplines would experience
 21 a significant spike in contact with people who were
 22 deeply anxious about what it meant for them, how long
 23 this would go on for, and indeed, Shout can reflect that
 24 quite candidly in terms of announcements made by
 25 prime ministers in relation to the pandemic.

5

1 Q. I think Shout, is that a young persons hotline?
 2 A. It is.
 3 Q. I should just remind you that Module 8 has dealt with
 4 young people, it's really interesting to hear it again,
 5 but it was --
 6 A. No, it was all round --
 7 Q. -- it was adults as well who were calling. Of course.
 8 Now, what local Minds have described is the access
 9 to community mental health services being reduced, and
 10 essentially charities like Mind in some ways filling the
 11 gaps. Is that a fair sort of description of what you
 12 felt you were doing?
 13 A. Yeah, absolutely. So what we understood at the time was
 14 that statutory services quickly closed down. So both
 15 services by -- run by local authorities and the NHS
 16 quickly disappeared. So we saw a rapid decline in our
 17 service users' ability to continue with any level of
 18 support. So -- and this is not an attack on the NHS or
 19 local authorities because absolutely we understand the
 20 circumstances they were in.
 21 Nonetheless, our local Minds had to step into that
 22 gap and so instances where service users were shielding
 23 or they were unable to access support for serious mental
 24 illness, our services stepped in, either remotely or by
 25 providing kind of safely-distanced support.

6

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

5 What you're saying is really interesting and I think
 6 people tend to speak a bit faster when we're having
 7 conversation --

8 A. I'm north London too, so it definitely is very fast.
 9 I'll slow down.

10 Q. Yeah, let's both slow down and let's take it a little
 11 bit slower now in terms of the next few questions.

12 You've talked about community mental health services
 13 not being as accessible, Mind trying to fill the gap,
 14 but clearly they couldn't entirely fill the gap.

15 A. No.

16 Q. And you say at paragraph 93 of your statement that in
 17 particular, the people who had pre-existing physical and
 18 mental health conditions, they were requiring more
 19 support, but some reported despite that, feeling a sense
 20 of unsupportedness during the pandemic; is that correct?

21 A. Of course. I mean, it absolutely is correct. So local
 22 Mind services primarily are dealing with people's mental
 23 health challenges, but we do also accept that many of
 24 our service users will have co-existing conditions,
 25 mainly, you know, lung, heart, ability to get around,

7

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

5 So, of course, if you were a shielding individual,
 6 it would be very difficult for you to access services.
 7 So you might be able to access some online resource, but
 8 being able to go and see your GP or being able to access
 9 a community group, et cetera, became impossible, and so
 10 for people with health conditions, physical
 11 disabilities, there was an additional layer of
 12 structural barriers that they had to experience. It
 13 wasn't just they couldn't access, but actually we
 14 couldn't get to them.

15 Q. Thank you. Now, in terms of specific types of Mind
 16 services where there was an increased demand, at
 17 paragraph 14 you say that in particular bereavement
 18 support and suicide prevention services saw
 19 unprecedented demand; is that correct?

20 A. It is.

21 Q. And just on that point, we heard some expert evidence
 22 yesterday that suggested they hadn't established any
 23 clear evidence of increased suicides, but the expert
 24 thought that that cohort, people with severe illness,
 25 would be at increased risk; does that fit with your

8

1 experience --
 2 **A.** It does.
 3 **Q.** -- in demand?
 4 **A.** It does. So what we saw was an increase in people with
 5 suicidal ideation, so we expanded our emotional support
 6 helpline for that reason, because people were coming to
 7 us with ever increasing complexity, ever increasing
 8 levels of acuity in terms of their distress. So in
 9 terms of worries about suicidality at that time,
 10 everybody was very, very concerned, and so we ensured
 11 that our suicide prevention services across the piece
 12 expanded as much as they could and in fact we had some
 13 support from local authorities to do that.

14 **Q.** Thank you.
 15 **A.** In terms of bereavement services, it's also the case --
 16 obviously people started to lose individuals really
 17 quickly, and certainly from a mental health perspective
 18 this brought people who'd never accessed mental health
 19 services to us before. And so immediately we had to
 20 spring to life some quite significant surge plans to
 21 respond to that demand.

22 **Q.** Thank you. And I'll come back to that at the end of
 23 your evidence, specifically bereavement support.
 24 Dr Hughes, I now want to move on to a number of
 25 reports that Mind produced during the pandemic which you

9

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

10

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

11

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

12

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

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

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

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

19 **A.** That's right.

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

13

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

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

15 **A.** That's right.

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

17 **A.** Absolutely.

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

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

14

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

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

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

15

1 lost.

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

4 **A.** Yes.

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

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

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

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

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

16

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

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

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

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

22 Q. Yes, and a positive one?

23 A. And a positive one, yes.

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

17

1 online is the most popular way to cope" -- again, this
2 is from 2020 -- "amongst both young people and adults."
3 No surprise particularly there, but just to flag the
4 remainder of coping strategies, when you look at the
5 detail of what you're describing there, are essentially
6 harmful behaviours, it seems?

7 A. Absolutely, yes.

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

14 A. (Witness nodded)

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

16 A. Mm.

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

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

18

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

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

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

19

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

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

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

16 A. Yes.

17 Q. Thank you.

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

25 A. Yes.

20

1 Q. And that described several studies showing that a lack
 2 of physical activity is associated with worsening mental
 3 health. And Doctor, at paragraphs 28 to 42 of your
 4 statement, you talk a lot about the work you did about
 5 encouraging activity; does that chime with what we've
 6 seen in our systematic review about worsening mental
 7 health being associated with lack of activity?

8 A. Absolutely. We have a firm belief that physical
 9 activity supports good mental health and so again, when
 10 we could see the immediate decline, we were very clear
 11 that we needed to ramp up our physical activity across
 12 the piece.

13 Q. Thank you. And it's right to say that this sort of work
 14 had been ongoing for some time prior to the pandemic?

15 A. Yes.

16 Q. But as the pandemic hit, you saw increased demand,
 17 particularly when sports facilities closed?

18 A. Yes.

19 Q. And, at paragraph 36, I want to ask you about some
 20 specific points about physical activity, and it touches
 21 on what we've just been discussing. Some people didn't
 22 find it very easy to use physical activity to cope; is
 23 that correct?

24 A. Yes, I mean many of the people who have serious mental
 25 illness have other co-existing physical issues too, and

21

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

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

20 Q. Yes, I'm going to come back to that point in a moment.
 21 One individual told you that they were exercising for up
 22 to 10 hours a day. You mention that. I just wanted to
 23 ask you about that. That physical activity wasn't an
 24 easy thing to give advice about, was it?

25 A. No, you're quite right. And indeed, for certain groups,
 22

1 physical activity -- if you're living with eating
 2 distress, for instance, physical activity can be
 3 incredibly problematic.

4 Q. Yes.

5 A. And excessive exercise is absolutely not great for your
 6 mental health either. So we had to be really cautious
 7 and thoughtful because we did not want to feed into
 8 that, those messages, but equally, we really wanted to
 9 hold on to the value that physical activity could place.
 10 So, again, those trauma-informed -- and I'll, kind of,
 11 be really clear about that: our physical activity
 12 services are trauma informed.

13 Q. Yes.

14 A. And so, from that perspective, being able to manage that
 15 distinction between harm and, you know, kind of,
 16 positive impact, will -- (overspeaking) --

17 Q. Yes, it's a balance, essentially?

18 A. It's a balance, yes.

19 Q. And you -- during the pandemic, you, created -- I think
 20 you've exhibited it to your witness statement, I don't
 21 need to take you to it, but a specific resource was on
 22 your website about healthy relationships with physical
 23 activity?

24 A. Yes.

25 Q. And that was because of this, this need for --

23

1 A. Absolutely, yes.

2 Q. -- sort of quite nuanced and carefully balanced advice?

3 A. Yes.

4 Q. Thank you.

5 I'm just going to take you through a couple of the
 6 other things that you mention that you developed in
 7 light of this concern about inactivity. You mention the
 8 delivery of 20,000 Get Active at Home leaflets and
 9 activity packs, and you delivered those because you were
 10 concerned about the digitally excluded, as I understand
 11 it?

12 A. Mm.

13 Q. I will turn now to the walking groups that you
 14 mentioned. So this is at paragraph 39 of your
 15 statement, and you described these groups being set up,
 16 as well as the online peer support, to really keep
 17 people who were particularly isolated on track; is that
 18 correct?

19 A. Yes, absolutely. Primarily because we know that people
 20 with particularly serious mental illness have, you know,
 21 a mortality rate of 15 to 20 years before the rest of
 22 the population, and so our desire to maintain healthy
 23 coping mechanisms, including physical exercise, was
 24 a priority. We felt deeply concerned that the
 25 deterioration in all of the physical activity would

24

1 contribute even more so to that incredibly painful stat.
 2 Q. Yes. I'm just going to touch on that, because we heard
 3 evidence yesterday about that striking statistic. It's
 4 a pre-existing feature --

5 A. Yes.

6 Q. -- severe mental illnesses and mortality rates being
 7 15 to 20 years lower. But what you describe in your
 8 statement is something that was ongoing to try to
 9 address that statistic; is that correct?

10 A. Yes.

11 Q. But during the pandemic, is it right to say that efforts
 12 to focus on that group were redoubled in terms of the
 13 mortality risk from not doing any physical exercise?

14 A. Indeed. So we know that people with serious mental
 15 illness were five times more likely to die during the
 16 pandemic, and physical health challenges were absolutely
 17 key and core to that. And so we knew that this would
 18 happen during the pandemic, and so our response was not
 19 just about supporting people's emotional health but we
 20 needed to attack the physical health piece too.

21 And providing walking groups, et cetera, was not the
 22 only intervention we took; we also assisted people with
 23 accessing vaccines and, you know, doing all of those
 24 things too, because we were really concerned about that,
 25 the impact of that overall.

25

1 Q. It would be right to say that this is a very hard to
 2 reach part of society?
 3 A. Incredibly.
 4 Q. And you described in your statement, paragraph 42.2,
 5 a lot has gone into that initiative. You described
 6 Oxfordshire Mind, Active Oxford, Oxford Mental Health
 7 Partnership and funding from Sport England's Tackling
 8 Inactivity and Economic Disadvantage fund?

9 A. Yes.

10 Q. So a lot goes into trying to devise something to shift
 11 that statistic?

12 A. Absolutely. You know, this has been the reality for
 13 people with serious mental illness for some time, so
 14 this is a known quantity, this has been something that
 15 we in the mental health community have been trying to
 16 attack, and physical activity is one way of doing it.
 17 And so we have been working with Sport England, and in
 18 fact our sports and physical activity work has been
 19 ongoing for about 15 years.

20 Q. I'm just going to touch, before we move to another
 21 section of your statement, on a couple of other
 22 specifics that you have noted about the pandemic, again
 23 related to physical of the group we've been talking
 24 about. You say at paragraph 20 of your statement you
 25 became aware of some people with those severe illnesses

26

1 being unable to access food because they weren't on the
 2 shielding list.

3 Was that a feature you noted in terms of physical
 4 health of people with mental illnesses?

5 A. Absolutely. So it was extraordinary that we found that
 6 people with serious mental illness were not immediately
 7 on the shielding registers. You know, even with SMI,
 8 serious mental illness, registers across primary care,
 9 for some reason that was a largely excluded group. Not
 10 in every part of the country but there --

11 Q. There were some instances of that?

12 A. Yeah, quite a lot, actually. I would probably say it
 13 was kind of 50/50 in terms of whether you were on the
 14 shielding list or not. And so the other part of that,
 15 though, is that in those instances, you would hope that
 16 mental health services then could step in and advocate
 17 for somebody, but that often lagged. That took some
 18 time to realise, well, who's missing? Who actually
 19 needs this support? And it demanded mental health
 20 services to reach out, which was right, because
 21 actually, whilst we'd call it a hard-to-reach group,
 22 it's actually the fact that we don't reach them. So for
 23 us it was really thinking through, how do we get to
 24 them, how do we identify these individuals? And that
 25 took time.

27

1 Q. One last specific insight that you've offered, telephone
 2 hearings for mental health review tribunals for the
 3 justice system were devised, but you highlighted that
 4 that could cause issues for patients for instance with
 5 paranoia or hallucinations. Was that a specific impact
 6 of the pandemic measures that you recall that Mind
 7 advocated for?

8 A. Yes, we found that -- I mean, far too many instances
 9 where those systems absolutely created impenetrable
 10 realities for these people who were very, very poorly.
 11 They couldn't access advocates in the same way, and so
 12 all of that, that whole system, became -- there was
 13 a lack of integrity to it for those reasons.

14 Q. Thank you.

15 I'm going to move on to another topic. Dr Hughes,
 16 your statement covers pretty much every aspect of
 17 Module 10's scope and we've heard a lot about mental
 18 health in general terms, but you talk in your statement
 19 also about the impact on workers and your staff that
 20 I just want to ask you about, because you raise a few
 21 points about your staff that have a broader resonance in
 22 some of the evidence that we've already heard and will
 23 hear.

24 At paragraph 45 of your statement a particular
 25 feature of the pandemic you describe, and that is a rise

28

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

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

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

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

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

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

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

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

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

30

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

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

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

20 A. Yes.

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

24 A. Yes.

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

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

3 A. Yes.

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

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

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

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

13 Q. Thank you.

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

22 A. Yes.

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

33

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

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

11 A. Yes.

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

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

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

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

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

34

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

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

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

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

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

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

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

25 If you're talking to families, "No, you can't sit
 36

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

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

15 A. Mm.

16 Q. So thank you very much for that.

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

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

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

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

20 Q. Yes.

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

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

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

9 And you say you think maybe there was a need for the
 10 research to be a bit more culturally competent. Can you
 11 briefly summarise what you mean by that in that context?
 12 A. Yes, so generally research comes from a very, kind of,
 13 normative model and therefore isn't often very
 14 culturally appropriate or thoughtful about what's going
 15 on in different communities. What we do know now is
 16 that actually in some of the black and minority ethnic
 17 groups that they have some protected factors, protective
 18 factors because of family connections and community. So
 19 we do know that there are some protective factors as
 20 well as some high risk.

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

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

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

9 Q. Thank you.

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

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

18 A. Yes.

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

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

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

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

21 **Q.** Yes.

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

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

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

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

7 **Q.** Thank you.

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

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

18 **Q.** Yes, we did.

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

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

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

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

9 **A.** Yes.

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

15 **A. (Witness nodded)**

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

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

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1 **Q.** Thank you.

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

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

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

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

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1 A. Yes.
 2 Q. And lack of access to mental health services during
 3 lockdown in that environment would have a particular
 4 impact on this group?
 5 A. Absolutely. And our ability as workers really
 6 compromised in terms of being able to know what's going
 7 on. So I come back to that point around, you know, if
 8 we're doing remote consultations, you know, we are
 9 limited in what we can see and know about the
 10 individual. Injuries can be, you know, hidden. What's
 11 going on in the environment can be hidden. And so our
 12 ability to intervene was deeply compromised.
 13 Q. And services going online clearly presented particular
 14 challenges --
 15 A. Yes.
 16 Q. -- that you've described for that group?
 17 A. Yes.
 18 Q. Thank you.
 19 Turning to people detained in prisons and detention
 20 centres. I think you say that Mind hasn't conducted any
 21 specific research on that.
 22 A. No, but I worked at the Centre for Mental Health at the
 23 time when we were commissioned by NHS to do a review of
 24 mental health in the prison service.
 25 Q. So I think you've said at paragraph 109, there was

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1 significant concern about that population during the
 2 pandemic, and understanding that there was
 3 a considerable deterioration in the mental health of
 4 detained people?
 5 A. Absolutely. So this is already an incredibly vulnerable
 6 cohort. This is, you know, a group often that has
 7 anything between 75 and 90% of people going into prison
 8 have some sort of mental health or learning disability,
 9 you know, or some vulnerability of some kind. So this
 10 is already a very vulnerable group of people.
 11 What we saw during the pandemic is that mental
 12 health support flatlined again overnight. We also so
 13 saw a massively -- a massive increase in the amount of
 14 time people were held in cells, for instance that often
 15 didn't meet human rights regulations.
 16 So, you know, exercise wasn't really an option.
 17 There were massive delays in accessing education. There
 18 were massive delays in staff accessing PPE so distance,
 19 you know, therefore they had to keep huge distances
 20 between officers and prisoners.
 21 We saw, you know, a lack of contact with family and
 22 friends, so any of those protective factors disappeared
 23 overnight and for people with serious mental illness,
 24 not being able to access medication, for instance, is
 25 life threatening.

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1 Q. Thank you.
 2 I'm going to turn finally to your experience of the
 3 bereaved, at paragraph 116 of your statement. Again,
 4 the Inquiry has received and will be hearing more
 5 evidence about this from other witnesses. I just want
 6 to ask you about one of the many case studies you
 7 present from a bereaved individual who has spoken to
 8 Mind, and it was mentioned in your opening statement, as
 9 well, on behalf of Mind.
 10 You cover the experience earlier in the statement,
 11 at paragraphs 93 to 97, the experience of disrupted
 12 mental health services, essentially. And what the
 13 account involves is a very negative experience during
 14 the pandemic in terms of the healthcare provided to a
 15 loved one before they died.
 16 And in summary, she says that her father was
 17 admitted to hospitals under the Mental Health Act, was
 18 not allowed visitors, she was very concerned about the
 19 adverse affect of that on him, and that sadly he died
 20 from complications of Covid. So that's what happened.
 21 In terms of what she's been left with, and you
 22 describe it in your statement, she's left with many
 23 concerns about his care, ventilation, and testing.
 24 And then moving on to his death, she wasn't able to
 25 see his body, there were only ten mourners allowed at

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1 his funeral, and she explains, and you set this out in
 2 your statement, a huge amount of resentment about what
 3 happened and a lack of closure.
 4 So, just taking that one example that you have cited
 5 quite a lot in your statement, can I ask you, do you
 6 think that having multiple layers of distress at each
 7 stage of the loss and bereavement process, does that
 8 have a particularly bad impact in terms of closure in
 9 the bereavement process, in your view?
 10 A. Absolutely. And first and foremost, I think -- I just
 11 want to say that Mind stands in heart and solidarity
 12 with all of those families that lost loved ones during
 13 those terrible days.
 14 I think that it absolutely does, and we, again, are
 15 seeing the legacy of that today. We are seeing complex
 16 grief, for the reasons that you describe, at every point
 17 of the story that you've highlighted. All of the
 18 ordinary things that you would expect a family to be
 19 able to do were taken away. And so not only did the
 20 individual die alone, effectively, the family also were
 21 unable to provide the support that they wanted to, and
 22 that they could have provided if they were allowed to.
 23 So, all of these aspects I think have, again,
 24 conspired to create a legacy of grief that we still, as
 25 a nation, are not really understanding. The 10,000

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 **A.** Yes.

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

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

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

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

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

15 **A.** A hundred per cent.

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

21 **A.** Yes.

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

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1 key workers being public facing and needing to enforce
 2 research -- restrictions and the abuse they might face,
 3 you've essentially suggested that some quite tailored
 4 support is needed for that; is that correct?
 5 **A.** Indeed, because it rests on so many factors. I mean,
 6 especially if you think about small communities, where,
 7 you know, somebody might be aggressive or violent in
 8 a shop, but that affects the entire community, right?
 9 So all relationships get damaged. So, in terms of the
 10 impact, the kind of halo effect of all of these things,
 11 it's not just on shop workers, it'll be on their
 12 families too. So, we do need to be able to think about
 13 a tailored intervention, we do need to be able to
 14 support individuals, but we also need to manage the risk
 15 of that. So it's not just about giving them the tools,
 16 maybe, to de-escalate or to understand a mental health
 17 crisis, but also to be able to keep themselves safe, and
 18 how do we do that, you know, in terms of alarms, making
 19 sure they do have relationships with the police locally
 20 and regionally, and I think all of those things, both
 21 practically and, kind of, philosophically, in terms of
 22 how we should be thinking about these things, need to
 23 come to bear.
 24 **Q.** Finally, I'll just run through four specific points that
 25 come from your statement shortly. Specific issues about

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1 challenging self stigma, particularly emergency workers,
 2 as you've described. In terms of vulnerable people, the
 3 importance of access to PPE, for both mental health
 4 wards and others, like charities such as yourself. And
 5 finally, you note the need for expanded suicide and
 6 bereavement support services. They seem to me to be the
 7 most pandemic-specific learnings?
 8 **A.** Yes.
 9 **Q.** Is there anything else that I've missed?
 10 **A.** No, I think that the only thing I'd probably add is that
 11 as we plan the next decade of mental health
 12 interventions, I would urge the government to make sure
 13 that they take on the learnings of what happened in the
 14 pandemic and create mental health services that attend
 15 to the legacy of that.
 16 **MS RAHMAN:** Thank you very much, Dr Hughes. There may be
 17 some other questions for you.
 18 **THE WITNESS:** Thank you.
 19 **LADY HALLETT:** There are. Mr Weatherby.
 20 Mr Weatherby is just there.
 21 **Questions from MR WEATHERBY KC**
 22 **MR WEATHERBY:** Thank you.
 23 Dr Hughes, I represent Covid Bereaved Families for
 24 Justice UK, and in fact the family member whose case you
 25 highlighted with respect to her father who was under

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1 a section. So I thank you for that.
 2 Just a very short point from us, and it goes back to
 3 some evidence you gave at the start of this session. In
 4 your statement at paragraph 9, you say that:
 5 "There has been a marked increase in the level of
 6 distress displayed by our beneficiaries during contact,
 7 with many citing that they're unable to access
 8 services."
 9 And that's at the beginning of the pandemic and
 10 that's the evidence you were giving.
 11 Did that include the inability of bereaved people to
 12 seek access to bereavement support as well as more
 13 general mental health access?
 14 **A.** Yes, I'm afraid it did in the early days, yes.
 15 **Q.** Yes, and that leads to your recommendation that that
 16 needs to be ramped up in future?
 17 **A.** Absolutely. It has to be a core part of mental health
 18 services going forward. I mean, obviously, grief is not
 19 a mental health issue per se.
 20 **Q.** No.
 21 **A.** But pandemic-related grief becomes a mental health
 22 issue.
 23 **Q.** Yes.
 24 **A.** And so our very clear recommendation is that that must
 25 be taken into consideration in the future, especially

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1 around the impact on families, but also in terms of the
 2 type of services that we support. So this is not just
 3 kind of, you know, ordinarily grief support would be
 4 very kind of gentle and low key.
 5 **Q.** Yes.
 6 **A.** We're talking about complex PTSD or complex grief which
 7 demands a clinical intervention.
 8 **MR WEATHERBY:** Yes, thank you very much, thank you.
 9 **LADY HALLETT:** Thank you, Mr Weatherby.
 10 Ms Douglas, who is that way.
 11 **Questions from MS DOUGLAS**
 12 **MS DOUGLAS:** Thank you, Dr Hughes. I act for Clinically
 13 Vulnerable Families.
 14 In your statement at 98.2 and it's where you're
 15 describing some of the insights provided by local Minds,
 16 you reported that the anxiety of avoiding catching
 17 Covid-19 and spreading it to vulnerable relatives was
 18 felt more acutely prior to lockdown when clinically
 19 vulnerable people felt helpless to protect themselves
 20 from getting infected.
 21 **A. (Witness nodded)**
 22 **Q.** And then you go on to note that after lockdown,
 23 restrictions started to ease, a top concern was about
 24 members of the public refusing to adhere to social
 25 distancing and other infection control measures.

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

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

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

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

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

4 **LADY HALLETT:** Thank you, Ms Douglas.
 5 Ms Sergides. Over that way.

6 **Questions from MS SERGIDES**

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

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

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

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

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

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1 acute service gap during the pandemic?

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

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

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

19 **A.** Yes, yes.

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

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

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

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

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

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1 incredibly painful, and during the pandemic particularly
 2 painful, and the legacy of that continues, and I think
 3 that the issue of burnout is one that we must attend to
 4 as a matter of urgency.
 5 **LADY HALLETT:** Thank you very much, Ms Sergides.
 6 Dr Hughes, you said that one of the roles of Mind is
 7 to advocate for those who suffer from mental health
 8 problems and issues of illness. If I may say so, you
 9 are an extraordinary advocate for Mind. You have been a
 10 very, very powerful witness and I'm extremely grateful
 11 to you for the help that Mind has given to the Inquiry,
 12 and obviously excellently represented by Mr Pezzani, but
 13 also for the help you've given. It's been a very
 14 interesting morning.
 15 **THE WITNESS:** Thank you, my Lady. I really appreciate that.
 16 **LADY HALLETT:** Very well, I shall return at 11.35.
 17 (11.22 am)
 18 (A short break)
 19 (11.35 am)
 20 **LADY HALLETT:** Ms Rahman.
 21 **MS RAHMAN:** My Lady, may I call the next witness, Professor
 22 Sarah Stewart-Brown.
 23 **PROFESSOR SARAH STEWART-BROWN (affirmed)**
 24 **LADY HALLETT:** Professor Stewart-Brown, thank you for coming
 25 to help us and for the work you've done for us so far.

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

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

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

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1 increases the chance of a negative outcome whilst
2 a protective factor reduces that chance or helps improve
3 outcomes.
4 Can you give us an example?
5 A. Yes. So, for example, smoking might increase your risk
6 of getting cancer but it doesn't dictate that you will
7 get cancer.
8 Q. So it's just a risk factor?
9 A. Just a risk factor.
10 Q. And, for instance, a protective factor might be, for
11 instance, wealth or something like that in terms of
12 mental health?
13 A. Indeed, indeed.
14 Q. Thank you. And then on that second question again on
15 page 7, it says that where data allows a range of
16 specific focus areas, risk factors, protective factors,
17 demographic characteristics or geographic location, have
18 been examined and you did that to understand how
19 different specific groups or populations were affected?
20 A. Yes, indeed. And I think we're going to come on to
21 a little bit about the methodology.
22 Q. Yes.
23 A. But the point about systematic reviews is you try and
24 find every possible study that could be relevant to your
25 topic and then you weed them down further from there,

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1 but you are constrained by what research has been
2 published.
3 Q. Yes, indeed. We are going to come up to that now.
4 Can I bring up the review INQ000659787, page 8,
5 please, and that talks about the methodology. And just
6 to understand the scale of what was involved that you
7 and your team were looking at, there were over 5,700
8 sources, studies, essentially, on mental health in the
9 pandemic, of which 2,700 were unique. Does that mean
10 there were a lot of references to the same study or does
11 that mean -- (overspeaking) -- duplication.
12 A. There were lots of duplicates and this research might be
13 published in the same way in
14 different -- (overspeaking) --
15 Q. And then you -- there's a lot to the report. There's
16 also a technical report attached to it explaining how
17 you identified what was a study that was robust. We'll
18 come back to that. You included 118 studies, and
19 ultimately, you excluded some of those because of
20 quality checks, and we've ended up with a list and it's
21 still 98 high-quality studies, essentially?
22 A. Yes, that's true.
23 Q. And can I just ask you, the fact that you've got so many
24 studies and sources all looking at the issue of the
25 pandemic and the impact on the population's mental

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1 health, does that tell you anything about the extent of
2 the impact -- or why was it, do you think, that so many
3 of these studies had looked at this particular issue?
4 A. Because I think people in the research community were
5 extremely concerned to document and find out what was
6 going on in the pandemic.
7 And I think one of the other things about this is
8 that some of the rules which would usually be there for
9 research studies and would enable you to get grant
10 funding were relaxed a bit during the pandemic, because
11 there was this real big concern to try to find out what
12 was going on, so there were more studies published, for
13 example, on -- invitations for people to take part in
14 them, rather than selecting a random sample of the
15 population.
16 So you just need to be a bit more careful about who
17 was part of that study and who wasn't.
18 Q. So, what you've done, you and your team have done, is
19 gone through many, many different studies and resources,
20 all of which were devised with the very laudable aim of
21 trying to work out what happened, but you have
22 fine-tuned the selection to something that we can really
23 draw some conclusions on?
24 A. And I suppose the large number is just evidence of the
25 fact that if you look at the technical report you can

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

9 **Q.** Thank you so much.

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

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

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

24 **A.** Yes, indeed.

25 **Q.** Thank you.

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

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

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

16 **Q.** Yes.

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

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

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

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

6 **A.** (No audible answer)

7 **Q.** Thank you very much.

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

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

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

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

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

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

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

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

5 **Q.** Yes.

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

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

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

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

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

3 **Q.** Yes.

4 **A.** So it matters.

5 **Q.** Yes.

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

9 **Q.** Thank you, Professor.

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

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

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

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1 the rise.

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

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

16 **Q.** Yes.

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

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

24 **A.** Yeah.

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

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

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

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

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

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

25 **A.** Yes.

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1 Q. And you do say there that you then see in that last
 2 period, presumably from the studies, an overlap with
 3 other societal pressures such as the cost of living
 4 crisis?
 5 A. Yes, indeed.
 6 Q. Thank you.
 7 A. And I think it's worth pointing out that the searches
 8 were done in October 2025, so we'd hoped to pick up any
 9 studies that were reporting on information up to that,
 10 but it takes quite a long time to do these studies and
 11 to publish them, so actually, the last data we have is
 12 from 2023.
 13 Q. Thank you very much, Professor. That's a very helpful
 14 time for us to now come to the findings of the review.
 15 So if I can bring up the review again, INQ000659787
 16 at page 17. And that, filtering all of the evidence
 17 that you've reviewed, is what the pattern over those
 18 periods of time tends to suggest.
 19 So if I could just ask you, please, Professor, just
 20 explain these findings, with the benefit of that slide
 21 in front of you, to us.
 22 A. Yes, well, I don't think it'll be any surprise to
 23 anybody to discover that the pandemic had a pretty
 24 dramatic effect on population mental health and, you
 25 know, from the first lockdown on, rates of mental health

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1 problems, psychological distress and, in fact, mental
 2 illness rose. And whilst it eased during the lockdown
 3 periods and then went up again when more restrictions
 4 came on, it didn't fall back to where it had started
 5 from, and by 2023, we're still seeing quite
 6 a significant rise in the levels of mental health
 7 problems relative to pre-pandemic levels.
 8 Q. And the pre-pandemic levels perhaps worth commenting
 9 upon. Even before the pandemic, nearly one in five,
 10 19.4% of adults -- women -- of adults -- did report
 11 psychological distress, that was before the pandemic,
 12 with certain groups more affected. But that has gone up
 13 during lockdown, unsurprisingly, and then you've got
 14 a partial rebound.
 15 Could I just ask you about that. In terms of the
 16 partial rebound, are there things such as employment
 17 that are particularly relevant to why some people
 18 rebound and some people do not after lockdown?
 19 A. Well, I think we'll probably go to that in looking at
 20 the more specific factors. So these were just, really,
 21 looking at the general trends.
 22 I think that what might be more important to add is
 23 that overall picture that we've painted hides different
 24 trajectories. So, for a proportion of the population
 25 you can see their mental health going -- getting worse

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

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

15 Q. Thank you.

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

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

24 So, again, review INQ000659787, page 19.

25 In the initial lockdown, towards the bottom of the

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1 page, just to remind us what we're talking about in
 2 terms of impact on mental health during this period:
 3 concentration difficulties, sleep problems --
 4 A. Yes.
 5 Q. -- feeling a lack of role and purpose, and just an
 6 inability to enjoy daily activities.
 7 Can I just ask you for a few key points arising out
 8 of those sorts of factors that are set out?
 9 A. Yes, these are the sort of things that people might use
 10 to get a handle on mental wellbeing that wasn't at the
 11 level of being ill.
 12 Q. Yes.
 13 A. And these are things that commonly go wrong when people
 14 aren't doing so well. And we're looking here
 15 particularly at the negative aspects of them, but it
 16 would have been more appropriate, possibly, to measure
 17 the people who were still sleeping well rather than
 18 those who weren't.
 19 Q. Yes. And what seems to be quite a striking statistic
 20 towards the end, inability to enjoy daily activities,
 21 that was the most significant deterioration.
 22 A. Yes.
 23 Q. And you go from 16.8% of people saying that in 2019 to
 24 46.2% in April 2020?
 25 A. Yes, exactly.

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1 **Q.** So we're not -- these aren't people who are reporting
 2 severe mental health conditions but an inability to
 3 actually enjoy life, very significantly --
 4 **A.** Well, these are people like you and me.
 5 **Q.** Well, you make a lot of assumptions, but yes, indeed.
 6 So, moving on to the impact not being experienced
 7 equally. Professor, we've heard a lot of evidence about
 8 this and pre-existing inequalities. I don't need you to
 9 delve into it in a lot of detail, but, in summary, you
 10 have pointed out in the review on a number of occasions
 11 that pre-existing inequalities have clearly played
 12 a huge amount of significance in how people have been
 13 impacted by the pandemic.

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

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

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

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1 who start off from a resilient perspective.
 2 **Q.** Of course.
 3 **A.** And I think that covers pretty much all the groups we
 4 were able to look at, because there was data available.
 5 **Q.** Thank you very much, Professor.
 6 So, the review has drawn these large conclusions
 7 about how people have reacted across the course of those
 8 five time periods. The final time period, you've
 9 identified that, in the longer term, there are still
 10 very elevated levels of distress despite the lifting of
 11 restrictions, and one question I've been asked to
 12 explore with you is whether or not you think that that
 13 could be related in some way to the number of people
 14 experiencing bereavement. Given the scale of
 15 bereavement that was experienced by the population, and
 16 perhaps the long-term nature of it, which the Inquiry
 17 has heard some evidence of, was that any part of the
 18 reviews that you looked at, a specific focus on
 19 bereavement?

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

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

4 **Q.** Yes.

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

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

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

12 **Q.** Statistically.

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

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

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

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

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

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

5 **Q.** Please do, yes.

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

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

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

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1 likely to get infected.
 2 Q. Physically affected?
 3 A. By the -- the virus was more likely to infect them and
 4 more likely to affect them severely and there was higher
 5 mortality rates.
 6 Q. Thank you. That's very interesting.

7 I'm going to move back to the specific factors --
 8 unless there's anything else, Professor. It's a huge
 9 report so if there's anything that we've missed
 10 then -- (overspeaking) --

11 A. No, no, those were the two areas I just wanted to --
 12 Q. Thank you.

13 Yes, so what the next bit of the report does is it
 14 does, I think you've said that you've done the best that
 15 you can, but leading back to the point about data gaps,
 16 you've gone through and you've said at each stage, well,
 17 at this stage of the pandemic there's less evidence, and
 18 is it right that comparing all of those different
 19 factors that I will list in a moment, it helps you
 20 identify where you're really short of data but just that
 21 exercise in itself would assist you to do that?

22 A. Yes, yes.

23 Q. And the factors that you have covered are by reference
 24 to the following 14 areas: age, gender, ethnicity and
 25 race, sexual orientation, socioeconomic status,

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1 occupation, housing and residential status, geographical
 2 differences, parents, pregnancy and maternity, caring
 3 status, disabled people and individuals with chronic
 4 illnesses, clinically vulnerable and clinically
 5 extremely vulnerable individuals, and finally, health
 6 status. So it's a huge endeavour, Professor.

7 A. Yes, and what we're doing is presenting whatever studies
 8 we could find in those particular groups.

9 Q. Thank you.

10 Now, Professor, obviously I'm not going to go
 11 through each and every part of the pandemic by reference
 12 to that, but we have, through various core participants,
 13 had some assistance with identifying some key questions
 14 about just the last few of those groups and the way that
 15 the review has approached it. So if I can ask you just
 16 a few questions about that.

17 The last three were, firstly, disabled people and
 18 individuals with chronic illnesses, and the last one was
 19 health status.

20 So just in relation to that, it's been pointed out
 21 that both of those sections, the disability in
 22 individuals with chronic illnesses and, secondly, health
 23 status, both of those sections will include conditions
 24 and impairments that have a substantial or long-term
 25 adverse effect on the ability to carry out day-to-day

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1 activities.
 2 A. Yes.
 3 Q. And so, for instance, we see, if you delve into that
 4 section, you've got chronic illnesses in both things
 5 like chronic pain, long-standing illness, is that
 6 correct? You've got that occurring in both those
 7 sections?

8 A. Yes, because there's a huge overlap, and you're just,
 9 you're limited to the definitions people have made in
 10 the particular paper you're looking at. So you then
 11 have to extrapolate from that that there's some people
 12 with chronic illness in this group so the data might be
 13 relevant.

14 Q. Would you say, then, that you should take those two
 15 sections together to get the full picture about the
 16 impact on people with disabilities?

17 A. Yes.

18 Q. Thank you.

19 The -- just again, a very specific point that's been
 20 asked about this, please help us if you're able to --
 21 I appreciate that it's a very long report, but the
 22 review says that at paragraph 3.2.12, whilst there was
 23 overall mental distress, the increase in people with
 24 disabilities or those with pre-existing health
 25 conditions was smaller or not statistically significant

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1 compared to non-disabled or those without the
 2 pre-existing health conditions. And the question is
 3 this: are you able to say whether that's against a sort
 4 of significantly higher baseline amongst those groups?

5 A. Yes, and I think we're going to see this in another
 6 group, and particularly one of those papers -- I mean,
 7 the focus of the paper was something else but you find
 8 this little nugget in the last couple of paragraphs of
 9 the results, and it is clearly pertinent to people with
 10 chronic illnesses -- I mean, health conditions can just
 11 be physical health problems or it can include all mental
 12 health problems. Disability can be defined very
 13 differently in these different surveys.

14 So, yes, there seemed to be in those studies
 15 something that was of relevance, and the overall marker
 16 was that people with chronic illness or disability on
 17 average have poorer mental health to start with --

18 Q. In the first place?

19 A. But in the actual rise. So, you know, from -- it didn't
 20 go from here to here, it went from there to there
 21 [indicates].

22 Q. Yes.

23 A. There was a lesser rise on the higher baseline in these
 24 groups.

25 Q. Professor, because you've done something visually with

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1 your hands, I'm going to try to attempt to describe what
 2 it is you did, but I might --
 3 A. -- (overspeaking) --
 4 Q. Could you just explain what you just did with your
 5 hands, in terms of the effect?
 6 A. Yes, so if you have the general population going from
 7 this level to this level [indicates], that's a baseline,
 8 but your people with disability or longstanding illness
 9 might have started there -- (overspeaking) --
 10 Q. Closer to the top line, yes.
 11 A. So the rise has been less. The difference is less.
 12 Q. I think everyone understands. I'm just attempting, for
 13 the stenographer, to try to sum that up.
 14 But the important point is that you might look at
 15 a statistic like that in a report and, you know, misread
 16 it to say that disabled individuals, you know, weren't
 17 that affected. That's not the case. They were already
 18 very affected by mental health, mental distress, and so
 19 the point at 3.2.12 isn't to be read like that.
 20 A. And also that those individuals where the general
 21 population's health came down quite significantly when
 22 the restrictions were eased, this group [indicates]
 23 didn't drop so much.
 24 Q. Yes. I see, so they stayed at a higher level?
 25 A. So it's complex to put an overall --

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1 Q. Again, it's been very helpful to ask about this
 2 particular part of the review, and what you've explained
 3 is that you're looking at a lot of studies. It may not
 4 be that the study is particularly signposted as being
 5 about disabled people, but you have managed to find
 6 something that you think is worth footnoting or
 7 referring to, and that's the next question, in fact.
 8 Footnote 289 covers sex and ethnicity or adults over
 9 the age of 50, on the face of it, and that is got from
 10 the description of the studies, 86, 20, and 16. I won't
 11 take you to the detailed description, but indeed it does
 12 seem to describe sex and ethnicity, the first paper.
 13 Refers to Covid-19 as an at-risk group as opposed to
 14 something specific on disabled people, that's the second
 15 one. And finally something about loneliness, physical
 16 activity and mental health. Again, it's a geriatric
 17 paper.
 18 So the points being made is, you know, are these
 19 studies that are footnoted there actually focused on
 20 disabled people?
 21 A. They have comments or issues that they're reporting
 22 which are relevant to that group, but that wasn't their
 23 main purpose when they set out.
 24 Q. And did they disaggregate for disability? It sounds
 25 not, from what you're saying. You're just saying that

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1 they were mentioned?
 2 A. We've been able to pull up a couple of the papers and
 3 have a look. I mean, I would need to spend a little
 4 time working out exactly, but certainly one of them had
 5 this little nugget about people with disabilities and
 6 chronic illness towards the end, which was very specific
 7 to them.
 8 Q. Thank you. I'm going to leave that section of the
 9 report now, whilst again thanking you for the detailed
 10 consideration against all of those groups in society.
 11 Really important to look at that, with that level of
 12 detail.
 13 Can I now take you to the concluding sections of the
 14 review.
 15 Again, the reference is INQ000659787.
 16 And if we could go to page 63, these are your
 17 concluding reflections.
 18 Again, we can all read it, but could you, as the
 19 senior academic consultant, sort of sum it up for us.
 20 Where did you get to in terms of the patterns and the
 21 reflections, having looked at all of that evidence?
 22 A. Well, there's a couple of patterns that were really
 23 robust and strong that we haven't actually touched on
 24 yet, and these were where there's very large groups of
 25 the population. So with both age and gender, there were

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1 really important findings within the most robust
 2 studies, and particularly with age, the -- there was
 3 a clear evidence that the younger age groups, the
 4 younger adults whose mental health started a bit poorer,
 5 there, the rise in mental health problems amongst that
 6 group was really importantly more than in the other age
 7 groups, and that actually across the population it was
 8 the elderly whose mental health deteriorated less during
 9 the pandemic.
 10 And that's particularly important because the young
 11 were those who were least at risk from the virus, and
 12 whose mental health seems to have been impacted more
 13 adversely, and has come back -- not come back to the
 14 level where it was before. So this is --I think this is
 15 one of the really key things that came out of this
 16 report.
 17 And the other thing was the impact on women, where
 18 again we've got a disparity in the starting point in
 19 that women's mental health is less good, but the effect
 20 on women was clearly very dramatically more so than on
 21 men, in terms of the reporting of their mental health.
 22 And whilst you can still see the same patterns of easing
 23 when the restrictions came off and then getting worse
 24 when they went on again, this is a finding of -- an
 25 extremely robust and very important finding.

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

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

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

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

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

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

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

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

25 Q. Thank you.

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

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

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

15 Q. Yes.

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

25 And the other clear protective factor that came out

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

7 So those were important protective factors that we
 8 identified.

9 Q. Thank you, Professor.

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

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

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

18 A. Yes.

19 Q. That's good --

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

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1 and social support of some sort were protected.

2 **Q.** Thank you.

3 Ultimately, that statistic, looking at multiple
 4 lockdowns and the pandemic as an experience as a whole,
 5 what you've provided is the statistic of 40% of people
 6 kept feeling high levels of stress or distress during
 7 lockdowns, and I take it that you feel that conclusion
 8 is pretty robust?

9 **A.** Absolutely. Absolutely. And certainly, you know, 50%
 10 of people at some stage dipped into what we might call
 11 a clinical level of mental health problems.

12 **Q.** Thank you.

13 Now, I would now like to, before we do get to data
 14 gaps, just look at a conclusion that you've reached at
 15 page 68. So, same INQ reference, but page 68.

16 And drawing it all together, whether or not all of
 17 these impacts that you've described were actually caused
 18 by the pandemic, and what you've said there is that most
 19 of the studies reviewed clearly cannot provide a direct
 20 cause and effect, but they show associations between the
 21 pandemic and these changes. It's not absolute proof.

22 But then you go on to essentially conclude that it's
 23 very likely that the pandemic played a major role and
 24 you've given these three features there. Could I ask
 25 you just to explain those to us: timing, inconsistency,

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1 exposure and impact.

2 **A.** Yes, epidemiologists are very often focused with this
 3 issue because they'll observe an association between one
 4 thing and another thing, and did it, did one cause the
 5 other? And so a lot of effort has gone in this
 6 discipline to saying: so what are the factors that we
 7 might consider which would really end up with us
 8 believing that A does cause B? And they're not a single
 9 thing; they are a cumulative number of things. And when
 10 you get to the end of the list, you're a hundred per
 11 cent sure, but when you're halfway through the list, you
 12 might be 70% sure, for example.

13 And so one of the key things is that all these
 14 studies looked at mental health at one point in time and
 15 then they looked at mental health at another point in
 16 time, and related that to what was going on in the
 17 pandemic at that time. So you're seeing shifts in
 18 mental health which are related to what was going on in
 19 terms of the virus, the lockdowns, and the vaccines. So
 20 that's an important -- that the trajectories follow each
 21 other.

22 **Q.** Yes.

23 **A.** The other thing is that you -- and this is where the
 24 systematic reviews come in as really important -- if you
 25 get the same findings or similar findings, in a lot of

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1 different studies, you're going to go: mm, this is
 2 something that is really robust and that we need to take
 3 into account.

4 And then the other thing that these studies gave us
 5 was that the greater -- if you've got the greater
 6 exposure to whatever you're considering to be the risk,
 7 like the pandemic or the lockdown effects, the greater
 8 effect on the outcomes.

9 So these are pretty strong evidence, and whilst
 10 other factors may well have come in and played a part,
 11 and they may have played a part disproportionately on
 12 different populations, there is absolutely no doubt in
 13 my mind, having looked at all this data, that the
 14 pandemic had a profound and I think not really
 15 anticipated effect on the mental health of the
 16 population in the UK that has not gone back to where it
 17 was before.

18 So we've seen a resetting of the population's health
 19 at a level which is very detrimental to lots of things
 20 that we might care a lot about.

21 **Q.** Thank you so much, Professor.

22 Can I ask you now to -- let's go to page 73, same
 23 INQ reference. And this is this issue of gaps. So
 24 you've looked at all of these studies, and you have
 25 noted some key gaps, and when we go to individual groups

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1 you'll see the odd use of the red traffic light, or
 2 amber, to try and investigate and get what you described
 3 as nuggets of information about groups, and I'm not
 4 going to ask you about the ones that you've listed.
 5 What I'm going to ask you about is some others that
 6 others in the room today have asked me to clarify with
 7 you whether or not there's more to say about that.

8 But the list that you've given there, just taking it
 9 in turn, ethnic minorities, sexual and gender
 10 minorities, caregivers, individuals with pre-existing
 11 conditions, specific occupational groups, survivors of
 12 gender-based violence and abuse, parents, especially
 13 single parents, pregnant women and maternity, and
 14 I think finally -- no, penultimate, no, not finally --
 15 older adults, individuals with Long Covid, individuals
 16 in specific settings which are set out there, and
 17 finally, clinically vulnerable and clinically extremely
 18 vulnerable groups.

19 So you've set out there specific population groups
 20 where you felt that there are -- there's just a lack of
 21 data in the various ways described.

22 **A.** Yes. Just to add to that. It would have been wonderful
 23 to have found studies relevant to these populations, but
 24 we can't go back and get that data so no further
 25 research can tell what happened to those particular

100

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

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

19 **Q.** Thank you.

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

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

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

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

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

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

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1 **Q.** We've heard that this morning, yes.
2 **A.** -- the shielding would have been -- the shielding would
3 have been really not a good idea, because that would
4 have been further damaging their mental health and then
5 their infection risk.

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

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

19 **Q.** Thank you.

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

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

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1 of study to engage the prison population in something
2 like this, who are, you know, a disaffected group.
3 **Q.** Yes. And I think some of these questions that I'm
4 coming to our dealing more with the issues that we're
5 touching on.

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

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

10 **Q.** Indeed, yes.

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

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

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

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1 Q. Thank you.

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

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

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

12 Q. Yes, it was later on.

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

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

15 A. Okay.

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

21 So I'll come back to those two questions.

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

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1 I think.

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

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

9 Q. Yes.

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

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

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

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1 A. I mean, I think the research did not give us that

2 information. You know, it would be astonishing if it
 3 wasn't important, but I can't say anything on the basis
 4 of the data we looked at.

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

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

16 A. Um ...

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

20 A. Yes.

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

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

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

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

14 So --

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

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

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

23 A. Yes.

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

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1 A. Yes.

2 **LADY HALLETT:** Let's take the pandemic out of the equation.

3 A. Yes.

4 **LADY HALLETT:** If they were on the rise before --

5 A. I -- (overspeaking) --

6 **LADY HALLETT:** -- which we should have expected to

7 see -- (overspeaking) --

8 A. Yes, they would have gone on rising, but the trajectory

9 is completely different.

10 **LADY HALLETT:** That's the key.

11 A. And we're not at a point now where you would have

12 expected the trends, the gradual trends, to end up. So

13 we're not there yet.

14 **LADY HALLETT:** Okay, your second thought now.

15 A. I might need to go back. What it was -- we need to

16 just -- I mean I think that's the end of that. We must

17 carry on looking at population mental health in this

18 way, and to particularly look at age and gender, the big

19 groups that you really can tell something about.

20 So those studies must be commissioned, I imagine

21 they will be being commissioned, but ... there may be

22 a tendency to sort of forget about it. Everybody, all

23 the academics, were rushing into Covid when it happened,

24 and doing studies that contributed to their credibility,

25 and value. And now it's gone away, there's

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

2 So I think it is important that's remembered.

3 **MS RAHMAN:** Well, Professor, you and your team made

4 a massive contribution to recording what happened.

5 Thank you very much for all of that work, to the whole

6 of your team, and also for explaining it to us so

7 engagingly today.

8 A. There was just the one more point from this, which was

9 not about the trends, but that we -- there is a little

10 bit of evidence in this that it was -- there were two

11 things. There was the virus, which was terrifying and

12 had huge impacts, and there was the control measures.

13 Different countries had different levels of control

14 measures, and we know those different levels of control

15 measures had an impact on the virus and its spread.

16 We could commission studies that looked at different

17 approaches to control measures and the mental health

18 studies that were done in those populations, and make

19 a comparison with mental health as an outcome on a par

20 with all the illness and disability that went on with

21 Covid, many of which, most of which, people have

22 recovered from.

23 So I think that's a very doable study that could be

24 put in place, but probably would need to be

25 commissioned.

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1 **MS RAHMAN:** Thank you very much. There may be some more

2 questions for you.

3 **LADY HALLETT:** There are.

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

5 **Questions from MR WEATHERBY KC**

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

7 Professor, I represent the Covid Bereaved Families

8 for Justice UK group. And I have just one point, and

9 it's about data gap, I'm afraid. You've given a lot of

10 evidence about that, but this is a specific point about

11 bereavement, so I think it may be slightly different.

12 At page 13 of the report, or the study, you refer to

13 data availability as a limitation on your findings, and

14 noting in particular, and I quote:

15 "... although data extraction on bereavement using

16 validated grief measures was attempted, none of the

17 included studies reported bereavement outcomes,

18 consequently, no quantitative analysis was possible for

19 this domain."

20 And my question is, are you, first of all, able to

21 help us as to why there is this dataset deficit with

22 respect to that? And having noted the lack of available

23 research data on bereavement and mental health outcomes,

24 is this an area where further research is required, both

25 now and in a future emergency?

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1 A. I think there is room for a lot more research on

2 bereavement and its impact, and I think particularly

3 I've referred to good death and a bad death, and what

4 went on in the pandemic could not be described as a good

5 death under any circumstances, and the effect that those

6 have on the mental health of the bereaved ongoing, but

7 I don't know that that needs to be linked to a pandemic.

8 And I think it's unlikely to be able to be -- I mean,

9 it -- you have to prioritise what is going on in terms

10 of research in the context of a pandemic, where

11 everybody's frantically trying to do things. And

12 I think those questions could be answered outside

13 a pandemic and possibly a little more reflectively.

14 **MR WEATHERBY:** Right. Thank you.

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

16 Mr Wagner.

17 Mr Wagner sits at the back there.

18 **Questions from MR WAGNER KC**

19 **MR WAGNER:** Thank you.

20 Good afternoon, Professor. I act for Clinically

21 Vulnerable Families.

22 A. I'm having a little trouble hearing you.

23 Q. Can you hear me now?

24 A. A bit better.

25 Q. Okay, I'll speak a bit closer to the microphone.

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

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

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

25 **Q.** I suppose you're answering a slightly different question
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1 about what that category would include, and of course,
 2 that would be a longer conversation. But do you see, in
 3 principle, the value of attempting to find some sort of
 4 category where you could include clinical vulnerability
 5 because it has an analytical benefit for mental
 6 health -- for studying people's mental health?

7 **A.** Yes, I'm sure it would be valuable.
 8 **Q.** Yes. And do you think it would assist, in that respect
 9 also, if clinical vulnerability to disease in general
 10 was recognised as a distinct characteristic or
 11 a population group?

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

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

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

2 **A.** Yes.

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

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

7 **Q.** Yes.

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

9 **MR WAGNER:** Thank you.

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

11 Ms Moffatt who I think is over there.

12 Questions from MS MOFFATT

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

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

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

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

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

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

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

11 **MS MOFFATT:** Thank you.

12 **LADY HALLETT:** Thank you.

13 Now I have Ms Davies, who is that way.

14 Questions from MS DAVIES KC

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

16 **A.** I can.

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

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

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

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

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

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

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1 warrants further research?
 2 **A.** So I would not in any way question your fundamental
 3 premise, but the review wasn't able to offer any
 4 additional information on that, because of the various
 5 factors that we've talked about already.
 6 And I'm sure this would be a valuable research
 7 endeavour. It's quite a difficult one, because
 8 gender-based violence offers a lot of shame and people
 9 don't come forward to talk about it a lot. And
 10 particularly with the migrant population, it's a very --
 11 needs to be a very thought-out, reflective piece of work
 12 as to how you would find the truth in that population.
 13 And that's not compatible with the, sort of, types of
 14 research that can contribute to the main question we
 15 were answering in this part of the Inquiry.

16 **Q.** Thank you.

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

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

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

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

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

21 **Q.** Thank you.

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

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

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

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

8 Thank you, my Lady.

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

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

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

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

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

18 **LADY HALLETT:** All right. Thank you very much indeed.

19 Well, that completes the questions we have for you,
 20 Professor. Thank you so much for all your help and the
 21 help of your team. I really don't envy the task that
 22 you all had, I hope you had a really supportive and
 23 excellent team around you.

24 **THE WITNESS:** Yes.

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

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

7 **THE WITNESS:** Thank you.

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

9 Very well, I shall return at 1.55.

10 (12.55 pm)

11 (The Short Adjournment)

12 (1.56 pm)

13 **LADY HALLETT:** Ms Blackwell.

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

17 **PROFESSOR TOM SHAKESPEARE (affirmed)**

18 **PROFESSOR NICK WATSON (affirmed)**

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

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

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

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

25 Please can you both confirm that that is the expert

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

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

4 **PROFESSOR WATSON:** I confirm.

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

7 **PROFESSOR SHAKESPEARE:** Yes.

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

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

12 **PROFESSOR WATSON:** They do.

13 **Q.** Thank you very much.

14 May I also thank you for returning to the Inquiry.

15 For those who don't know you, I'm going to introduce you
 16 again.

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

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

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

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1 of Jan --

2 **Q.** Congratulations.

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

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

7 **PROFESSOR WATSON:** Yeah.

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

11 **PROFESSOR WATSON:** Yeah.

12 **Q.** Thank you very much.

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

18 **PROFESSOR SHAKESPEARE:** Yes, correct.

19 **PROFESSOR WATSON:** Correct.

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

24 **PROFESSOR WATSON:** Yes.

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

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

3 **PROFESSOR SHAKESPEARE:** Yes.

4 **PROFESSOR WATSON:** Yes.

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

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

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

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

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

24 And I'd just like to ask you, please,

25 Professor Watson, if you can help us with the areas in

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1 particular that are lacking.

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

11 And then I think the other area where there's a big
 12 shortage of data is around the intersection between
 13 disability and other protected characteristics, around,
 14 for example -- for people from black and ethnic
 15 minorities or poverty or gender or other, sort of,
 16 social characteristics.

17 **Q.** Thank you. You tell us your report that there are
 18 evidence gaps, for example around violence and hate
 19 crime, gender-based violence --

20 **PROFESSOR WATSON:** Yes.

21 **Q.** -- leisure activities and also housing.

22 **PROFESSOR WATSON:** Yes, those were -- we couldn't find
 23 anything on that, yeah.

24 **Q.** And is there also data lacking in terms of those who
 25 were delineated as clinically vulnerable and clinically

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1 extremely vulnerable?

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

10 So, for example, there are easy markers around, say,
 11 people who are immunocompromised or so on, so there is
 12 that that becomes very difficult and there is a shortage
 13 of data specifically looking at clinically extremely
 14 vulnerable people.

15 **Q.** Thank you. Well, staying with definitions for the
 16 moment, at paragraph 15 of your report you use the term
 17 "disability" as that defined by the Equality Act of
 18 2010?

19 **PROFESSOR WATSON:** Yes.

20 **Q.** Which says that a disabled person is defined as someone
 21 with a physical or mental impairment which has
 22 a substantial or long-term adverse effect on their
 23 ability to carry out normal day-to-day activities.

24 **PROFESSOR WATSON:** Yes.

25 **PROFESSOR SHAKESPEARE:** Yes.

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1 **Q.** And we heard yesterday from Professors Herrick and
 2 Majeed about the definitions of clinically vulnerable
 3 and clinically extremely vulnerable people, and
 4 particularly from Professor Herrick that those
 5 definitions changed over the course of the pandemic, and
 6 indeed, were different at times between all four nations
 7 of the UK, and different across the world.

8 **PROFESSOR WATSON:** Mm-hm.

9 **Q.** Did that cause confusion for those that it affected?

10 **PROFESSOR WATSON:** Definitely because there was a lot of --
 11 people didn't know whether they were clinically
 12 vulnerable or not or whether they were vulnerable to the
 13 pandemic or more vulnerable than others and we had in
 14 Scotland different criteria used to England and it did
 15 create that -- that did create problems.

16 **PROFESSOR SHAKESPEARE:** And certainly that would be
 17 a problem for anybody, particularly if they had
 18 a learning disability, because they would not
 19 understand. And so lots of folk who were maybe
 20 clinically extremely vulnerable or clinically vulnerable
 21 or disabled people would not know if they were at risk
 22 if they went out of their homes. So yes, it was
 23 a concern. A lot of uncertainty.

24 **PROFESSOR WATSON:** And I think also made worse by the
 25 digital exclusion that disabled people experienced that

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1 we touched on in our last report.

2 **Q.** Yes.

3 **PROFESSOR WATSON:** So there was a lack of ability to access
 4 the detailed information that certain people who had
 5 ability to use the digital media.

6 **Q.** Thank you. The definition of disabled people is
 7 wide-ranging.

8 **PROFESSOR WATSON:** Mm-hm, yes.

9 **Q.** It encapsulates a lot of people, doesn't it? And lots
 10 of those people will also have other difficulties.

11 I want to ask you about the tailored response which
 12 local authorities should be perhaps considering in terms
 13 of, let's say, disabled women who need to relocate
 14 because of domestic abuse. Does there need to be
 15 consideration given to a flexible, portable package,
 16 really, for people who for instance fall into that
 17 category, and how should that be done?

18 **PROFESSOR SHAKESPEARE:** Well, I think definitely and

19 particularly -- we know that rates of violence are
 20 higher for disabled people, we know that they're higher
 21 for women than men and things, and things like
 22 Women's Aid or any provision made by a local authority
 23 needs to be accessible and understand that they may well
 24 have women and girls, men and women, men and boys, who
 25 need their facilities. So they need to be accessible

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

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

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

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

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

3 So it's well established that people with a learning
 4 disability have more underlying conditions than without.
 5 **Q.** Thank you. And drawing this together, your
 6 recommendation is that a better way of identifying
 7 people who are vulnerable, and extremely vulnerable, is
 8 a marker on GP records.

9 **PROFESSOR WATSON:** Yes.

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

20 **Q.** Thank you.

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

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

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

8 What are we looking at here?

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

13 **Q.** Yes.

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

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

20 **PROFESSOR WATSON:** Yes.

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

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

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1 compared to non-disabled people.

2 **Q.** Yes.

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

9 **Q.** Yes.

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

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

18 **Q.** Thank you.

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

22 And do we see a similar pattern there?

23 **PROFESSOR WATSON:** Yes.

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

25 **PROFESSOR WATSON:** 70, yeah.

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

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

4 Q. Yes, thank you very much.

5 We can take that down, please.

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

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

13 **PROFESSOR WATSON:** Mm-hm.

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

20 **PROFESSOR WATSON:** Yes.

21 Q. So similar patterns across the UK?

22 **PROFESSOR WATSON:** Yes.

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

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

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

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

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

17 Q. Thank you.

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

20 **PROFESSOR WATSON:** Mm-hm.

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

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

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

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

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

25 **PROFESSOR WATSON:** Yeah. And I think at the time of the
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1 passing, there was a lot of concern expressed across the
 2 disabled people's organisations and organisations for
 3 disabled people, who started to express concern around
 4 the Coronavirus Act, and this became -- I mean, quite
 5 rightly expressed concern, which again created that sort
 6 of -- which represented their concern that their
 7 communities were telling them.

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

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

25 We did a survey of people who received domiciliary
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1 care and their workers, and found that they were
 2 neglected.
 3 Q. I think, Professor Watson, you also told, us about
 4 a single mother living in Scotland who explained to you
 5 her fears and her isolation and how that affected her?
 6 **PROFESSOR WATSON:** I think -- I mean, when we were doing --
 7 the research we did during the pandemic, we interviewed,
 8 I mean, several parents of older disabled children,
 9 whose young people went to a day service or a day centre
 10 of some form or another, and those were closed
 11 overnight, and care and support for their older child
 12 became their responsibility. Many of them had to
 13 furlough because they couldn't carry on working and
 14 manage the care of their child. And, I mean, one of
 15 them told me she'd heard nothing from social services
 16 for over a year and she was just left looking after her
 17 child. And I think that people felt this unsupported,
 18 they felt -- and we found things like -- some of the
 19 work, we found that care workers who were normally being
 20 working with people with learning disabilities was
 21 shifted to work in a more health-focused thing.
 22 So the emphasis was, in the early stages of the
 23 pandemic, was about saving the NHS and not about
 24 ensuring that social care was -- or some form of --
 25 level of social care continued.

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1 And I think, as Tom said, you know, twice -- there
 2 was some discussion of the care home sector but twice as
 3 many disabled people receive care in the domiciliary
 4 care setting than in the care home setting.
 5 Q. And as for the levels of anxiety and depression that you
 6 found, there were similar findings, weren't there, for
 7 those defined as clinically extremely vulnerable people?
 8 **PROFESSOR WATSON:** Yes.
 9 Q. And I'd like to have a look, please, at the witness
 10 statement of Lara Wong from Clinically Vulnerable
 11 Families, who tells us about this, and it's
 12 INQ000657970, at page 10 and paragraph 20.
 13 This relates to impact on mental health and
 14 wellbeing, as we've been discussing, and she says:
 15 "The pandemic created sustained psychological
 16 pressures for Clinically Vulnerable people that went
 17 beyond the immediate threat of infection. Extended
 18 shielding ([both] formal or informal), repeated
 19 disruption to healthcare access, and prolonged exclusion
 20 from everyday activities meant that risk management
 21 became a constant feature of daily life. Many
 22 experienced the erosion of protective measures as
 23 a signal that their safety was no longer a public
 24 priority, amplifying feelings of isolation and
 25 abandonment. Their challenges were often compounded by

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

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

6 **PROFESSOR WATSON:** Yes, yes.

7 Q. Thank you.

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

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

25 **PROFESSOR WATSON:** And their families.

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1 Q. And their families, yes, of course.
 2 **PROFESSOR WATSON:** And, I mean, I spoke to one parent -- one
 3 family where the family had essentially split up, where
 4 the mother went to live with their disabled offspring
 5 and the father stayed with their two other non-disabled
 6 children, so that they could keep them safe. You know,
 7 it created real trauma and real tension across the
 8 family.

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

13 **PROFESSOR WATSON:** Uh-huh.

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

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

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1 "There was a slight decrease in anxiety following
 2 vaccinations ... where the proportion reporting high
 3 anxiety decreased from 86.4% to 82.4% ... [and]
 4 A further decrease was observed between [July and
 5 October of 2021], and [November of 2021 and January of
 6 2022] ... [although] Loneliness rose from 38.4% during
 7 the first lockdown to 54.4% by June of 2022, following
 8 the introduction of the 'Living with Covid' policy.

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

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

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

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

6 **Q.** Thank you.

7 Please could we display the article from the Office
 8 for National Statistics entitled 'Coronavirus and the
 9 social impacts on disabled people in Great Britain'.
 10 It's at INQ000417407.

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

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

16 We can see:

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

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

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

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

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

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

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

3 **Q.** Thank you.

4 Reading on:

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

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

15 Again, is that something that accords with your
 16 decision?

17 **PROFESSOR WATSON:** Yeah, definitely.

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

24 **Q.** Yes.

25 **PROFESSOR WATSON:** And I think, you know, having, again,
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1 those people with -- the withdrawal of social care,
 2 having to rely more on family members, it increased the
 3 idea that they were -- they felt more of a burden
 4 because they were having to ask family members to
 5 provide care that previously they had been able to get
 6 through social care.

7 **Q.** Yes, thank you.

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

13 [Witnesses both nodded]

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

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

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

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

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

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

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

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

11 **PROFESSOR SHAKESPEARE:** Yes.

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

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

17 **PROFESSOR SHAKESPEARE:** Yes, eventually.

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

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

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

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

7 **PROFESSOR WATSON:** Yes.

8 **PROFESSOR SHAKESPEARE:** Yes.

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

10 **PROFESSOR WATSON:** Yes.

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

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

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

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

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

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

5 A contributor told Every Story Matters:

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

10 And another contributor said:

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

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

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

25 And they were very, very bored. They were very

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1 isolated, and, as a result, bored.
 2 **Q.** Thank you. Now we've talked about the Coronavirus Act,
 3 I also want to talk, please, about do not attempt
 4 cardiopulmonary resuscitation notices. The Inquiry has
 5 already heard evidence about these notices, but from
 6 your point of view, Professor Watson, could you just
 7 explain to my Lady what the effect of those was when
 8 they were first brought into force and how, perhaps, it
 9 changed over time?

10 **PROFESSOR WATSON:** Well, I think initially they -- NICE
 11 published a report, as I think we say in our report
 12 here, NICE published a report about frailty score and
 13 DNACPRs, and this created a fear. There was talk of
 14 sort of GPs sending out blanket letters to all their
 15 participants. My own wife got phoned up by the GP, she
 16 has asthma, to ask if she wanted this to be put on her
 17 records. And I think that this just -- again, coupled
 18 with the Coronavirus Act, it created this fear and then,
 19 as Tom said, the "Don't worry, the only people who are
 20 dying are disabled people" and then you get told your
 21 social care is going to be withdrawn and then you're
 22 told "Actually, if you do get sick we're not going to
 23 attempt to make you better."

24 So this created a feeling of -- and added to that,
 25 you've got that social isolation that you pointed to in

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1 the last document you showed. This whole feeling of
 2 we're not important, we're not part of the mainstream,
 3 they don't really care about us. So that added to the
 4 feelings of -- the, you know, all of the -- it's no
 5 wonder people felt anxious and felt lonely, and had
 6 levels of depression, and so on, when those sorts of
 7 things were going on.

8 And there was just a real fear about "If I get sick,
 9 they're not going to make me better."

10 **PROFESSOR SHAKESPEARE:** That NICE guideline which says that
 11 people who have complete dependence on personal care
 12 from whatever cause were the maximum score. You know,
 13 many, many disabled people, and clinically extremely
 14 vulnerable people, are completely dependent on care, but
 15 that doesn't mean anything for their ability to enjoy
 16 life or to participate in life. Many people work, like
 17 Lady Campbell, she was -- I know she was very -- or --
 18 I know she was very concerned, and rightly. Because
 19 when you apply a DNACPR order to somebody, lots of
 20 people reported that their normal healthcare needs were
 21 also deprioritised. So it's not just if they were dying
 22 or in need of CPR, but also their general healthcare
 23 needs.

24 **Q.** And the Care Quality Commission reviewed the DNACPR
 25 policies, did they not, and found that there had been,

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1 in their words, unacceptable and inappropriate DNACPRs
 2 being made at the start of the pandemic?

3 **PROFESSOR WATSON:** Yeah.

4 **Q.** Strong words.

5 **PROFESSOR WATSON:** Unusually strong for the Care Quality
 6 Commission to make and I think it -- those words make
 7 the point, very clearly, that it was -- the move
 8 inappropriate. Not just inappropriate. Beyond
 9 inappropriate.

10 **LADY HALLETT:** I'm sorry to interrupt, it's a perfectly
 11 valid point, I'm not attempting to undermine the point
 12 that you made, but it's just that what I have heard in
 13 other modules about the use of these notices was there
 14 was a belief and a fear that there were blanket
 15 policies.

16 **MS BLACKWELL:** Yes.

17 **PROFESSOR WATSON:** Yes, yeah.

18 **LADY HALLETT:** But in fact the evidence doesn't show that
 19 there was a blanket policy.

20 **MS BLACKWELL:** No.

21 **LADY HALLETT:** But it does show that there were instances of
 22 people like a GP not understanding that this shouldn't
 23 happen.

24 **PROFESSOR WATSON:** Yes.

25 **MS BLACKWELL:** Yes, thank you my Lady.

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1 **PROFESSOR SHAKESPEARE:** Thank you for the correction. In
 2 the initial stages it was not -- it was felt to be
 3 a blanket policy. There's no -- not necessary evidence
 4 it was. So for example, Professor Watson, his wife just
 5 has asthma, she's not disabled in any way that I can
 6 see, she's a wonderful woman, and she does not need
 7 support but she was sent a DNACPR letter by her GP.

8 **PROFESSOR WATSON:** Not a letter, a phone call.

9 **PROFESSOR SHAKESPEARE:** A phone call, I beg your pardon.

10 **Q.** On that point, my Lady, Professor Watson, at
 11 paragraph 60 in your report you talk about discovering
 12 a GP in Wales who had sent out blanket communications to
 13 disabled and other patients so it would appear that even
 14 if the intention was not to use it in that way, there
 15 was a misunderstanding --

16 **PROFESSOR WATSON:** Yes.

17 **Q.** -- at that level and that's what was taking place.

18 And I think you say that that is but one example
 19 of --

20 **PROFESSOR WATSON:** Mm-hm, yes.

21 **Q.** -- of many.

22 **PROFESSOR WATSON:** Yes.

23 **Q.** We've touched on social care, and you've told us that
 24 there was a real fear of social care duties being
 25 removed and a lack of understanding, perhaps, of

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

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

16 **Q.** Yes.

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

24 **Q.** Yes.

25 **PROFESSOR WATSON:** And I think if there'd been much better,
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1 much greater involvement, we would have resolved a lot
 2 of these problems earlier on.

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

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

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

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

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

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

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

17 **Q.** Yes.

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

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

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

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

21 **PROFESSOR WATSON:** Mm.

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

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1 **PROFESSOR WATSON:** Mm-hm.

2 **PROFESSOR SHAKESPEARE:** Nick can talk about the
3 organisations, but the communication changed and
4 obviously sciences was gradually expanding its
5 understanding but the communications were not always
6 clear so, for example, lack of sign language in the main
7 British UK announcements, but also we found that people
8 with learning difficulties or disabilities would often
9 say, "What did that mean?" You know, ringing up their
10 families and say, "What should I do now?" They just
11 didn't know. It wasn't clear, and they changed.

12 **Q.** The Inquiry heard a significant amount of evidence
13 yesterday about shielding. So I'm not going to take you
14 to that except to ask you about the information you
15 provide at paragraph 54 of your report where you say:

16 "One of the key problems with shielding appears to
17 be the lack of consultation with those deemed vulnerable
18 or the organisations that represent them. The response
19 was not what was wanted and the problem could have been
20 avoided with more involvement of disabled people and
21 their organisations. In the early stages of the
22 pandemic, the category was based solely on clinical
23 judgement which, given the circumstances, was
24 undesirable, but as the pandemic progressed, the
25 communities became aware of the challenges that they

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1 faced, and there was, thereafter, little engagement with
2 them."

3 So as a general point, has your research disclosed
4 that there was very little negotiation, consultations,
5 involvement, really, with those representing disabled
6 people and clinically vulnerable people?

7 **PROFESSOR WATSON:** Yes, I think that would be the case. And
8 I think -- I assume we'll come on to it later, but this
9 was where the third sector stepped up and provided that
10 support in shielding and I think that --

11 **Q.** Yes, well, let's move on to that, please,
12 Professor Watson because I know you both want to pay
13 tribute to the great supporting institutions who are the
14 third sector, who stepped in, filled the gaps, gave
15 advice, and really assisted during the course of the
16 pandemic.

17 **PROFESSOR WATSON:** I think, you know, without the third
18 sector, and the way they stepped up, the way -- they are
19 much fleeter of foot than the statutory agencies, they
20 were much more able to change the way things -- and
21 also, much closer to the communities. So they were able
22 to know what was going on and, you know, in the early
23 stages of the pandemic it was organisations like Glasgow
24 Disability Alliance, Inclusion Scotland, Inclusion
25 London --

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1 **PROFESSOR SHAKESPEARE:** Equal Lives.

2 **PROFESSOR WATSON:** Equal Lives, yes, who ran surveys of
3 their members and brought the needs of disabled -- how
4 disabled people had been treated to the public
5 attention. And I think this created a -- they showed
6 the plight of disabled people, but they were also --
7 they changed the way they worked, you know, things like
8 the Centre for Inclusive Living in Glasgow became
9 a major provider of PPE because they recognised, so they
10 went out and they sourced their own because they saw
11 that people living in their own homes weren't getting
12 access to PPE so they stepped in and provided this
13 service where others -- where it wasn't being provided.

14 They challenged the digital exclusion of disabled
15 people, they, you know -- and part of it was because
16 their funding streams were made, you know, they were
17 just told by the local authorities "Spend the money as
18 you want". And so money that might have been used for
19 running theatre groups or so on, they bought computers
20 in. They ran -- sent laptops or pads to -- or tablets
21 to people. They ran classes to show people how to use
22 them. They set up things, you know, that --
23 organisations for people with learning disability set up
24 chatrooms for disabled people, ran regular evenings,
25 discos and so on, for people to come together. And it

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1 was them that were -- they were the groups who held
2 things together during this pandemic.

3 **PROFESSOR SHAKESPEARE:** Both the existing groups and people
4 coming together to provide those facilities, which they
5 lacked in the public, where they were not offered so
6 they provided them themselves.

7 **Q.** Thank you.

8 At paragraph 66 of your report, you do say there
9 were regional differences in the way that governments
10 worked with the third sector. You say that there's some
11 evidence that governments in Scotland, Wales and
12 Northern Ireland were more likely to work with disabled
13 people's organisations than was the case in England.

14 **PROFESSOR WATSON:** Mm.

15 **Q.** You give the example of the Minister for Health and
16 Social Care in Scotland setting up a group and meeting
17 regularly with the major disability organisations. But
18 you also talk of there being a complaint, really, about
19 how far that went, whether or not it was really
20 effective. Because Jim Elder-Woodward from
21 Inclusion Scotland has told you that a recurring theme
22 was that Inclusion Scotland was increasingly presented
23 with a near final draft policy and plan at meetings, and
24 therefore, although there was an indication that there
25 had been inclusion and consultation, in fact, in

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1 practical terms, it mattered very little?

2 **PROFESSOR WATSON:** It wasn't really what you'd call
3 co-production. It was telling people "This is what
4 we're going to do, what do you think?" rather than "How
5 shall we solve this problem?"

6 **Q.** Thank you.

7 Now, before I turn to ask you about reflections on
8 lessons learned and recommendations, there is one
9 additional point, and I suppose it reflects upon a lack
10 of data and a need for further research, but it's into
11 black and ethnic minority disabled people and those who
12 were clinically extremely vulnerable. And you deal with
13 this at paragraphs 73-75 in the report.

14 Is it right that there is a paucity of data and
15 there needs to be more reach into this area?

16 **PROFESSOR WATSON:** Yes, I think there's a lack of data --
17 there's a general lack of data around ethnicity and
18 disability, I'd say, and this was demonstrated during
19 the pandemic.

20 **PROFESSOR SHAKESPEARE:** For example, when we did a survey,
21 we talked to -- interviews, rather -- we talked to lots
22 of organisations, lots of individuals. We tried very
23 hard to get organisations of black and ethnic minority
24 people, and we failed. So that is partly our fault but
25 it is also partly that there weren't those to consult

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1 with.

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

3 I'm going to summarise, I hope accurately, and,
4 please, you will tell me if there's anything you would
5 like to add to this, your reflections on lessons
6 learned. You say at paragraph 77:

7 "The best outcomes were achieved when those affected
8 by decisions were included in the planning process."

9 And we've just confirmed that now.

10 "... there was a lack of co-ordination between the
11 various sectors and this affected service delivery."

12 There was:

13 "The failure to take into account the needs of those
14 who received domiciliary social care and poor
15 acknowledgement of the importance of the sector created
16 significant problems ..."

17 There was communication to disabled people and those
18 who were clinically extremely vulnerable being of a poor
19 level, and "both groups were left feeling ignored and
20 unsupported".

21 You say:

22 "The key role played by the Third Sector in helping
23 disabled people and those who were clinically vulnerable
24 and extremely vulnerable has to be acknowledged."

25 And I hope that you've been given the opportunity to
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1 do just that.

2 **PROFESSOR WATSON:** (Witness nodded)

3 **Q.** And as far as recommendations are concerned, you go on,
4 starting at paragraph 82, to say this:

5 "Further research is needed to explore the
6 intersection between disability and other protected
7 characteristics, geographical location and socioeconomic
8 status."

9 But:

10 "Social care needs to be seen as an equal partner to
11 health care and the importance of domiciliary care needs
12 to be recognised.

13 "Better coordination [is needed] between statutory
14 services and ... local and national governments and the
15 third sector.

16 "Greater consultation with the third sector
17 organisations [is needed, together with] ...
18 coproduction of services."

19 There needs to be:

20 "Better communication and dialogue with disabled
21 people and those who are clinically extremely
22 vulnerable."

23 There needs to be:

24 "A better way of identifying people who are
25 extremely vulnerable, for example [as we've discussed]

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1 a marker on GP records."

2 And finally, there needs to be:

3 "More secure funding for the Third Sector."

4 **PROFESSOR SHAKESPEARE:** Yes.

5 **PROFESSOR WATSON:** Yes.

6 **Q.** Is there anything that I've left out or anything that
7 either of you would like to add?

8 **PROFESSOR WATSON:** No.

9 **MS BLACKWELL:** Professor Shakespeare, Professor Watson,
10 thank you very much. I think there may be a couple of
11 additional questions.

12 **LADY HALLETT:** There are couple of questions and I think the
13 first one is from Mr Wagner, who is over that way.

14 **Questions from MR WAGNER KC**

15 **MR WAGNER:** Can you hear me?

16 **LADY HALLETT:** I can now.

17 **MR WAGNER:** You've spoken quite a bit about the crossover
18 between clinical vulnerability and disability and other
19 factors. Would it be fair to say that the impact of the
20 pandemic and the UK's response to it may have been quite
21 different for disabled people and clinically vulnerable
22 people, as in obviously there's obviously some crossover
23 between the categories, but there are also some quite
24 significant differences?

25 **PROFESSOR SHAKESPEARE:** I would have thought, as our
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1 evidence suggests, both groups would have been exposed
 2 to obviously the easements, both would have been exposed
 3 to the Coronavirus Act and the guidelines in terms of
 4 social activity and so forth. So there is difference,
 5 but there's also a -- they're all vulnerable. They felt
 6 they were vulnerable. Whether truly or not, they felt
 7 they were vulnerable. And care was limited for
 8 definitely disabled people, but some clinically
 9 extremely vulnerable people, but it would also have
 10 depended on certainly health but social services, and
 11 they would not have had access to those.

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

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1 faced.
 2

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

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

20 I entirely understood the definitional issues, and
 21 there's lots of crossover. Would you also agree there
 22 is a value in having a separate clinical vulnerability
 23 definition or category, because it highlights particular
 24 groups of people? For example, the immunocompromised,
 25 for whom there are very specific challenges, and I think
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1 health care, and facing dangerous environments because
 2 of poor air quality or spreading the virus, or whatever
 3 it would be, but would you agree that there is a value
 4 analytically in maintaining some kind of category of
 5 clinical vulnerability?

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

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

18 Thank you.

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

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

22 Questions from MS SERGIDES

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

24 Professors, can you hear me?

25 **PROFESSOR WATSON:** Yes.

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

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

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

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

25 On screen? I'm grateful.

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

4 **PROFESSOR SHAKESPEARE:** Yes.

5 **PROFESSOR WATSON:** Yes.

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

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

18 **PROFESSOR SHAKESPEARE:** Yes.

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

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

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

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

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

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

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

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

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

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

17 **MS BLACKWELL:** It does.

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

22 **MS BLACKWELL:** Thank you.

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

24 (3.01 pm)

25 (The hearing adjourned until 10.30 am on
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1 Monday, 23rd February 2026)

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