

Monday, 23 February 2026

(10.29 am)

MS BLACKWELL: My Lady, good morning. Can I check that you can see and hear me?

LADY HALLETT: I can thank you, Ms Blackwell. Good morning.

MS BLACKWELL: Thanks, we can see and hear you too. Good morning. May I begin this week by calling Dr Clare Wenham, please.

DR CLARE WENHAM (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 10

MS BLACKWELL: Will you give your full name, please.

A. Yes, it's Clare Wenham.

Q. Thank you very much. Dr Wenham, you should have in front of you a copy of your report on unequal gender impacts of the pandemic.

A. Yes.

Q. Which bears our reference number INQ000657974.

Please can you confirm that that is the expert report that you've provided for the purposes of this module.

A. Yes, it is.

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

A. Yes.

Q. And that any opinions that you have stated in the report

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and discrimination, which you said was pervasive across UK society prior to the onset of the pandemic. And you said that government policy always has a role to play in ameliorating patriarchal social norms that serve to subjugate women, and without conscious efforts and resources the unequal position of women will be exacerbated?

A. Yes.

Q. In Module 10, you have prepared and are giving evidence today about a report which really sets up and takes off where you left off in Module 2, because it deals with how the Covid-19 pandemic exposed and intensified existing gender inequalities across the United Kingdom, with women disproportionately affected in multiple and intersecting ways.

And what you tell us at paragraph 2 of your report is that, from increased unpaid care responsibilities and heightened risk of job loss in female-dominated sectors, to disruptions in access to healthcare and rising rates of mental distress, the crisis magnified structural disparities across our society, and that these impacts were particularly severe for women already facing disadvantages, such as single mothers, disabled women, ethnic minority women, migrant women, and those in precarious work, which deepened socioeconomic

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represent your true and complete professional opinions.

A. Yes.

Q. Thank you. Welcome back to the Inquiry. I know that you were last here during the public hearings for Module 2; is that right?

A. Yes.

Q. I will introduce you again, if I may. You are an academic expert in global health security, global health governance, and global health policy, and you hold the position of Associate Professor of Global Health at the London School of Economics?

A. Yes.

Q. You have a PhD in international relations. And during the Covid-19 pandemic, you co-founded the Gender and Covid-19 Research Group, bringing together academics from 11 countries to conduct real-time gender analysis to identify and analyse the gendered dynamics of the response. And you have advised the European Union, World Health Organisation, United Nations Women, the European Parliament, World Organisation for Animal Health and the German government on policy related to gender and epidemics and pandemics?

A. Yes, that's correct.

Q. Thank you very much.

In Module 2, you gave evidence on gender inequality

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inequalities.

Your evidence today predominantly, then, examines the unequal effects of the pandemic on women in the UK, highlighting how public health measures, economic shocks and service disruptions contributed to widening gender gaps.

And you have also set out to show in your report any unequal effects on men in the UK, where it's possible for you to have done so within the area of your expertise.

Can we start then, please, with a discussion of rates of infection, morbidity and mortality, which you start to tell us about at paragraph 3 in your report.

You say:

"There were notable gender differences in infection rates of Covid-19 in the UK, influenced by biological, social, and behavioural factors."

Explain to us, please, Dr Wenham, what those differences were.

A. Well, so, for example, we know that, overall, infection rates were pretty much parable [sic] between men and women across the UK, if you look at the whole pandemic as a whole.

Q. Yes.

A. But we know at different stages in the pandemic,

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1 different people were more likely to be infected than
 2 others. So, for example, earlier on in the pandemic, it
 3 was more likely that women were infected. Now, this
 4 partly was a testing bias because, if you remember early
 5 on in the pandemic, it was only certain populations who
 6 were able to get tested, including healthcare workers,
 7 so you see this disproportional increase. But then we
 8 see that these infection rates are also predicted by the
 9 sectors of the economy people are working in.

10 **Q.** Right.

11 **A.** So we see differences of infection between people who
 12 are working in frontline sectors, healthcare workers,
 13 people working in schools, people working in retail, you
 14 know, people where you are coming into contact with
 15 people much more are more likely to be women, and
 16 therefore we see increased positivity amongst those
 17 people.

18 Now, that is then different to rates of mortality,
 19 and again, it's, you know, now undisputed that, you
 20 know, men were more likely to die in the pandemic but --
 21 and again, different sectors of male labour forces were
 22 more likely to die than women's, for example, but it's
 23 important to note that there are these differences in
 24 both infection rates, positivity and mortality between
 25 men and women both based on, you know, where people are

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1 **A.** Yes.

2 **Q.** So it made a difference, depending on the type of work
 3 that people were doing, and as you've said, the exposure
 4 that that brought them to risk of contact in the
 5 pandemic?

6 **A.** Absolutely. If you're working in a sector of the
 7 economy which can be done at home, and you can stay at
 8 home, you're less likely to be infected with the
 9 disease. If you're working in a hospital or education
 10 setting you're more likely to come into contact with
 11 multiple people in the course of a day, and in the UK,
 12 people who work in the healthcare sector, in the
 13 education sector, are more likely to be women than men.

14 **Q.** Right. But you tell us at paragraph 7 that male
 15 healthcare workers experienced a statistically higher
 16 Covid-19 mortality rate compared to the general
 17 population and to their female counterparts, while the
 18 risk of death for female healthcare workers was
 19 comparable to that of the general population.

20 **A.** Yes.

21 **Q.** What might be the reason for that?

22 **A.** I think it's -- we don't necessarily know for certain,
 23 or I certainly can't tell you today what that is. It's
 24 probably multiple factors around, you know, intersecting
 25 factors of who those male healthcare workers were, there

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1 working, where they are on a day-to-day basis, how
 2 they're getting infected, you know, there are biological
 3 differences that we are learning more and more about,
 4 and I am not a clinician so I defer to clinicians to
 5 explain this, but, you know, different responses to how
 6 male and female bodies respond to viruses.

7 But we also know, and there's decades of research,
 8 that, you know, health seeking behaviours are different
 9 between men and women, right?

10 **Q.** Right.

11 **A.** So you're more likely to maybe test if you're a woman,
 12 therefore it might be that there are higher positive
 13 infection rates amongst women because women are more
 14 likely to go and get tested in the first place than men.

15 **Q.** Right.

16 **A.** We also know the converse, being that men are more
 17 likely to delay health seeking behaviour, so it might be
 18 that men had poorer outcomes because they delayed
 19 treatment for longer, for example, because that is
 20 a recognised trend in how men and women interact with
 21 health services.

22 **Q.** Thank you. So lots of different factors to consider --

23 **A.** Yeah.

24 **Q.** -- including one that you've just mentioned,
 25 occupational risk.

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1 are multiple other intersecting factors.

2 **Q.** All right, thank you very much.

3 Were pregnant women at greater risk than
 4 non-pregnant women?

5 **A.** Yes, we know that there were, you know, poorer outcomes
 6 for pregnant women infected with Covid, particularly
 7 those in their third trimester of pregnancy. We saw
 8 these risk factors both in terms of maternal mortality
 9 and an increased rate of maternal mortality for
 10 people -- for women who were infected with Covid, but
 11 this also manifested in pre-term labour and stillbirth
 12 increases.

13 **Q.** Yes.

14 **A.** And again, I think it's important to note that this
 15 wasn't uniformly across pregnant women across the UK.
 16 It disproportionately -- the impacts disproportionately
 17 fell on black, Asian and minority ethnic women, pregnant
 18 women in the UK.

19 **Q.** Thank you. You deal with this at paragraph 9 of your
 20 report, and you say that those with underlying health
 21 conditions, those who were clinically vulnerable, or
 22 overweight or over the age of 35 and from a minority
 23 ethnic group were particularly at risk. And you give
 24 some statistics from Oxford University.

25 You say that significant ethnic disparities were

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1 shown, 55% of pregnant women admitted to hospital with
2 Covid-19 were from black, Asian and minority ethnic
3 backgrounds despite those groups accounting for only 25%
4 of births in England and Wales and that Asian women were
5 four times and black women eight times more likely than
6 white women to be hospitalised with Covid-19 during
7 pregnancy.

8 What did your research find in terms of disparities,
9 geographical disparities across the United Kingdom?
10 **A.** We don't necessarily have broken down data on
11 geographical disparities but I think it's important to
12 highlight here that these impacts on pregnant women
13 across racial lines in the UK do mirror broader risks of
14 maternal mortality and poorer health outcomes for women
15 across the UK in routine pregnancies outside of Covid.
16 I mean, in the UK you're much more likely to die if you
17 are a black woman who is pregnant than a white woman who
18 is pregnant, and I think this mirrors broader structural
19 inequalities in our healthcare system for pregnant women
20 in the UK.

21 **Q.** Thank you. You then go on to discuss, in your report,
22 the risk of death for disabled females, at paragraph 10.
23 Did you find that the more severely disabled the female
24 was, the higher the risk of death?

25 **A.** Yes.

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1 **Q.** Thank you. And you conclude this section of your
2 evidence by telling us at paragraph 13 of your report
3 what the main lessons for us to take from your research
4 and findings are.

5 And please could we display INQ000657974, which is
6 your statement, Dr Wenham, and have a look at what you
7 say the main lessons are in this area. You say first of
8 all that:

9 "There may be gendered differences in infection with
10 future pathogens. These may be caused by biological
11 reasons, or social differences in society or employment
12 or in gendered differences in behaviour."

13 That:

14 "Recognising these patterns early can then lead to
15 enhanced and targeted public health interventions to
16 protect those at greatest risk."

17 That:

18 "Enhanced public health messaging and communication,
19 in accessible formats, are needed to target those who
20 are less likely to believe they are at risk, or be less
21 able to protect themselves from that risk, for example,
22 those from lower socioeconomic groups or those more
23 likely to be receiving health or social care".

24 Just pausing there, does that also include a need to
25 ensure that messaging and communication is translated

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1 **Q.** And did you also find that women were 20% more likely to
2 report Long Covid than men?

3 **A.** Yes, absolutely.

4 **Q.** Were you able to assist in terms of any reason for that?

5 **A.** Well, again, I think it's multifaceted. I don't think
6 there's one simple answer. I think, for example, women
7 are more likely to report healthcare symptoms so it
8 might be a reporting tension.

9 **Q.** Yes.

10 **A.** Women are also more likely to be undertaking unpaid care
11 within homes or in communities and therefore they might
12 be less able to recover as much as men if they are also,
13 you know, looking after children, looking after their
14 neighbours, looking after elderly relatives and
15 therefore that might impact recovery times.

16 There's also increasing evidence coming out now
17 showing the relationship between those who -- the
18 greatest risk of people experiencing Long Covid being of
19 menopausal age women, and the similarities in symptoms
20 reporting between Long Covid and menopause and,
21 actually, it might be a tension around how these issues
22 are being reported, and a confusion around providers' or
23 healthcare providers' understanding both those issues in
24 and of themselves but, you know, there's definitely
25 interrelationship between those two areas.

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1 into different languages to touch those women in society
2 who are not able to understand them in the English
3 language?

4 **A.** Absolutely. We know that, you know, women are not
5 a homogeneous group. Women who are most at risk from
6 all of the issues I detail in this report are those who
7 are -- are those who have multiple intersecting
8 characteristics, including language barriers. So, you
9 know, being able to reach the most vulnerable, the
10 most -- the least able to protect themselves from
11 whatever area we're talking about is paramount to
12 enhance women's experience of future pandemics.

13 **Q.** Thank you. And finally in your list, to:

14 "Ensure that PPE is available for all those in
15 frontline health and social care roles, or those in
16 a range of settings who require PPE, and in appropriate
17 sizing for women's bodies. Other mechanisms for
18 reducing infections such as mechanical ventilation or
19 air filtration should also be available, protecting all
20 without gendered variance."

21 And I know that is repetitive of what my Lady has
22 already heard in previous modules.

23 Thank you. We can take that down.

24 Turning then to physical health, access to health
25 and access to social care services. You tell us at

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1 paragraph 15 that in general, women tend to report
2 healthier behaviours than men, for example healthier
3 dietary choices and lower alcohol consumption, but that
4 men tend to report engaging in more physical activity.
5 Were those patterns reflected throughout the pandemic?
6 **A.** No, actually, what we saw -- what the research has shown
7 during the pandemic is that women's diet became poorer,
8 with women eating less fruit and vegetables in general
9 than men and eating -- you know, being -- resorting to
10 eating, you know, fast food and high salt and sugar food
11 to a greater extent than that of men, and that women's
12 physical activity also decreased compared to that of
13 men.

14 But with, you know -- if -- you know, the first wave
15 of the pandemic, when we went into lockdown, everybody's
16 physical activity decreased, but men's physical activity
17 returned to baseline quicker than that of women.

18 We also saw that -- a trend emerging across the UK
19 of alcohol consumption: women reported drinking more
20 during lockdown compared to men, who reported drinking
21 less compared to baseline, compared to pre-pandemic
22 levels.

23 So this paints a picture of, you know, poorer
24 everyday health of women during the pandemic. And
25 I think that that's important when we also think about

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1 than men because women are more likely to be the users
2 of these services, mainly because of the fact that women
3 are more likely to, you know, over a reproductive
4 lifestyle -- reproductive life course, are more likely
5 to be engaging with health services, because, like
6 I said before, women are more likely to seek healthcare
7 than men, you know, the kind of behavioural
8 differences --

9 **Q.** Yes.

10 **A.** -- and women are more likely to be the amongst taking
11 children to GP services, taking elderly relatives,
12 taking neighbours. So it affects women more than men if
13 that provision is changed.

14 **Q.** Interrupted, yes.

15 **A.** Yes.

16 **Q.** Thank you.

17 I'm going to ask you specifically about five areas
18 of healthcare. Firstly, impact on breast cancer.

19 You tell us at paragraph 20 that the Covid-19
20 pandemic significantly disrupted breast cancer screening
21 services across the UK during 2020, 2021, leading to
22 delays in diagnosis and treatment.

23 Did all four areas of the UK experience the same
24 level of service disruption?

25 **A.** So, we saw service disruption in all four countries, or

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1 women's mental health, because these -- we know that
2 diet and exercise and alcohol consumption can all affect
3 mental health, and the sort of protective
4 characteristics or protective measures that a healthy
5 diet and healthy lifestyle have on mental health, and
6 how that might then impact how women and men experienced
7 the pandemic differently.

8 **Q.** Yes, thank you. We'll look at mental health in
9 a moment. But, first of all, access to primary and
10 preventative healthcare, you tell us at paragraph 19
11 that:

12 "It is well accepted in academic literature that
13 women use GP services more than men ... For example, in
14 the UK, consultation rates are 32% lower in men than
15 women ..."

16 Was that also reflected across the pandemic? Or is
17 that something that you were able to look into?

18 **A.** So we don't have data necessarily about the change in,
19 you know, utilisation of -- or gendered utilisation of
20 GP services during the pandemic, or at least not to my
21 knowledge. It might be out there. But what's important
22 to note is that when services were disrupted because of
23 the pandemic, when they moved to telephone
24 consultations, when they moved to, you know, reduction
25 of provision in general, this will impact women more

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1 all four nations in the UK, but to greater and lesser
2 extents. So it wasn't the same. And the ways in
3 which -- or the durations for service disruption and the
4 mechanisms by which they sought to try to catch up some
5 of that disruption were different in the different
6 administrations.

7 **Q.** Thank you.

8 Next, cervical screening services. Were those
9 activities suspended in many locations, and did you find
10 that between April and June 2020 the number of cervical
11 screening samples received at laboratories in England
12 dropped by up to 91% compared to the expected figure
13 before the pandemic, and taking that out of the
14 equation?

15 **A.** Yes, it did. So we saw a significant -- well,
16 90 something per cent drop, and then a significant
17 effort to try to catch up again, but there still was
18 a shortfall of about 6% overall. So there still was
19 a gap from what would have been expected in that year --
20 in those years to what actually happened.

21 **Q.** Thank you. What did you find in terms of prostate
22 cancer diagnosis?

23 **A.** So, again, there was a 30% reduction in prostate cancer
24 diagnosis, and there's increasing evidence now showing
25 that when men were presenting, it was at a later stage,

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1 because of the preventative screening efforts being
 2 suspended.
 3 **Q.** Thank you.
 4 You've mentioned menopause services. Were they also
 5 disrupted, particularly at the beginning of the
 6 pandemic, and were many routine and non-urgent services
 7 suspended for longer, including the cancellation of
 8 appointments, the redeployment of staff, and disrupted
 9 training for clinicians and other health professionals?
 10 **A.** Yes, absolutely.
 11 **Q.** And again, was that position across all four nations?
 12 **A.** To the extent that we that have the data.
 13 **Q.** Yes, right. Is there a difficulty presented by a lack
 14 of data that's split into the four nations?
 15 **A.** Yes, so the ways that these are -- that all these
 16 screenings are measured and recorded is different in
 17 each of the devolved administrations, and therefore
 18 you're not always measuring exactly the same thing when
 19 you look at service disruptions. When you look at what
 20 is being counted, is it about, you know, people coming
 21 in, people being invited, samples being received?
 22 There's multiple different ways of how and what is being
 23 considered between the different administrations.
 24 **Q.** Right. Thank you.
 25 Finally on this topic, impact on elective care. Did

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1 a difference to their access or use of such services; is
 2 that right?
 3 **A.** Yes, that's correct.
 4 **Q.** Changes in maternity services, care delivery, and
 5 maternal death rates in interactions with healthcare
 6 providers. You've touched upon maternal death rates
 7 already, but is it right that maternity services as
 8 a whole were significantly disrupted by Covid-19, which
 9 led to widespread changes in care delivery and reduced
 10 interactions with healthcare providers for pregnant
 11 women, and an increase in risks, therefore, for women
 12 and babies?
 13 **A.** Yeah, absolutely. So, you know, it's well established
 14 in the literature that multiple antenatal appointments
 15 lead to the best possible outcomes for mother and baby,
 16 which is why, in the NHS, we have so many routine
 17 appointments offered to women. Now, during the
 18 pandemic, many of such appointments were moved to
 19 telephone consultations, and therefore women weren't
 20 getting the same level of care, arguably, than they were
 21 prior to the pandemic.

22 This is also true in the postnatal period. And one
 23 of the concerns has been that the impact this might
 24 have, both on the physical health of mother and baby,
 25 but also on the kind of mental health and postnatal

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1 you find that there was a 60% increase in waiting list
 2 times during the pandemic?
 3 **A.** Yes, for gynaecological services. So gynaecology was
 4 the area of medicine and clinical practice that was most
 5 disrupted in terms of wait lists during the Covid-19
 6 pandemic, with many of the services being considered
 7 elective and therefore, you know, not urgent in the same
 8 way as the other clinical specialities, and therefore
 9 it's the area which we've seen the greatest, you know,
 10 wait times, you know, waiting lists now of over a year
 11 that still remain.
 12 **Q.** So continued disruption?
 13 **A.** Continued disruption, yes.
 14 **Q.** Thank you.
 15 Access to sexual and reproductive healthcare
 16 services next, please.
 17 You tell us at paragraph 26 that the closure of
 18 sexual and reproductive health clinics
 19 disproportionately affected women, who are the biggest
 20 users of these services in the UK.
 21 **A.** Yes.
 22 **Q.** And that approximately one quarter of respondents to
 23 a survey -- to a national survey conducted online,
 24 including open text responses, in the summer of 2020,
 25 reported that social distancing measures had made

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1 challenges that many women face and their kind of
 2 perinatal mental health that might experience poorer
 3 outcomes as a consequence of this lack of engaged care,
 4 face-to-face care in the antenatal period.
 5 **Q.** Yes, and the Inquiry has heard, and will hear again,
 6 that also where face-to-face meetings and appointments
 7 did take place with pregnant mothers, they often had to
 8 attend those alone and without their partners?
 9 **A.** Absolutely.
 10 **Q.** And that had an effect on their experience?
 11 **A.** Absolutely. So and I think it's important that we
 12 remind the Inquiry, it's not just those appointments
 13 that women were going to on their own but also we saw
 14 significant limitations on birth partners being present
 15 during birth and so women were having to give birth
 16 alone, and I think that is, you know, it sends shivers
 17 down my spine just thinking about these poor women who
 18 were having to give birth alone at the most vulnerable
 19 stage in their lives, arguably, and, you know, the fact
 20 that we know that -- I can't remember the exact
 21 statistics off the top of my head but, you know, 70% of
 22 birth partners or 70% of trusts reported some
 23 limitations on birth partners' participation and I think
 24 that's a really notable finding.
 25 **Q.** Thank you. And just to put some figures onto the

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1 evidence that you've just given, at paragraph 29 you
 2 tell us that 53% of women in England with recent
 3 experience of maternity care felt they had experienced
 4 changes to their care during Covid-19, and 35% had
 5 antenatal appointments cancelled, 32% of women
 6 experienced changes to their plans for birth, and 50% of
 7 women stated that they wanted more midwifery contact in
 8 the postnatal period.

9 **A.** Yes, and I think also just to add, you know, if the
 10 service provision isn't there, then women might turn to
 11 their family, friends and community for such support.
 12 But if that was also being limited, then I think there
 13 was this real impact of women, you know, going through
 14 birth, postnatal periods, very much on their own.

15 **Q.** Yes. Some of the reasons that you give for poor
 16 experience during the pandemic, particularly in relation
 17 to women, are structural and systemic discrimination,
 18 racism, bias in health settings, fragmented care and
 19 poorer baseline health caused by socioeconomic
 20 inequalities.

21 How should that have been planned for and prevented,
 22 and what steps, do you think, Dr Wenham, can and perhaps
 23 should be taken to ensure that those experiences are not
 24 repeated in a future pandemic or other health emergency?

25 **A.** Well, so, you know, the social determinants of health
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1 this because they do it on a day-to-day basis. It's
 2 just recognising that that's not just in the routine but
 3 it's also in the emergency that, you know, case numbers
 4 aren't just case numbers. Those are people who
 5 experience life, interactions with health services,
 6 interactions with all social services, in different ways
 7 to each other.

8 **Q.** One of the measures that was taken, an emergency
 9 measure, I suppose, it could be described as, was
 10 a change in relation to abortion provision, wasn't it,
 11 in England and Wales? Tell us about that, please.

12 **A.** So prior to the pandemic in England and Wales you had to
 13 have a face-to-face appointment with a medical
 14 professional to obtain a medical abortion, tablets, to
 15 be able to perform a medical abortion that had to be
 16 taken in a clinical setting. Now, this has --
 17 elsewhere, including in Scotland, it was allowed to
 18 have -- prior to the pandemic, you were able to take
 19 this medication in the privacy of your own home and
 20 there have been no safety concerns linked between taking
 21 such medication in a clinical setting or a home setting.
 22 Indeed, globally, in many parts of the world, you can
 23 take this safely at home.

24 In England and Wales during the pandemic, mechanisms
 25 were changed to allow women to take the medical abortion
 23

1 that you outline, the fact that we know that, you know,
 2 people from lower socioeconomic groups, people who are
 3 ethnic minorities in the UK, are more likely to
 4 experience poorer health outcomes isn't new, right?
 5 That's not because of the pandemic; that's just in
 6 general.

7 And so knowing that, and then planning for your
 8 pandemic policy or your pandemic response, taking into
 9 account these factors, to me, should be a given because
 10 it's routine activity in a healthcare system to
 11 understand that the most vulnerable in society are the
 12 ones who are going to experience any health issue, with
 13 poorer outcomes.

14 **Q.** Yes.

15 **A.** So putting that front and centre, recognising those
 16 inequalities, I think that there's sometimes a tendency
 17 to want equality for everybody and therefore write
 18 neutral policies as if everybody experiences or everyone
 19 should have the same opportunity to the same outcome or
 20 to the same access to services, but actually recognising
 21 the limitations and the barriers of accessing those
 22 services are different between different people and
 23 therefore service provision needs to look different for
 24 different people is a really important lesson that
 25 should be learned although, indeed, health services know
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1 tablets in their own home to try to reduce the
 2 interaction with the health service in the clinical
 3 settings and reduce the burden on the health sector at
 4 that time and it has been -- you know, it has now
 5 allowed women to have, you know, have a termination on
 6 their own terms in their own home and it's something
 7 which has continued subsequent to the pandemic, as well.

8 **Q.** Thank you.

9 Turning to look at formal and informal social care,
 10 please. You tell us at paragraph 36 that this
 11 disproportionately impacted women, and you also talk
 12 about caring responsibilities that 80% of adult social
 13 carers are women and that ethnic minority women are
 14 over-representative in paid and unpaid care roles.

15 You then go on to tell us that migrant women and
 16 those with no recourse to public funds were working in
 17 the care sector and therefore at particular risk with no
 18 alternative than to work and therefore increase their
 19 exposure to risking -- catching the virus.

20 And you go on to say that women, particularly older
 21 women, or those with disabilities, were more likely to
 22 rely on formal care.

23 You don't comment on disabled women living in their
 24 own homes or other settings. Are you able to provide
 25 any comment on the impact on disabled women as
 24

1 recipients of domiciliary care or, indeed, unpaid care,
2 for example disabled women living in their own homes who
3 used and relied on formal and informal caring services?

4 **A.** So we don't have, or I don't have data to give you, you
5 know, a very clear picture on that but we have to assume
6 that the same is true, which is if there's a reduction
7 of service provision it will affect disabled women or,
8 indeed, anybody in receipt of such care. Whether they
9 are in formal settings or in domiciliary care, the same
10 impacts will be true: that you are -- that women are the
11 greater users of such services and also the providers of
12 such services. So any disruption affects both supply
13 and demand of those services for women.

14 **Q.** Thank you, yes. And for disabled women who relied on
15 domiciliary and unpaid care in their own homes, in your
16 opinion, would the impact of domestic abuse on disabled
17 victim-survivors be compounded by the fact that their
18 perpetrators were often their carers and during
19 lockdown, would often be their only carers?

20 **A.** So, again, I don't have any evidence to be able to give
21 you an affirmative answer to that question. However, we
22 do know that disabled women are one of the most
23 vulnerable groups from a domestic abuse standpoint, and
24 therefore it is likely that if -- you know, if it is
25 those carers who are their abusers, as well, then that

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1 dependent because of gender norms in the UK, but also
2 partly because of the gender pay gap, and if you're in
3 a heterosexual couple with dual earners, you might
4 choose the person who earns the most to keep full-time
5 employment, and, you know, the person who earns the
6 least, which tends to be the woman, to reduce hours or
7 stop working.

8 **Q.** Thank you. The Inquiry has heard about the uplift to
9 UCL. You tell us at paragraph 43 that the number of
10 Universal Credit claimants rose by 90% between March and
11 October of 2020, with 2.2 million new applicants in the
12 first two months alone.

13 Did women struggle, though, to access timely or
14 sufficient support such as Universal Credit? And if so,
15 why do you think that might have been?

16 **A.** Well, so, for example, we know that the single household
17 payment was an issue. We know that that -- particularly
18 those who are on low-income, who are in precarious work,
19 or single parents, might have struggled with such
20 a payment mechanism.

21 **Q.** Yes.

22 **A.** And it's also a risk factor for domestic abuse, that we
23 know -- we'll come on to later in our conversation, but
24 that, you know, the power around resources is also
25 something to bear in mind at this point.

27

1 would pose a significant risk. But again, I don't have
2 any data to point to that precisely.

3 **Q.** Thank you. Turning away from healthcare now and towards
4 finances, and I'm conscious that this was the subject,
5 really, business and finance, of Module 9. I'd like to
6 ask you about pre-existing inequalities going into the
7 pandemic. Is it right in your opinion, Dr Wenham, that
8 women were more likely than men to lose jobs, to be
9 furloughed, or to reduce paid hours during the lockdown?

10 **A.** Yes, and I think, if I may, there are sort of three
11 reasons as to why women might have experienced that
12 differently to men.

13 **Q.** Yes.

14 **A.** The first one being that women and more likely to be
15 working in sectors of the economy that were shut down
16 first, so in the education, in retail, in hospitality,
17 those are feminised sectors of the economy in the UK,
18 and therefore when they closed, women's employment was
19 more at risk.

20 We also know that women are more likely to have
21 shouldered the unpaid care burden within households when
22 school closures occurred. So you might have taken
23 a step back from your paid employment to look after your
24 children, for example, or a reduction of hours to be
25 able to facilitate homeschooling. And that's partly

26

1 **Q.** Thank you.

2 You then go on to discuss disabled women, and you
3 say that they "experienced sharper economic shocks and
4 reduced access to support". And at paragraph 46 you say
5 that black, Asian and minority ethnic women were more
6 likely than white women or black, Asian and minority
7 ethnic men to report income loss, difficulty affording
8 essentials, and increased caring responsibilities. And
9 importantly, in your opinion, many disabled men and
10 women were in receipt of legacy benefits such as
11 Employment and Support Allowance, which were excluded
12 from the £20 uplift applied to Universal Credit, and
13 that that policy decision created what you describe as
14 a two-tier system of support during the pandemic,
15 thereby deepening existing inequalities and leaving
16 disabled women on legacy benefits at greater risk of
17 financial hardship?

18 **A.** Yes.

19 **Q.** What impact did the two-tier system of support that you
20 describe have on disabled women, and what effect might
21 that have had on their existing inequalities? And were
22 there additional risks identifiable for disabled women
23 as a result?

24 **A.** Well, so, I mean, again -- that comes up again and again
25 in every sector of this report, and indeed my previous

28

1 evidence. It's the intersecting nature of all these
2 issues.
3 **Q.** Yes.
4 **A.** So the compounded vulnerabilities that different women
5 across society face, you know, create greater
6 inequalities and discrepancies. Now, the chances of the
7 people who were still on legacy benefits being those
8 most vulnerable in society is high. The ones who are,
9 you know, least likely to be able to actively move on to
10 a new payment mechanism, for example.

11 I think it's also important to note that the new
12 challenge experienced by disabled women from a finance
13 perspective was the fact that they might not have been
14 able to go back to work with the same readiness as their
15 non-disabled counterparts, particularly if they felt
16 they were clinically vulnerable and didn't want to go
17 back into a workplace when the reopening occurred,
18 because they were worried about their own health, for
19 example. And so this creates a compounded vulnerability
20 for their finances if actually that means they're then
21 continuing on less pay or reduced hours or, indeed, lose
22 their job because they're unwilling to put themselves at
23 greater risk being in a public setting.

24 **Q.** Thank you.

25 At paragraph 52 you tell us that for migrant women
29

1 restrictions, which representatives said perpetrators
2 took advantage of to control victims. Domestic abuse
3 and safeguarding workers, as well as interpreters, were
4 also not considered 'key workers' and therefore unable
5 to provide support in person to victims and survivors."

6 And that seems to chime with the research that you
7 work conducting and the results that you were getting,
8 Dr Wenham.

9 **A.** Absolutely.

10 **Q.** Thank you.

11 Turning to housing, please. You tell us at
12 paragraph 56 that, in England, only 2% of white British
13 households were officially overcrowded before the
14 pandemic compared to 24% of Bangladeshi, 18% of
15 Pakistani, and 16% of black African households.

16 What happened during the pandemic, and in
17 particular, did you find that elderly South Asian women
18 in multi-generational households were significantly at
19 higher risk of dying from Covid than others?

20 **A.** Yes. And so, again, this -- it's not my research, but
21 research by Nafilyan and colleagues showed that elderly
22 South Asian women were at greater risk of dying from
23 Covid, and they attribute this to spending greater time
24 in an overcrowded home and performing caregiving roles,
25 making them, you know, more at risk of household

31

1 with no recourse to public funds, the effect of income
2 loss was even more severe, and that many, as we've
3 already established, worked in insecure sectors such as
4 care and cleaning, yet, as we know, were excluded from
5 furlough, Universal Credit and housing support.

6 And just to reflect on what was being said at the
7 Domestic Abuse and Safeguarding Roundtable, could we
8 have a look at the summary report, please, INQ000587973?
9 Yes, thank you very much.

10 Could we go to page 5 and highlight paragraph 11 on
11 this topic.

12 Thank you very much.

13 "The pandemic had specific impacts on some groups of
14 victims and survivors. For example, victims and
15 survivors with no recourse to public funds and migrant
16 women faced difficulties accessing the online or
17 telephone support available during the pandemic. This
18 was because they lacked the means to purchase telephones
19 or data, access WiFi or other technological equipment.
20 They also faced language barriers and were fearful that
21 information shared online could be sent to the
22 authorities and affect their immigration status.
23 Without British Sign Language interpreters for
24 government messaging, d/Deaf victims and survivors
25 didn't receive basic information about the rules and

30

1 transmission of disease.

2 **Q.** Thank you.

3 And in terms of homeless women, at paragraph 59, you
4 tell us that while men made up the majority of rough
5 sleepers and were thus more visible in public discourse
6 and policy responses, women, who account for around 60%
7 of statutory homelessness households, were more likely
8 to experience hidden homelessness, such as sofa surfing
9 or remaining in unsafe domestic situations.

10 And as informal living arrangements collapsed,
11 frontline workers reported rising numbers of women
12 requiring urgent assistance, including survivors of
13 domestic abuse?

14 **A.** Yes.

15 **Q.** In considering the impact of lockdown restrictions,
16 let's go back momentarily, please, to have a look at the
17 Domestic Abuse and Safeguarding Roundtable Summary
18 Report and, in particular, paragraphs 59 and 60, to see
19 what was being said during the course of this particular
20 roundtable.

21 While representatives said they had significant
22 concerns about the impact of the pandemic on access to
23 safe accommodation:

24 "The pandemic restrictions and social distancing
25 measures resulted in reduced capacity at many refuges

32

1 making it difficult to accommodate those in urgent need,
2 and furthermore, according to the representative for the
3 Local Government Association, there was uncertainty in
4 how refuges could operate while following restrictions,
5 particularly around contact between people from
6 different family units. Before the pandemic, Southall
7 Black Sisters and Solace Women's Aid operated an
8 open-door policy, but they had to stop this during the
9 pandemic, and this affected [sic] some victims and
10 survivors from accessing safe accommodation.

11 "The demand for safe accommodation during the
12 pandemic was greater than the accommodation available.
13 Solace Women's Aid saw a doubling of referrals to
14 refuges between early March and the end of April 2020,
15 which was a challenge to accommodate. The
16 representative for Mankind Initiative said that the
17 increase in demand for safe accommodation could not be
18 met because of a lack of availability, compounded by
19 those already in safe accommodation having nowhere to
20 move ... to during the pandemic."

21 Finally, before leaving this topic, please could we
22 display the Shadow Pandemic Shining a Light on Domestic
23 Abuse during Covid report. It's at INQ000475125.

24 I think that you've had an opportunity of looking
25 and considering this report, Dr Wenham.

33

1 a third of women's housing situations had worsened
2 because of the perpetrators' actions since the start of
3 the pandemic. This same survey found that prior to the
4 pandemic, 14% of women were in rent or mortgage arrears
5 because of the perpetrators' economic abuse and that
6 this had increased to 25% since the start of the
7 pandemic."

8 So therefore bringing together the influence on both
9 the financial aspects of women's lives and also the
10 housing situation, particularly of those women who were
11 being subject to domestic abuse.

12 **A.** Absolutely.

13 **Q.** Thank you.

14 We can take that down, please.

15 In your view, Dr Wenham, what learnings should be
16 embedded in future emergency plans to prevent a repeat
17 of the disproportionate health harm borne by women and
18 in particular homeless women?

19 **A.** Well, I think it's about recognising that this shouldn't
20 be an afterthought, right? And that, you know, if
21 you're asking people to, in this instance stay at home,
22 then we have to recognise that, you know, home and
23 housing is a vital part of that and for many women that
24 is not a safe place or not a secure place, and
25 therefore, building into pandemic planning or emergency

35

1 And could we scroll down, please, to the second
2 page. We can see here that the researchers and authors
3 come from all manner of -- thank you very much for
4 highlighting that -- all manner of relevant
5 organisations. And then if we could turn to page 49,
6 please, and highlight the first two paragraphs under
7 one -- 7.1.5. We can see here:

8 "Covid-19 has had a negative impact on women's
9 housing situation. For many women living with their
10 perpetrator, the introduction of lockdown would have
11 meant being trapped at home, almost 24 hours a day with
12 their perpetrator. A Women's Aid survey investigating
13 the impacts of the Covid-19 pandemic with women
14 victim-survivors found that perpetrators used Covid-19
15 as a tool for abuse in connection to their housing
16 situation, refusing to take precautions to stop the
17 spread of the virus and/or forcing their household to
18 live under unnecessary strict measures and making it
19 harder to flee."

20 And that:

21 "Perpetrators' use of economic abuse further
22 destabilised women's housing situation during the
23 pandemic. This may include restricting, exploiting
24 and/or sabotaging housing and accommodation. A survey
25 carried out by Surviving Economic Abuse found that over

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1 planning, the realities of how women experience safety
2 and security within their homes should be, you know,
3 a paramount part of the planning phase and not a second
4 thought, which is what happened during the pandemic.

5 **Q.** Thank you.

6 I want to touch very briefly, please, on skills,
7 training, apprenticeships and education. At
8 paragraph 73 you tell us that:

9 "The Covid-19 pandemic disrupted adult education and
10 training across the UK, affecting both apprenticeships
11 and other further education pathways for learners aged
12 19 and over."

13 How, in particular, did that affect women who were
14 hoping to train or join an apprenticeship?

15 **A.** Well, so again, if falls down intersecting lines so, you
16 know, women who also have other intersecting
17 inequalities or vulnerabilities may have experienced
18 this to a greater extent. One of the key ways we saw
19 this was through additional care burdens that women were
20 facing. So they weren't necessarily able to continue
21 with education or their training if they also had to
22 assume childcare responsibilities or community care or
23 elderly care responsibilities.

24 We also know that there were tensions around access
25 to remote learning and digital engagement with gendered

36

1 and age-related and socioeconomic group status,
 2 differences in access to digital tools, to be able to
 3 move online for such education and training
 4 opportunities.

5 **Q.** Thank you.

6 And at paragraph 90 you tell us that unpaid
 7 childcare responsibilities and homeschooling affected
 8 women's wellbeing more than men, and there were
 9 increased rates of anxiety and depression reported
 10 amongst women compared to men in relation to unpaid care
 11 within the home, and you go on to say that single
 12 parents, approximately 85% of whom are women,
 13 particularly suffered from increases in unpaid care work
 14 during the pandemic. These women have consistently
 15 reported increased concerns of financial insecurity,
 16 risks of falling into poverty, and increased mental
 17 health concerns because of that.

18 **A.** Absolutely, yes.

19 **Q.** Yes. And evidence from your report indicates that
 20 women, especially racialised women, reported larger and
 21 more persistent declines in mental health wellbeing than
 22 men during the pandemic, linked to heightened
 23 loneliness, as we've just seen, heavier unpaid care and
 24 service disruptions. Was this an exacerbation of
 25 structural inequalities that were already present before

37

1 **Q.** Thank you.

2 We've touched upon it already, but I want to ask you
 3 now about exposure to violence, please, and the impact
 4 of the pandemic on new forms of domestic abuse.

5 You tell us at paragraph 93 at:

6 "Covid-19 exacerbated existing risks of and exposure
 7 to, violence against women and girls. Lockdown
 8 measures, economic instability, social isolation and
 9 distancing created conditions which intensified the
 10 likelihood of violence occurring in the first place, and
 11 in turn limited women's access to support services."

12 But what were the new forms of domestic abuse that
 13 your research disclosed, that happened during the course
 14 of the pandemic?

15 **A.** Absolutely. And I should say this isn't my research but
 16 research from others in my field, and I know that you've
 17 got another piece of evidence or witness this morning --

18 **Q.** Yes.

19 **A.** -- who is much more of an expert in this than I am, but
 20 the research summary that we have is that there were new
 21 forms of violence and abuse, such as exploitation of
 22 pandemic fears. So, abusers not being willing to engage
 23 in social distancing, not being willing to wear a mask,
 24 coughing on victims, for example. We also know that
 25 there was abuse related to access to technology and

39

1 the pandemic?

2 **A.** Absolutely.

3 **Q.** Yes.

4 **A.** So we know that women are more likely to
 5 experience greater anxiety than men. We know that women
 6 are more likely to, during the pandemic, have suffered
 7 greater sense of isolation and loneliness. Women tend
 8 to have more friends and bigger social groups than men,
 9 and, therefore, when restrictions on social mobility
 10 came in, that tends to affect women's engagement with
 11 friends, family, more so than men, who are more likely
 12 to have fewer and smaller close-knit friend groups.

13 I think you also have to take into account that, for
 14 example, if you were starting to -- when restrictions
 15 ease and you're able to meet up with people, when the
 16 rule of six, for example, came into play, if you are
 17 also a primary caregiver, you have to count your
 18 children within that rule of six, which meant that you
 19 could meet up with fewer people at that time --
 20 obviously the more children you have, the fewer people
 21 you could meet up with at any one time -- and so there
 22 are these differences in how women were able to engage
 23 and maintain friendships and social interaction and
 24 things that we know are protective factors for mental
 25 health, isolation and loneliness.

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1 whether people -- whether victims were able to, you
 2 know, speak to their friends, speak to their family, use
 3 the telephone, use the internet.

4 And then access to treatment and food, which was
 5 obviously not as easy if you were being -- if you were
 6 at home rather than in normal society, as another way of
 7 controlling and coercing victims.

8 **Q.** You set out at paragraph 96 some statistics in relation
 9 to domestic abuse rates. You say that by April 2020,
 10 Refuge, the UK's largest domestic abuse charity, had
 11 reported a 700% increase in calls to its helpline in
 12 a single day, and that by May 2020 the charity had
 13 reported a 957% increase in web traffic, that by June
 14 of 2020, Marie Stopes International reported a 33% rise
 15 in domestic violence reports related to seeking
 16 reproductive services, that the National Domestic Abuse
 17 Helpline received 40,000 calls in the first three months
 18 of the first lockdown, an 80% increase on pre-pandemic
 19 figures, and that Rape Crisis centres reported a 41%
 20 increase in sessions of specialist support between 2019
 21 to 2020 and 2020 to 2021. Some shocking statistics
 22 there.

23 **A.** Yes. I would just add, though, that we have a tension
 24 in the measurement and data around domestic violence,
 25 and again the next witness, I'm sure, is much more able

40

1 to speak to this, but we know it's a very underreported
2 issue --
3 **Q.** Yes.
4 **A.** -- and therefore we have to rely on proxy indicators,
5 such as calls to helplines or web service traffic, or
6 administrative data such as police records, to try to
7 give an indication of trends that are emerging but it's
8 very hard to get accurate statistics because of the
9 clandestine nature of domestic violence and abuse and
10 the challenges that women face in reporting such abuse.

11 **Q.** Thank you.

12 And this, in fact, is reflected in the information
13 that was provided to the Domestic Abuse and Safeguarding
14 Roundtable.

15 Please could we have a look briefly at page 4,
16 paragraph 4, of that report. Thank you very much.

17 "Reports of domestic violence to the police were low
18 at the start of the pandemic given victims and survivors
19 were either unable to report as they were trapped with
20 their perpetrator, or because they were not sure if it
21 was possible to report to police during a public
22 emergency. However, reporting figures increased as
23 lockdown restrictions began to ease. Representatives
24 felt that the level of reporting did not reflect the
25 actual number of domestic abuse incidents during that

41

1 And this is where you draw together all of the
2 evidence that we've just considered.
3 "Domestic violence should have been considered as
4 a likely consequence of lockdown measures from the
5 start."

6 You say:

7 "Recommendations for the future could include ..."

8 The following:

9 "104.1 Early recognition of the impact of pandemics
10 and lockdowns on domestic abuse, and the particular
11 risks faced by those women from black, minoritised,
12 disabled and migrant communities and those with no
13 access to public funds.

14 "104.2 Domestic violence support mechanisms excluded
15 from social distancing and lockdown provision from the
16 start (ie so there is safe refuge for
17 victim-survivors)."

18 That there's:

19 "104.3 Early planning, consultation and engagement
20 with the [violence against women and girls] sector,
21 including increased funding to domestic violence
22 charities in the early stages of a health emergency to
23 facilitate additional provision of care and support for
24 victims and potential victims."

25 That there's:

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1 early pandemic period. Although domestic abuse often
2 goes unreported, they thought even fewer people were
3 reporting offences during the first lockdown as
4 emergency services were overwhelmed or support was not
5 available."

6 Yes, thank you very much.

7 At paragraph 99 you tell us that:

8 "In the UK, in the first month after the initial
9 lockdown, the rate of homicide in women was more than
10 twice the average of two women a week, and the highest
11 rate in the last 11 years ... [but that] Such a trend
12 did not continue over the course of the pandemic, with
13 domestic homicides (the majority of the victims of which
14 are women, and the crime committed by men) not appearing
15 to have increased substantially ... [but that]
16 Since 2021, Northern Ireland has the joint highest rate
17 of femicide in Europe, and the highest rates of domestic
18 violence in the UK ..."

19 **A.** Yes.

20 **Q.** Thank you.

21 Let's go back to your report, please -- and
22 reminding ourselves, it's INQ000657974 -- and have
23 a look at paragraph 104.

24 Which is at page 37 to page 38. Thank you. It
25 begins at the bottom of page 37.

42

1 "104.4 Clear, accessible and translated messaging
2 that those experiencing domestic abuse are permitted to
3 leave their homes, and about safeguarding duties and
4 statutory rights of those feeling abuse.

5 "104.5 Training of community members to identify
6 risk behaviours (such as postal workers, community
7 workers and others that may visit door to door
8 routinely).

9 "105.5 Greater investment in domestic violence
10 mitigation strategies in routine times to mitigate
11 potential challenges at a time of crisis. This can
12 involve [you say] working with potential abusers to
13 identify the root cause of their violence."

14 Is there anything that you would like to add to
15 that, Dr Wenham?

16 **A.** Well, I just think in general these, you know, the
17 domestic abuse and violence discussion during the
18 pandemic is it's -- it's a challenge of supply and
19 demand, right? Which was the demand for such services
20 dramatically increased. Now, we don't have the actual
21 data, as we've talked about, because of limitations, but
22 we know there was an increase in demand for such
23 services. But supply and provision of such services
24 were reduced because of social distancing and
25 restrictions and interactions, and that just seems

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1 counterintuitive.

2 And at a time of crisis going forward, once
3 demand -- once we know demand is going to increase --
4 and I note and remind the Inquiry that, you know, other
5 health emergencies prior to Covid saw similar challenges
6 around domestic abuse and violence, so it was a known
7 outcome, and so, therefore, you know, demand should --
8 supply should match demand.

9 And so it's about increasing service provision and
10 it's increasing support of such services to victims of
11 domestic abuse and increasing supply of available safe
12 housing, available safe spaces, available care to
13 victims, so that as demand goes up, we have the
14 necessary supply to match it.

15 Q. Thank you.

16 The final topic I want to discuss with you is mental
17 health. I know that you were specifically asked not to
18 cover that because we had our own systematic evidence
19 review under way, but we have touched upon it briefly,
20 and I just would like to display the part of the
21 systematic evidence review which deals with mental
22 health and gender. Thank you very much.

23 For the record, it's INQ000659787, and could we
24 turn, please, to paragraph 3.2.2 which should begin at
25 page 30. Thank you very much.

45

1 homeschooling. Some women also reported a sharp decline
2 in their ability to enjoy everyday activities, and
3 mothers in particular reported doing less physical
4 activity. This reduction in physical activity was
5 associated with worse mental health outcomes for
6 mothers, as doing less exercise during lockdown was
7 associated with a higher chance of depression and
8 anxiety."

9 Then the next period of time is entitled "Easing and
10 summer", that's July to October 2020.

11 "Women experienced a slightly greater reduction in
12 average psychological distress comparing to men,
13 suggesting some short-term improvement, but this was
14 compared to a higher baseline level."

15 Then moving to the second/third lockdowns and
16 winter, November 2020 to March 2021, we see that:

17 "The reintroduction of restrictions during the
18 second and third lockdowns was associated with a renewed
19 deterioration in mental health."

20 And that:

21 "One study reported that women's mental health
22 worsened more than men's during this period."

23 If we go finally, please, to the easing and
24 post-pandemic period, which is April 2021 to May 2023,
25 we see that:

47

1 So:

2 "This section examines gender differences in mental
3 health and wellbeing across the pandemic period.
4 Evidence is moderate to strong, with multiple large,
5 high-quality UK longitudinal studies consistently
6 showing that women experienced worse mental health
7 outcomes than men, both before and during the pandemic."

8 If we can move down, please, to see how this is
9 reflected across the time periods, thank you.

10 The pre-pandemic baseline, so:

11 "Prior to the pandemic, women consistently reported
12 poorer mental health than men, including higher levels
13 of anxiety, depressive symptoms, loneliness and lower
14 life satisfaction. Studies found that women had higher
15 levels of symptoms such as tiredness, insomnia, trouble
16 concentrating and psychological distress across
17 different groups based on their health behaviours such
18 as drinking and eating habits", which we've touched
19 upon.

20 Moving into the initial lockdown period, thank you.

21 We can see that:

22 "During this period, women on average spent
23 significantly and disproportionately more time on
24 childcare and housework than men. This included unpaid
25 care responsibilities, including housework and

46

1 "Mental health symptoms declined following the
2 easing of restrictions, indicating a partial recovery.
3 However, distress levels remained higher than before the
4 pandemic throughout this period. Women continued to
5 report higher symptom levels than men."

6 Can we assume, Dr Wenham, that that may have been
7 for all the reasons that you've set out in your evidence
8 this morning?

9 A. Absolutely. I think, you know, I think that there must
10 be -- or it's important to look at the variation between
11 the women in these different sectors, right, because
12 you've talked about mothers, for example, compared to
13 women, and I think we need to recognise the different
14 ways that mental health and anxiety were going to be
15 experienced by different types of women during the
16 pandemic. So if you are also homeschooling and working
17 and a single mother, you're going to experience much
18 poorer mental health outcomes, for example, than if you
19 are a women with no children who is able to work at home
20 and, you know, affluent enough to not be worrying about
21 financial challenges.

22 And so I think, again, it's important to
23 disaggregate who it is that are being considered in each
24 of these samples. But yes, it's consistent with all
25 different parts of this report.

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1 **Q.** Thank you. We can take that down, please.
 2 You set out lessons learned, recommendations, across
 3 the whole this piece of work at paragraph 112, and many
 4 of these we have already covered during the course of
 5 your evidence. Is there anything else which you would
 6 like to add to the recommendations that you have already
 7 made about the improvement of the plight of women for
 8 next time?

9 **A.** Well, I think -- I mean, most of it is all set out and
 10 I don't want to repeat it all for the sake of repeating
 11 it but I think it's important to note that women aren't
 12 a homogeneous group and that different women are going
 13 to experience any health emergency or other crisis in
 14 different ways. But I think that the tendency towards
 15 neutral policy making obscures these differences of how
 16 women experience life in society in the UK, or indeed
 17 anywhere in the world, and that recognising the
 18 real-life implications of every policy, every action, is
 19 vital to actually understanding how such a policy will
 20 work. Because if people -- if women aren't able to, you
 21 know, survive -- to, you know, afford to eat or feed
 22 their children or, you know, not experience severe
 23 mental health outcomes, they might not then engage in
 24 the policy in the same way.
 25 And so if you're looking to, you know, stop a health
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1 say, women are not a homogeneous group.
 2 But, for example, in relation to postnatal mental
 3 health care, mental health impact of unpaid care,
 4 financial and housing insecurity, loneliness and
 5 isolation and domestic violence, as just exemplars.
 6 The question is: based on your research, how do you
 7 consider the service disruptions and contractions
 8 impacted on women's mental health needs during the
 9 pandemic?

10 **A.** Well, I would add that I wasn't asked to comment on the
 11 mental health in particular so I haven't got a section
 12 in my report on mental health. But it would be part of
 13 the multi-faceted landscape you've just described of the
 14 different reasons of why women were experiencing poorer
 15 mental health and then their inability to access
 16 services may have compounded each and any one of those.
 17 But again, I don't have any data to back up that point;
 18 it would just be my expert opinion based on the variety
 19 of other challenges that women faced from a mental
 20 health perspective.
 21 **MR PEZZANI:** I see. Thank you very much.
 22 **LADY HALLETT:** Thank you, Mr Pezzani.
 23 Dr Wenham, that concludes your evidence. Thank you
 24 so much for the help you've given to the Inquiry, both
 25 in the last module -- was it Module 2?
 51

1 emergency, you want everybody engaging in that policy
 2 and so recognising the limitations on people's
 3 engagement or women's engagement, is actually a good
 4 public health measure because it can lead to better
 5 adherence and uptake of future policies and future
 6 public health requirements in a health emergency.
 7 So it's not just about gender; it's about getting
 8 better public health outcomes because you recognise the
 9 realities of people's lives in our society.
 10 **MS BLACKWELL:** Thank you.
 11 Dr Wenham, thank you very much for your evidence
 12 this morning.
 13 My Lady, you have given permission for Mr Pezzani on
 14 behalf of Mind to ask a question, and so may I ask him
 15 to do that now.
 16 **LADY HALLETT:** Mr Pezzani.
 17 **Questions from MR PEZZANI**
 18 **MR PEZZANI:** I'm very grateful.
 19 Dr Wenham, good morning, I'm Roger Pezzani asking
 20 a single question on behalf of Mind. This, I think,
 21 relates to your point about supply and demand. We
 22 understand that routine mental health care and access to
 23 therapy were restricted during the pandemic, and just as
 24 many women's mental health needs increased during
 25 lockdown, different reasons for different women; as you
 50

1 **THE WITNESS:** Yes.
 2 **LADY HALLETT:** I'm losing track of time now -- and in this
 3 module. I'm really grateful to you. Some very
 4 interesting information you've provided and expert
 5 opinion, so thank you for your help.
 6 **THE WITNESS:** Thank you.
 7 **LADY HALLETT:** Very well, I shall break now and return
 8 at 11.55.
 9 **MS BLACKWELL:** Thank you, my Lady.
 10 (11.38 am)
 11 **(A short break)**
 12 (11.55 am)
 13 **LADY HALLETT:** Ms Blackwell.
 14 **MS BLACKWELL:** My Lady, can you see and hear me?
 15 **LADY HALLETT:** I can, thank you.
 16 **MS BLACKWELL:** May I call the next witness, Ms Gisela Valle.
 17 **MS GISELA VALLE (sworn)**
 18 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 10**
 19 **MS BLACKWELL:** Thank you. Will you give your full name to
 20 the court, please.
 21 **A.** Yes, Gisela Valle Garcia.
 22 **Q.** Thank you. And Ms Valle, you should have in front of
 23 you a copy of your witness statement, which bears our
 24 reference number INQ000652188.
 25 Can you confirm, please, that this is the witness
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1 statement that has been provided jointly on behalf of
 2 the DA Group organisations for the purposes of
 3 Module 10?
 4 **A.** That is correct.
 5 **Q.** Thank you. And can you also confirm that any facts
 6 stated within the witness statement are true to the best
 7 of your knowledge and belief?
 8 **A.** Correct.
 9 **Q.** Thank you.
 10 I'm going to begin by providing a description of the
 11 registered charities which contribute to the Domestic
 12 Abuse Group. The first is the Southall Black Sisters,
 13 which is a black feminist organisation founded in 1979,
 14 dedicated to empowering black, minoritised and migrant
 15 women and girls, particularly those fleeing violence
 16 against women and girls. For over four decades, it has
 17 been advocating for the rights and safety of some of
 18 society's most marginalised women and provides
 19 counselling, support groups, and education classes
 20 in London, and conducts policy work, campaigning,
 21 research, professional training and community education
 22 and development.
 23 **A.** Correct.
 24 **Q.** Solace Women's Aid was established over 50 years ago and
 25 is one of the single largest providers of services for

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1 services that existed for women migrating to the UK from
 2 Latin American. And in the 42 years since its
 3 inception, it has supported the practical and strategic
 4 needs of Latin American migrant women, as well as black
 5 and ethnic minority migrant women, nationally, facing
 6 intersectional violence and discrimination shaped by
 7 their race, class, gender, and immigration status.

8 It established an advice, information and advocacy
 9 service, to inform women of their rights and enable them
 10 to access services in a culturally, linguistically and
 11 gender-specific setting.

12 And during the pandemic, your organisation adapted
 13 its services to remote delivery, to ensure continuity of
 14 support for Latin American and migrant women
 15 experiencing violence, and provided essential
 16 information about Covid-19, about rights and access to
 17 services, in Spanish and Portuguese.

18 **A.** That is correct.

19 **Q.** Thank you.

20 One of the key impacts of the pandemic for
 21 victim-survivors of domestic abuse was as a result of
 22 lockdown, and we know from your statement that the
 23 impact of lockdown impacted victim-survivors of domestic
 24 abuse in multiple, often overlapping, ways. I will ask
 25 you about those impacts as we go through your evidence,

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1 victim-survivors of women and girls in the UK. It was
 2 established to prevent violence and abuse and provide
 3 services to meet the individual needs of
 4 victim-survivors, predominantly women and children. Its
 5 mission is to end the harm done through gender-based
 6 violence, and to work alongside victim-survivors to
 7 achieve independent lives free from abuse. And it is
 8 the lead agency in several partnerships across London,
 9 delivering domestic abuse services, including advice,
 10 advocacy, refuge, resettlement, counselling and
 11 therapeutic support and children's support. And it
 12 operates 24 refuges, and it adapted in the pandemic to
 13 maintain all refuge provision whilst adapting community
 14 and therapeutic services to be delivered remotely.
 15 **A.** Correct.
 16 **Q.** During the pandemic, Southall Black Sisters and Solace
 17 Women's Aid launched a crisis project offering safe
 18 emergency accommodation with specialist support to women
 19 and children across London during the pandemic, and it
 20 provided accommodation and support to 205 women from
 21 May 2020 to September 2021, including 73 who had no
 22 recourse to public funds.
 23 You, Ms Valle, are Director of the Latin American
 24 Women's Rights Service, which was founded in 1983 by
 25 a group of Latin American women who saw a gap in the

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1 Ms Valle, but can I first ask you about the impact of
 2 the pandemic and lockdown on domestic abuse levels and
 3 trends.

4 At paragraph 27 of your report you tell us that the
 5 impact of the pandemic and that of lockdown were
 6 interrelated, and yet each also had distinct effects as
 7 well as cumulative impact.

8 **A.** Yes.

9 **Q.** For victim-survivors of domestic abuse, it was often the
 10 combination of the pandemic and lockdown that amplified
 11 that abuse; is that right?

12 **A.** That is correct.

13 **Q.** And at the same time, the pandemic introduced more
 14 subtle dynamics of abuse of control and patterns of
 15 abuse, allowing an abuser to exploit, for instance,
 16 fears of infection, restrictions of movement, and to
 17 further isolate or control victim-survivors?

18 **A.** Yeah, that is correct. I think just to add a little bit
 19 to that, domestic abuse gets to thrive in situations
 20 where there is no hope of disrupting the dynamics of
 21 power and control at the centre of domestic abuse.

22 **Q.** Yes.

23 **A.** So we had the pre-existing barriers experienced by
 24 certain groups, more than others, but then the pandemic
 25 itself and the lockdowns introduced new barriers, and

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1 systems. And I think the reason why we saw the jump in
2 the demand for the services that we saw is precisely
3 because once perpetrators were aware that there were
4 no -- there were new measures of controlling victims,
5 they used them to full advantage. Once victim-survivors
6 were trapped in situations where they have no hope of
7 contacting anyone outside of the home where the
8 perpetrator was, it reinforced that dynamic.

9 So the pandemic kind of adds fuel to the fire that
10 already exists in the situation of domestic abuse. It
11 amplifies, it makes it easier, and it makes it a lot
12 harder to exit that situation, and we saw that through
13 a range of measures.

14 **Q.** Thank you. And we'll turn in a moment to look at new
15 types of abuse that were apparent throughout the course
16 of the pandemic.

17 But you also tell us that countries that experienced
18 earlier outbreaks of the pandemic to the UK, such as
19 China, Germany and Italy, began reporting rises in
20 domestic abuse before similar trends emerged in the UK,
21 and that that was reflected in the overall increase in
22 reports of domestic abuse that all three of the DA Group
23 organisations, as well as others in the violence against
24 women and girls sector saw --

25 **A.** Yes.

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1 to me."

2 I think at the same time, the low footfall during
3 the lockdowns leads to another dynamic, which is women
4 who realise that the risk of staying home is much
5 greater than the risk of, for example, failing to comply
6 with regulations, they just decide to take the case. So
7 we see less cases, we see higher risk, and then once
8 those restrictions eased, then we see that jump in
9 demand for services.

10 **Q.** We've just heard from Dr Wenham this morning that in
11 terms of the level of domestic abuse complaints or the
12 calls for assistance in terms of domestic abuse, there
13 is a danger of simply looking at the figures without
14 understanding the underlying factors that may lead to
15 more women feeling able to ask for support and make
16 complaints, and that the numbers not necessarily really
17 reflecting what's going on at the time.

18 Can we look, please, on this topic, at the Domestic
19 Abuse and Safeguarding Roundtable report. It's
20 INQ000587973.

21 I think, Ms Valle, that you were present at the
22 roundtable, were you not, that was split into two
23 sections? There were national groups and you were
24 present at the -- I'm going to call it the specialist
25 section --

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1 **Q.** -- is that right? Because all three DA Group
2 organisations experienced significant increases in
3 demand for their support services during the pandemic,
4 creating cycles of fluctuating demand --

5 **A.** Yeah.

6 **Q.** -- that were characterised by what you describe as low
7 footfall --

8 **A.** Yes.

9 **Q.** -- because of the pandemic restrictions, but high
10 helpline calls. So was that something which -- to which
11 you had -- or your organisations had to adapt?

12 **A.** Yes, it was two separate things. So one is, once the
13 lockdowns are put in place, victim-survivors are very
14 aware that they're trapped in a situation with
15 perpetrators so we see the fluctuations going down
16 because there's no way of making a phone call when
17 somebody can listen to that conversation, and enact
18 retribution as a result of that. Of course children are
19 also in the house. I mean, everything is set up in
20 a way that will restrict the ability of survivors to
21 come forward and say, "We need help."

22 As situations start easing, of course there is
23 opportunities for these survivors, including women and
24 others who are experiencing domestic abuse for the first
25 time, to come forward and say, "This is what's happening

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1 **A.** Yes.

2 **Q.** -- of the procedure? And let's look, please, at what's
3 said about the impact on reporting domestic abuse to the
4 police. It begins at paragraph 24:

5 "The increase in intensity of abuse during the
6 pandemic was not initially reflected in increased
7 reporting to the police or an increased demand for
8 domestic abuse support."

9 25:

10 "Representatives stressed that low levels of
11 domestic abuse reporting to the police were not unusual
12 before the pandemic. They said that many victims and
13 survivors do not report domestic abuse or pursue cases
14 and victims and survivors often do not report domestic
15 abuse incidents immediately after they occurred. For
16 these reasons there are significant gaps in the
17 knowledge relating to perpetration of abuse."

18 And there's an example given there by the Welsh
19 Local Government Association:

20 "A person experiences domestic abuse maybe 10 times
21 before they will report it. It depends where someone is
22 on their journey. You can go from someone who has lost
23 their temper and there is one incident to someone who
24 deliberately has a campaign of abuse."

25 And if we read on:

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1 "However, as lockdown eased there was an increase in
2 reporting of domestic abuse and referrals to support
3 services. Representatives saw this as an indication
4 that perpetrators had been exerting greater control
5 during periods of lockdown restrictions. They also
6 attributed this increase in reporting as restrictions
7 eased to victims and survivors not knowing whether they
8 were able to report domestic abuse during an emergency,
9 or if the police would be able to do anything about
10 their situation given the lockdown. This pattern of
11 increased reporting continued, with the representative
12 for Rape Crisis England and Wales noting that in 2021-22
13 saw the highest annual figure of recorded rape offences
14 in England and Wales to date."

15 I just want to go now to paragraph 28, please,
16 finally on this topic:

17 "Government agencies and legal and justice services
18 reflected, that one adaptation which proved effective
19 during the pandemic was the transition to online court
20 hearings for domestic abuse cases, particularly for
21 non-molestation orders, as victims did not have to be in
22 the room with their perpetrator. However, this was not
23 sustained and most courts have since returned to
24 in-person hearings".

25 And we'll look in a moment at the impact on justice
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1 calls between April and June 2020, [which was] a 65%
2 increase.

3 "Victim Support reported that, in May 2021, the
4 number of referrals received for victim-survivors of
5 domestic abuse was 25% above, and rape was 23% above
6 volumes of the same referrals received in
7 early 2020 ..."

8 That:

9 "In the first three months of lockdown, calls to the
10 National LGBT+ helpline increased by 50% with use of the
11 web chat increasing by 30% ..."

12 And that the charity:

13 "Imkaan reported its members saw increases in
14 referrals between 60% and 300% during [the] first
15 lockdown ..."

16 Now, these figures chime very much with the figures
17 that Dr Wenham has given us during her evidence this
18 morning.

19 And finally:

20 "Surviving Economic Abuse reported an 85% increase
21 in website traffic; [and]

22 "A year of MARAC data collected by SafeLives for
23 2020 shows [increases] in cases heard during lockdown
24 periods, followed by sharp increases during the
25 following quarter, demonstrating the potential impact of

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1 for those who were complaining of domestic abuse.

2 Thank you. We can take that down now.

3 I'd like to take you, please, to paragraph 37 of
4 your report and to talk about wider sector trends in
5 reporting.

6 Thank you.

7 If we look at what's set out at paragraph 37, you
8 say that:

9 "... the picture is complex, with organisations
10 recording different figures during the change in
11 [non-pharmaceutical interventions], [but] the overall
12 and significant increase in rates of domestic abuse and
13 demand for frontline services was [in fact] sector-wide.

14 "The report by Women's Aid 'Shadow Pandemic -
15 Shining a light on domestic abuse during Covid' [which
16 we've looked at in part this morning] shows [the
17 following]:

18 "Refuge reported a 61% increase in helpline contacts
19 during the pandemic compared to the pre-pandemic
20 baseline ..."

21 They went from about 10,500 visits per month in the
22 first three months of 2020 to an average of 73,595 per
23 month between April 2020 and February 2021, which was
24 a sevenfold increase.

25 "The National Domestic Abuse Helpline logged 40,397
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1 restrictions on support provision processes."

2 **LADY HALLETT:** Sorry to interrupt, Ms Blackwell, I think you
3 said "increases" and it says "decreases".

4 **MS BLACKWELL:** Oh, I'm so sorry. Yes, you are right,
5 my Lady, of course.

6 Yes, "decreases in cases heard during lockdown
7 periods".

8 And we'll look at that in a moment when we come to
9 the justice sector.

10 But taking those figures together, what did your
11 organisations discover about the effect of domestic
12 abuse wider reporting trends across the pandemic period?

13 **A.** I think it reinforced the notion that victim-survivors
14 are clearly very good at managing and dealing with risk.
15 And what we're talking about is that where there are
16 situations that increase risk for them, they will adapt
17 to that situation. So, as I mentioned, during lockdowns
18 you're trapped with the perpetrator, it's very difficult
19 to have a phone call or to go outside to access support,
20 so you're going to go to the next best thing, which is
21 going to be the increase in use of chat services, or
22 online services, or looking at websites and finding out
23 information.

24 As the possibility of going outside increases with
25 the easing of the lockdowns, then the risk assessment

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1 will modify accordingly: "Now I can go outside, now
2 I can go and talk to someone, now I can get a referral
3 to services." And that's what survivors do.

4 So, once either the survivor or the perpetrator is
5 able to freely leave the house, then they will take on
6 the first opportunity to come forward.

7 I think probably the most problematic aspect has to
8 do with the statistics by the police, because there is
9 a significant question around why survivor services are
10 seeing this movement that the police is not seeing, that
11 the figures remain flat. And that actually talks about
12 how different groups, for different reasons, do not have
13 trust in coming forward to police.

14 If you add to that the fact that restrictions are
15 changing and, you know, the rules are constantly
16 changing throughout this period, there's no clarity
17 around where domestic abuse survivors are sitting in the
18 level of priorities that the police and other statutory
19 services have at that moment, it's very easy to
20 understand why, you know, we're seeing fluctuations as
21 survivors are managing risk but the police are not
22 seeing those fluctuations.

23 And for me, perhaps the key thing about this is that
24 police being a primary, you know, first responder in
25 situations of higher risk, it begs the question as to

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1 I'd like to look at paragraph 38 of your statement,
2 please, which confirms the police and justice sector
3 reporting patterns. You say that:

4 "While calls to helplines increased significantly,
5 calls to the police during this period were not
6 increasing at the same rate."

7 Presumably for the myriad of reasons which you've
8 just provided to the Inquiry.

9 You go on to say that:

10 "Unlike some European countries, the large increase
11 in reports to police did not happen in England and
12 Wales ... By mid-April 2020, police were informing the
13 Home Office that the police-recorded domestic abuse
14 incidents were the same as they were in April 2019, but
15 they were aware of the difficulties of reporting
16 domestic abuse to them because of the social isolation
17 measures in place. Victim-survivors of domestic abuse
18 were not only deprived of opportunities to call the
19 police, they were also fearful [as you have told us] of
20 the potential ramifications of doing so whilst trapped
21 in their homes with their perpetrators ..."

22 And that:

23 "Migrant women with insecure immigration status
24 faced additional barriers, to accessing support due to
25 the routine practice of data-sharing between the police

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1 what measures should have been put in place at that
2 point to enable police to continue performing that
3 function.

4 I'm just going to finish by saying that of course
5 different groups are going to be affected by all these
6 differently. Our beneficiaries, for example, are
7 migrant women. They're subject to immigration control.
8 They know it's not safe to come forward to statutory
9 services because of data sharing. And the involvement
10 of immigration enforcement in their cases not for
11 safeguarding measures but really for enforcing borders,
12 that might have consequences for them or their children,
13 in a variety of ways. But this is replicated across
14 other groups. We know that deaf and disabled survivors,
15 for example, have a massive struggle both with
16 interpretation and also with being believed by statutory
17 services. We know that the LGBTQ community is going to
18 experience its own barriers.

19 And perhaps the one thing that is missing here is
20 a better understanding how these groups experience the
21 situation in different ways and, more importantly, what
22 measures need to be put in place to make sure that those
23 who are most at risk can have the level of support they
24 need to come forward.

25 Q. Thank you.

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1 and Home Office, when victim-survivors reported abuse,
2 stoking fears of deportation."

3 So all of what you've just set out, encapsulated
4 there.

5 Let's look, please, at paragraph 40 please, of your
6 report, where you give some figures:

7 "An Office for National Statistics report on
8 domestic abuse prevalence and trends (year ending
9 March 2022) ...found [the following]:

10 "No significant change in prevalence of domestic
11 abuse experienced by adults aged 16-59 compared with
12 pre-pandemic levels.

13 "Police recorded [1.5 million or so] domestic
14 abuse-related incidents and crimes in year ending
15 March 2022. [Which] was an increase of [just over
16 120,000] compared with the year ending March 2020 and
17 increase of 40,706 from year ending March 2019."

18 And that the:

19 "Number of domestic abuse-related crimes continued
20 to increase, rising by 7.7% between March 2021 and
21 March 2022 and which constituted a 14.1% rise compared
22 to the year ending March 2020.

23 Q. Did this only provide a partial picture, though, in
24 terms of the statistics that were collected by the ONS?

25 A. It does provide only a partial picture because there is

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1 such a stark difference with what was coming through
 2 frontline services like ours, and others, nationally.
 3 But as I say, it's even more problematic than that
 4 because while we had a massive struggle getting our data
 5 across to government departments in order to make
 6 decisions around pandemic measures and mitigation that
 7 could have been put in place for domestic abuse
 8 survivors, it's impossible for us to compete with the
 9 level of access. So if the police is saying "Nothing is
 10 changing, nothing is happening, the pandemic is having
 11 no effect on rates of domestic abuse and all forms of
 12 violence against women and girls", then the police --
 13 the government will make decisions accordingly.

14 I think it's really very crucial both to understand
 15 why, in the context of a pandemic, again, your first
 16 responder and emergency service you see no change in
 17 trends and what that says about trusting the police
 18 generally, but also about the exclusion of the
 19 information that was vital at that time, coming from
 20 specialist violence against women and girls services,
 21 and I think it really gives very good context as to why
 22 measures to support domestic abuse survivors takes so
 23 long to come into place, and really, are quite limited
 24 in terms of the scope of what was needed to respond to
 25 the crisis in the context of a pandemic.

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1 The report also confirms that black and minoritised
 2 women are three times more likely to be in precarious
 3 and insecure work, often on zero-hours contracts, and
 4 less likely to qualify for furlough or Statutory Sick
 5 Pay and that Women's Budget Group, that organisation,
 6 estimates that without drastic action the pandemic is
 7 likely to set back economic equality between men and
 8 women by decades.

9 So the report really confirming that for women,
 10 domestic abuse during the course of the pandemic, really
 11 from start to finish, and particularly during lockdown,
 12 was a serious concern, and that the effects of the
 13 lockdown provisions that were introduced by the
 14 government also had a higher rate of effect for black
 15 and minoritised women than others in society.

16 You say at paragraph 56 of your statement that the
 17 inherent nature of lockdown created conditions for
 18 perpetrators to exert control while creating challenges
 19 for victim-survivors to seek support, which we've just
 20 looked at. And in terms of, in terms of accessing
 21 informal support, did increased isolation from social
 22 networks created by the lockdown conditions create
 23 further abuse opportunities?

24 **A.** Yes, definitely. I think, just thinking about a lot of
 25 the information that you have put forward, the key thing

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1 **Q.** Thank you.

2 Turning then to the specific impact of lockdown on
 3 victim-survivors of domestic abuse, you say at paragraph
 4 48 of your statement that:

5 "Existing structural inequalities shaped how
 6 individuals encountered both the virus and restrictions,
 7 explaining why lockdown effects were not experienced
 8 equally."

9 And I'd like to display, please, the Women's Aid
 10 Shadow Pandemic Shining a Light on Domestic Abuse During
 11 Covid report from October 2021.

12 It's at INQ000475125. We looked at this briefly,
 13 I think, with Dr Wenham.

14 Oh, I'm told, my Lady, I'm so sorry for the delay,
 15 the screen is frozen.

16 Well, we don't need to display it. I can put to you
 17 the parts which I was going to take us to.

18 The report states, in the clearest terms, that
 19 domestic abuse is a gendered issue in the sense that
 20 women experience higher rates of repeated victimisation
 21 and are much more likely to be seriously hurt or killed,
 22 and are more likely to experience a wide range of
 23 coercive and controlling behaviours, and we'll come to
 24 that in a moment as to how that increased during the
 25 case of the pandemic.

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1 to understand is where black minoritised migrant women
 2 and other disadvantaged groups are at the beginning of
 3 the pandemic.

4 **Q.** Yes.

5 **A.** So for the beneficiaries that access our services, for
 6 example, we know that they are in overcrowded
 7 accommodation, they are going to have very precarious
 8 employment, usually no recourse to public funds, and no
 9 access to healthcare services, and so on and so forth.

10 **Q.** Yes.

11 **A.** So we already know that the conditions are there. For,
 12 you know, the increase in domestic abuse to happen,
 13 because a lot of avenues are already closed to them, as
 14 the pandemic comes on, you know, you realise that if
 15 you're in precarious employment, for example, as
 16 a cleaner, you still have to go out there and you still
 17 have to work. In some cases employers took the
 18 opportunity to reduce contracts, but then you still have
 19 no recourse to public funds. So the employer will
 20 decrease your income, your -- the state will not
 21 supplement it in any way through furlough scheme or
 22 access to welfare benefits, you're going to be at higher
 23 risk because you're in overcrowded housing and then
 24 you're under the control of the perpetrator.

25 So that means that for these women, the risk of

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1 domestic abuse is much higher to begin with, it
 2 increases with Covid, and then you have all the
 3 opportunities that the lockdown and the pandemic itself
 4 present -- present to them. So either you're going to
 5 be at risk of infection, for example, if the perpetrator
 6 refuses to abide by the restrictions, or you're going to
 7 be at risk of becoming unemployed if, for example, the
 8 perpetrator decides to control your access to data, if
 9 you can work from the home, or decides to control access
 10 to money and suddenly you can't be on public transport
 11 in order to go to your job, or will have control of the
 12 bank accounts and so on and so forth.

13 So the effects of all of these things happening, so
 14 the things that were before and the things that happened
 15 during the pandemic, is that, by the end of it -- not
 16 only have women experienced higher rates of domestic
 17 abuse or increased instances of domestic abuse, but by
 18 the end of it, their position is going to be even more
 19 precarious than it was at the beginning.

20 There is a lot that we have seen. And we knew this.
 21 As the pandemic was happening, and I was having
 22 conversations, for example, to access funding, I said to
 23 the funders, "I mean, this is not -- once the healthcare
 24 restrictions ease up, this crisis is going to be lasting
 25 for three to five years after that happens."

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1 movements and not allowing her to leave the house, and
 2 the first time that she did leave the house was to go to
 3 the vaccination centre, and that the vaccinator had
 4 attended training at the Solace Women's Aid refuge space
 5 and was able to identify the signs of abuse, and in fact
 6 arranged for that older woman to go straight to a refuge
 7 from the vaccination centre.

8 So she had it spotted from somebody. But the point,
 9 I suppose, is that because she'd been following lockdown
 10 restrictions, she had been at home with her abuser for
 11 a long time, and there was no outside agency able to
 12 identify that that was happening, and to take measures
 13 to stop it happening.

14 The second example that you give is at page [25],
 15 paragraph 72 of your statement.

16 The statement INQ number for our record
 17 is 000652188, and it's the case study of Josephine.

18 Are we able to display that? We can. Thank you
 19 very much. We're back in business.

20 We can see here that:

21 "Josephine was referred to [Solace Women's Aid]
 22 before the pandemic following serious physical assaults.
 23 After reporting the abuse and seeing her perpetrator
 24 cautioned, she felt empowered. When the pandemic
 25 started, she had minimal contact with her ... key worker

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1 And I have not been proved wrong in what we're
 2 seeing coming to services. So, levels of debt, the fact
 3 that, for example, if you need emergency accommodation
 4 you need to move houses, then suddenly you have to find
 5 new employment.

6 **Q.** Yes.

7 **A.** You know, all of those, all of those situations will
 8 carry on much, much longer, leading to worse outcomes in
 9 terms of equality. And, I would say, not only gender
 10 equality but also racial and ethnic minority equality as
 11 well. When you have two in the same person, then the
 12 effects are going to be much higher and much longer
 13 lasting.

14 **Q.** Yes. I'd like to just pause and reflect upon two
 15 examples of what you've just described, that you give in
 16 your statement. The first is in relation to domestic
 17 abuse victim-survivors who were complying with lockdown
 18 restrictions and so they lost contact with their social
 19 networks. As you've described, perhaps they had been
 20 furloughed, they were spending a lot of time in the
 21 house. And so there were -- well, there was a reduced
 22 opportunity for services to identify that that abuse
 23 that was happening.

24 And at paragraph 65 you describe the example of an
 25 older victim-survivor whose husband was controlling her

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1 due to her demanding role as a key worker. In April,
 2 A&E referred Josephine back to [Solace Women's Aid].
 3 She revealed she had avoided contact because she didn't
 4 want to admit she had moved back in with her abuser.
 5 She explained she felt she had no choice but to do this
 6 because she needed to protect a vulnerable family member
 7 who was shielding, and as a key worker, she feared
 8 infecting them. The abuse had escalated and she felt
 9 trapped. Her key worker then secured temporary
 10 accommodation for her, but the perpetrator persisted
 11 with continued contact attempts, fake social media
 12 profiles, and spreading false information about her to
 13 friends and colleagues."

14 The reason that I wanted to pause on that example is
 15 that the Inquiry heard last week that it wasn't -- it
 16 isn't just victims of domestic abuse who matter; it's
 17 also other family members, and -- but lots of women have
 18 care responsibilities for other family members, and
 19 there needs to be a consideration of the effect of
 20 moving out of the family home, that that will have on
 21 other family members.

22 Is that something which your organisation has
 23 experience of, and how might that lead to a domestic
 24 abuse victim-survivors remaining in the family home
 25 when, really, there is an alternative?

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1 A. Yeah, I mean, we see it a lot, particularly with women
2 with children, that they -- as I said, they're really
3 good at assessing risk, and also at taking
4 responsibility for those under their care.

5 In our experience, part of the problem is that the
6 conditions for them to safely exit situations are not
7 always there. In this case, you know, it was because
8 the family responsibility, but in a lot of the cases
9 that we see, and Southall Black Sisters sees as well,
10 it's because generally they're not offered a place to
11 go.

12 Q. Right.

13 A. So, all of these considerations are always revolving
14 around in the minds of survivors. They're constantly
15 assessing, they're constantly reassessing, and making
16 the decisions that are best for them, given the
17 circumstances.

18 I think one of the key things to -- again, to think
19 about is how we can make those circumstances a lot
20 easier for them, to not only safely escape -- because
21 the second example that you were presenting to us, she
22 left, but she was forced to come back in light of the
23 circumstances.

24 Q. Yes.

25 A. How can we make those circumstances such that survivors

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1 beginning."

2 So both situations appear to have occurred. Some
3 perpetrators abusing for the first time, but others
4 certainly taking advantage of the additional access to
5 the victim-survivors.

6 A. I mean, I'm always a little bit worried about when we
7 make these categorisations. And of course the economic
8 situation in a household will have an impact on the
9 dynamics that are developing within that household. But
10 what we need to remember when we're talking about
11 domestic abuse, is that this is about power and control.
12 Domestic abuse happens where power and control are
13 allowed to exist, where, you know, somebody is able to
14 control another somebody for whatever reason. And it
15 decreases where power and control dynamics are
16 disrupted.

17 So it's difficult to say, you know, that increase in
18 domestic abuse happens because of the economic situation
19 within a household. It's really more about where power
20 and control dynamics are able to flourish, and are able
21 to be exerted. So it might be that, you know, that
22 these perpetrators have exerted power and control in
23 other ways, by different means --

24 Q. Yes.

25 A. -- it wasn't recognised as domestic abuse, and in this

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1 not only can escape the abuse, but can do so in a way
2 that's sustainable for them and for the people under
3 their care?

4 Q. Thank you.

5 In terms of the types of domestic abuse that was
6 seen during the pandemic, I'd just like to put up on to
7 the screen, please, two paragraphs from the Domestic
8 Abuse and Safeguarding Roundtable Summary Report at
9 page 7, and in fact could we please just highlight
10 paragraphs 16 and 17.

11 We'll start with paragraph 16, please. Thank you.

12 "Most representatives suggested that generally, the
13 pandemic did not directly lead to people becoming
14 perpetrators of domestic abuse for the first time.
15 Rather, the greater access to their victims allowed
16 existing perpetrators to carry out abuse more intensely
17 and in different ways. However, there were some
18 instances of perpetrators committing abuse for the first
19 time. The representative for the Convention of Scottish
20 Local Authorities noted that the financial and economic
21 strain of the pandemic put additional pressure on
22 households. They described how it had been reported by
23 frontline services that there were people who had never
24 experienced abuse seeking support because their family's
25 financial situation had led to abusive behaviour

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1 situation, it does become recognised.

2 It might be that victims themselves don't understand
3 what they're experiencing is domestic abuse. As it
4 happens, you know, some of the behaviours are so
5 normalised within society that it becomes very difficult
6 for survivors to understand this is what's happening.

7 Q. Yes.

8 A. I would say, yes, there were cases -- there were cases
9 of new perpetrators and new victims of domestic abuse
10 because the situation enabled those new cases to come
11 forward, and where economics might have been a factor,
12 but it's definitely not the defining factor, as well as
13 perpetrators that saw an opportunity to further
14 perpetrate domestic abuse against their existing or
15 perhaps new victims, which might also be the case.

16 Q. Yes.

17 A. If you remember once we all had to go in -- this is not
18 part of our evidence, but I read in the papers, people
19 decided, who were in new romantic relationships, that
20 they were going to isolate together, and this might be
21 that the victim had not experienced domestic abuse but
22 the perpetrator had perpetrated domestic abuse. So it's
23 really about understanding how the pandemic enabled
24 these dynamics to happen, and to continue uninterrupted.

25 Q. Thank you. I'm going to turn to paragraph 17 in

80

1 a moment and then just ask that we look also at
 2 paragraph 20. But in terms of the exacerbation of
 3 existing patterns of domestic abuse, you provide three
 4 examples in the report -- in your statement. You say
 5 economic abuse, controlling and coercive behaviour,
 6 which you referred to, and also physical and sexual
 7 abuse.

8 **A.** Yes.

9 **Q.** So with that in mind, let's look at paragraph 17 of this
 10 summary report.

11 "The nature of sexual assault in particular also
 12 changed during the pandemic. Rape Crisis England and
 13 Wales saw a rise in complex sexual abuse cases during
 14 the pandemic. For example, those co-habiting with their
 15 perpetrator during the pandemic often experienced
 16 a higher frequency and sometimes severity of rape and
 17 sexual assault given the increased opportunities the
 18 perpetrator had to abuse. As lockdown restrictions were
 19 eased and women were able to access services, Women's
 20 Aid England so there had been an increase in the
 21 frequency and extremity of what victims and survivors
 22 had suffered or were suffering, given they were trapped
 23 in homes with perpetrators for a longer period of time
 24 without a clear escape route."

25 If we just look finally on this topic, please, at

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1 that a victim-survivor has to using a computer, to
 2 contact services or to contact relatives and friends?

3 **A.** It's both the restricting of access, and sometimes it
 4 wasn't as sophisticated as controlling the computer; you
 5 can just pull out the wi-fi out of the router, out of
 6 the socket, and then that's it, no data. But also, in
 7 the use of technology as a method of surveillance. So
 8 you have seen in phones "Find my friends" and suddenly
 9 you're available to whomever is tracking you and of
 10 course much more sophisticated surveillance methods.

11 **Q.** And you also provide examples of a misuse of government
 12 messaging?

13 **A.** Yes.

14 **Q.** And also use of infection control measures as abuse.
 15 Can you give us an example of those types of new
 16 patterns of domestic abuse, please.

17 **A.** Yes. So the misuse of government messaging, it's very
 18 simple. Once you were told to stay home no matter what,
 19 and then the nuances don't come forward until months
 20 later, it's very easy to keep reinforcing the message:
 21 if you leave the house then you're going to be
 22 non-compliant with the required regulations. What was,
 23 at that point, the law of the land.

24 Without necessarily going into what exemptions were
 25 made for survivors of domestic abuse -- not that it was

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1 the experience of Hourglass, which is an organisation
 2 supporting older people experiencing abuse. They:
 3 "... described how sexual abuse cases reported to
 4 [them] towards older people doubled during the pandemic.
 5 They said the majority of their calls related to
 6 familial abuse, with calls relating to abuse perpetrated
 7 by neighbours also increasing significantly during this
 8 period, doubling from 3% to 6%. There was an influx of
 9 cases involving adult grandchildren committing abuse
 10 when staying with their grandparents or
 11 great-grandparents, because their parents worked in key
 12 worker settings and tried to limit their contact with
 13 their children to avoid exposure. Restrictions on
 14 leaving the house gave more of an opportunity for
 15 perpetrators within older people's homes to commit
 16 psychological, sexual and physical abuse."

17 Thank you, we can take that down now.

18 In terms of new patterns of domestic abuse, you
 19 provide four examples in your statement, and this
 20 evidence begins at paragraph 105. You describe
 21 exploitation of pandemic-related fears and
 22 restrictions --

23 **A.** Yes.

24 **Q.** -- of technology-facilitated abuse. Is that where
 25 a perpetrator may seek to restrict the level of access

82

1 clear in the beginning. In the beginning I think it was
 2 more about if you're experiencing harm than actually
 3 saying, "If you're experiencing domestic abuse or other
 4 forms of violence."

5 And then -- sorry, I forgot the second part of the
 6 question. If you can repeat it for me.

7 **Q.** Yes, it was a use of infection control measures as
 8 abuse.

9 **A.** Yes. So, again, if you are being told to stay at home,
 10 or if you have to leave because of work requirements, it
 11 you are a carer or if you work in the healthcare
 12 services, so if you're a cleaner, then the easiest way
 13 to disrupt that is to infect you.

14 And because of that point, is really -- what is
 15 coming through in the news constantly is how scary the
 16 situation is; you will do the best you do to avoid it.
 17 So if I essentially go and tell you, "You know, I'm
 18 going to go out because I'm going to go out", and then
 19 come and cough on you, of course that is a way of
 20 controlling.

21 I would probably just add that one of the things
 22 that we saw during this period that relates to both of
 23 these things is the lack of information made in
 24 different languages, and that might include other
 25 languages -- we use Spanish and Portuguese, but we know

84

1 other languages, including BSL, were not included in
2 this messaging, which made it a lot easier for
3 perpetrators to act with impunity with certain groups.

4 As well as, you know, the clear messaging around how
5 domestic abuse were going to be -- domestic abuse
6 survivors were going to be supported first and foremost,
7 that was also clearly accessible to communities like
8 migrant communities that were subject to immigration
9 restrictions and so on and so forth.

10 It's just about, if you do not have a message that's
11 very clear, very easy to understand, and accessible to
12 people in whatever language they need, then you're
13 giving perpetrators the perfect opportunity to continue
14 exerting power and control over their victims.

15 **Q.** Thank you.

16 Your joint statement, which has been prepared,
17 I know, by all three organisations that make up the
18 DA Group, contains many illuminating examples and case
19 studies of how the pandemic and the restrictions
20 affected women. And I'd like us to look, please, just
21 at one of these. It's the case of Valeria, which begins
22 at paragraph 138.

23 She contacted your organisation for the first time
24 during the Covid-19 lockdown.

25 "She was living with her husband, their two children
85

1 wellbeing.

2 "141. About a month later, Valeria contacted [Latin
3 American Women's Rights Services] again to report that
4 her husband had returned to work and her son had
5 [returned to] school, which significantly eased the
6 tensions at home. The reduction in time spent confined
7 together had led to a noticeable improvement in their
8 relationship dynamics."

9 The case illustrating "how the lockdown period
10 brought to the surface or intensified abuse behaviours
11 that may otherwise have remained hidden or less severe".

12 Thank you very much. We can take that down.

13 I'm going to ask for you to touch briefly, please,
14 upon the impact on service demand and access to support
15 services, because we've covered a lot of this.

16 There was digital exclusion --

17 **A.** Yes.

18 **Q.** -- as we've touched upon. Lack of safe spaces for
19 remote access to take place --

20 **A.** Yes.

21 **Q.** -- which you've already described at the beginning of
22 your evidence. And language barriers which existed and
23 continued to exist.

24 In terms of refuge accommodation challenges and
25 challenges in housing and access to disruption
87

1 and her eldest son from a previous relationship. Prior
2 to the lockdown, [she] described her relationship as
3 bearable. While there were occasional disagreements and
4 some controlling behaviours from her husband, the
5 situation had not escalated to what she recognised as
6 abuse."

7 And that's something which you've touched upon this
8 morning.

9 "However, the enforced proximity and pressure of the
10 lockdown significantly altered the family dynamic and
11 exacerbated pre-existing issues.

12 "139. During the lockdown, Valeria reported an
13 increase in verbal, emotional and psychological abuse.
14 He frequently belittled her with comments about how
15 'stupid' and 'useless' he thought she was. She
16 described feeling suffocated and trapped at home with
17 nowhere to go and feeling emotionally worn down by the
18 constant criticism and belittling from her husband. The
19 lockdown brought to the forefront the extent of her
20 husband's controlling behaviour, which had previously
21 been less apparent due to their separate work schedules
22 and activities.

23 "140. Valeria's children also began to witness and
24 experience the increased tension and conflict in the
25 home, which added to her distress and concern for their
86

1 generally, in this area, you describe at paragraph 184
2 something called gatekeeping practices. You say that in
3 housing offices, when domestic abuse victim-survivors
4 approached local authorities for support, there were
5 increases in questions being asked --

6 **A.** Yes.

7 **Q.** -- repeatedly, and evidence being sought for complaints
8 that were being made.

9 Did that have an effect upon the willingness of
10 domestic abuse victim-survivors in going to seek
11 assistance from local authorities?

12 **A.** Yes, of course. I mean, domestic abuse survivors
13 usually are under such pressure, and such stress
14 already, that what they need is a system that will
15 facilitate that. But we saw it with local authorities
16 and housing, as well, even caseworkers at the Latin
17 American Women's Rights Service, we had to spend two,
18 three, four hours to talk to someone about
19 accommodation.

20 The moment that survivors realise that the system is
21 not going to be there for them to help them in this
22 situation they reassess and say, "Okay, so as long as my
23 life is not at risk at this immediate moment, then maybe
24 I can hold off a little bit, go back to an abusive
25 situation."
88

1 Q. Yes.

2 A. So yeah, it has a massive effect. And once -- and once,

3 you know, the statutory services, housing and others, it

4 might be healthcare, it might be the police, continue

5 putting barriers in front of survivors, what will happen

6 is that the narrative brought forward, usually by

7 perpetrators, "Nobody cares, nobody will help you",

8 starts become a reality for the survivors.

9 So it will disincentivise survivors being able to

10 come forward because what they're seeing is that the

11 perpetrator is correct. Nobody cares and nobody helps.

12 So, "I'll do what I have to do in order to stay as safe

13 as possible."

14 Q. Yes.

15 A. And that might mean remaining in abusive situations for

16 longer.

17 Q. And you describe in your statement how some initiatives

18 which were brought into force by the government such as

19 the Everyone In initiative scheme, had many positive

20 impacts, but of course there were challenges for, for

21 instance, women with no recourse to public funds --

22 A. Yes.

23 Q. -- who feared losing their immigration status if they

24 accessed the scheme.

25 What measures, in your opinion, would have helped to

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1 A. -- very complex for survivors themselves to come and ask

2 for support as well as for statutory services to provide

3 it because the messaging is so complicated.

4 Q. Confused.

5 A. A very broad lifting of no recourse to public funds

6 would have had a significant effect because then both

7 sides of the conversation would know: you have access to

8 state support for the duration. Which was possible. We

9 saw it with the furlough scheme. We saw it with other

10 schemes. Resources were made available to support other

11 areas of the population that the government knew were

12 going to be highly impacted by the pandemic, but what

13 I cannot, to this day still, understand is why victims

14 of domestic abuse did not have that same level of

15 response, of, you know, consideration from the

16 government, which would have been, I would say, probably

17 no more impactful on the economy than, you know, the

18 furlough scheme.

19 Q. Yes, we have to be careful because we aren't

20 a decision-making module --

21 A. Sorry.

22 Q. No, no, you don't need to apologise, but your evidence

23 is clear on that point.

24 But despite the challenges, the three organisations

25 that make up the DA Group developed innovative

91

1 make that scheme, taking that as an example, more

2 effective for women with no recourse to public funds to

3 help mitigate the impacts of the pandemic?

4 A. I mean, I think women with no recourse to public funds

5 should have had that condition lifted for the duration

6 of the pandemic, as an emergency measure in making sure

7 that we're not putting them at risk, for the simple

8 reason that, with schemes like Everyone In, there's

9 a big problem with mixed accommodation, for example, so

10 you might be able to access something but you would have

11 to be strict homeless in order to access Everyone In,

12 but you don't know who is going to be your neighbour in

13 that accommodation.

14 If you have children, then the risk of something

15 happening to you or your children increases as well as

16 the mental health effects of being in an unsafe

17 environment. So moving from a very unsafe environment

18 to a slightly less unsafe environment, but continues to

19 be unsafe. One of the things that we saw at the

20 beginning of the pandemic was very simple messaging with

21 very broad measures: stay home, stay safe, save others,

22 you know, support the NHS. But with no recourse to

23 public funds, well, I mean, if you fill these conditions

24 maybe you can access this. If you -- so it's --

25 Q. Yes.

90

1 approaches, didn't they, in order to maintain support?

2 Can you tell us what those were, please.

3 A. Yes, I mean, for some of us it meant moving completely

4 to online remote provision.

5 Q. Yes.

6 A. And that might have been over the phone, over chat, over

7 websites. There were multiple innovations that were

8 done. But I have to say that for some of us it meant

9 going into the community and remaining within the

10 community to make sure that those women that would have,

11 for example, barriers to access technology would still

12 be able to access services.

13 Q. Yes. Some of the challenges that were apparent related

14 to the impact of the pandemic and lockdown on law

15 enforcement, didn't they?

16 A. Yes.

17 Q. I'd like to turn now to look briefly at that.

18 And were those challenges involving both access to

19 legal support and legal advice, and also delay in court

20 proceedings?

21 A. Yes.

22 Q. Yes. You tell us at paragraph 228 in the statement that

23 the pandemic caused huge delays to getting

24 victim-survivors legal support, solicitors were working

25 over capacity. It became challenging to find somebody

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1 to provide that legal advice.

2 **A.** Yes.

3 **Q.** And court delays became severe. The impacts, as I'm
4 sure everybody in the country is aware, have persisted
5 beyond the end of the pandemic.

6 But I'd like to ask you in particular about family
7 law proceedings, because at paragraph 231 in your
8 statement, you say that, as well as criminal and civil
9 cases, family law proceedings were affected in a similar
10 way. There were long-term consequences of delays in
11 those hearings that were either postponed or cancelled
12 due to lockdowns, and that had a direct effect on, for
13 instance, Non-Molestation Orders or child protection
14 proceedings.

15 **A.** Yes.

16 **Q.** How were your organisations able to provide support in
17 relation to these delays and lack of access to justice
18 procedures?

19 **A.** Well, where it was possible, we increased our reach.

20 **Q.** Yes.

21 **A.** We work overtime, we work with others in trying to do
22 this. In some cases, for example, we were asked to
23 provide translation services, and case workers just did
24 that, in order to enable that to happen. Generally, we
25 continued doing what we have been doing for a very long

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1 The Every Story Matters team heard from victims and
2 survivors of domestic abuse who were confined with their
3 abusers without any opportunities to escape their home
4 for respite. They told us about how scary and stressful
5 it was to be unable to leave their homes. Some told us
6 about how they were unable to access support services
7 that had previously helped them. Children's and young
8 persons' experience of domestic abuse or living in
9 a household with domestic abuse during the pandemic are
10 explored further in the Module 8 Every Story Matters
11 record.

12 But one contributor from England told the Every
13 Story Matters team:

14 "Being on my own with no support didn't bother me at
15 first, but when I had to deal with re-triggering
16 domestic abuse from my youngest's father, I felt
17 terrified, isolated, and very alone. I'd had support in
18 place before, but couldn't access the services needed
19 once the pandemic hit. I was scared and couldn't sleep
20 in case my ex came around drunk. The stress was
21 intense. I couldn't focus [on my PhD] and was also
22 trying to balance homeschooling. I'd be scared of
23 coming home to find my ex waiting, or worse still, in
24 the house."

25 Does that chime with the experiences that your

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1 time, which is to support survivors within the existing
2 conditions in the best way that we are able to.

3 But really, really, really, you know, it was a lot
4 of case worker, frontline worker, key worker hours, put
5 into that in order to facilitate those processes,
6 because we knew that the longer these things were going
7 to take place, the higher the risks for survivors, and
8 often for their children, were going to be.

9 **Q.** Thank you.

10 Let's look briefly, please, at the impact of the
11 pandemic and lockdown on health and wellbeing. You tell
12 us that the pandemic had profound and lasting effects on
13 the health and wellbeing of domestic abuse
14 victim-survivors. The combination of intensified abuse,
15 isolation from support networks, and reduced access to
16 mental health services, all of which we've covered,
17 created a perfect storm of psychological distress that
18 continues to affect some victim-survivors today.

19 **A.** Yes.

20 **Q.** I'd like to display, please, the Every Story Matters
21 mental health and wellbeing record. It's at
22 INQ000659895, at page 35.

23 And we can see here that this section of the record
24 relates to impact on victims and survivors of domestic
25 abuse.

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1 organisation was hearing about?

2 **A.** Yes. Definitely. As this case was being read, I was
3 thinking about the case that we put in our evidence from
4 Mariela, where she was saying, "I work as a cleaner in
5 St Thomas' Hospital. I am the one who cleans after they
6 take the bodies of people who died from Covid-19, and
7 I still feel safer than at home."

8 So the experiences are quite similar. I think the
9 effects of living through domestic abuse in an isolated
10 context, where there is a massive gap -- and we heard
11 that from testimony earlier today from Mind -- when they
12 gave testimony last week --

13 **Q.** Yes.

14 **A.** -- the fact that the support is just not there, and
15 you're trying to scramble -- how to deal with the
16 situation, without having the tools that would make it
17 much more bearable, became a massive crisis.

18 And I think, for survivors of domestic abuse, we're
19 going to continue seeing the effects of all of this
20 happening to them at the same time for a very long time.

21 **Q.** Thank you.

22 Turning to lessons learned. You've covered many of
23 them during the course of your evidence, Ms Valle.
24 I will seek to summarise what appears at the end of your
25 statement, and please feel free to add any which you

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1 want to add.
 2 Earlier interventions and funding.
 3 **A.** Yes.
 4 **Q.** A comprehensive messaging, clear messaging, and
 5 guidance.
 6 **A.** Yeah.
 7 **Q.** Joined-up services, improved coordination. That's in
 8 relation to public services, schools, medical services
 9 and frontline charities.
 10 Considering and dealing with long-term housing
 11 challenges.
 12 Recognition of key workers.
 13 And data collection, which the Inquiry has heard
 14 a lot of complaint about. Improved data collection --
 15 **A.** Yes.
 16 **Q.** -- across all of those who are likely to suffer domestic
 17 abuse.
 18 Is there anything that you would like to add to
 19 that?
 20 **A.** I think I would say that we need to have a much better
 21 understanding of how different groups are going to be
 22 affected disproportionately by this, and what measures
 23 need to be in place in order to support these
 24 differences.
 25 As we were talking about data, it keeps reminding me

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1 something with it?
 2 With the domestic abuse it is very simple. I mean,
 3 The Guardian reported that the increase in cases of
 4 domestic abuse was coming. And yet it takes -- it look
 5 a very long time to find the funding and put it in place
 6 in order for us to support these women.
 7 A lot of the things we had to do, and I know that
 8 our evidence covers things like burnout, we had to do it
 9 ourselves.
 10 **Q.** Yes.
 11 **A.** So I would say we need to understand much, much better
 12 who is going to need what kind of support much faster,
 13 you know, through the use of reliable data. We need to
 14 put measures in place that are broad reaching enough and
 15 simple to understand enough to have the effect of
 16 supporting these groups, and we need to seriously look
 17 at how the disproportionate effects in particular groups
 18 are going to have a much wider effect on the totality of
 19 the population.
 20 We talk about, you know, Mariela who was a cleaner
 21 at a hospital, who is in a hospital setting in context
 22 with healthcare providers, and in contact with, you
 23 know, people who are coming to access healthcare
 24 services in the context of a pandemic, and yet we don't
 25 give enough consideration as to how putting her at

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1 how the women that come through our services, for
 2 example, are almost always absent from this data, either
 3 from statutory services like the police, or sometimes
 4 from national charities, just because these women are
 5 not going to access those services.

6 At the same time, although the whole country
 7 experienced what was a really difficult, life-changing
 8 moment, the way that the women coming through our
 9 services experienced it was, if it's possible, much
 10 bigger in terms of scale and in terms of the disruption
 11 to multiple areas of their lives.

12 At this moment, two things that are very key are
 13 going to continue to happen. So while housing,
 14 healthcare, police, and others are almost impossible to
 15 access, the enforcement of border controls will remain
 16 intact. So you will have problems contacting the
 17 police, but the police will experience no disruption
 18 whatsoever in informing the Home Office Immigration
 19 Enforcement Team.

20 We know that because of lack of access to
 21 healthcare, the health situation of these survivors was
 22 much more precarious, and yet the provisions are not
 23 made in how can we take into consideration these
 24 pre-existing disadvantages that will have
 25 disproportionate effects on these populations and do

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1 higher risk of domestic abuse, of getting sick, of
 2 falling destitute, will create a higher risk further
 3 down the line, and so on and so forth.
 4 So I think it is understanding the differences that
 5 will put people at risk, women, children, you know,
 6 black and minoritised communities, migrant communities,
 7 to put the measures in place quickly, to address this,
 8 and to link how the different areas of life are going to
 9 impact these same communities to the detriment of the
 10 entirety of the population.
 11 Because again, these were our health workers, these
 12 were our carers, these were our cleaners, these were,
 13 you know, all the people that we said were essential
 14 during the pandemic were put at risk unnecessarily.
 15 **Q.** Yes.
 16 **A.** So better measures to be put in place, we know about the
 17 funding, we know about the suspension of certain
 18 conditions, we know about data collection. But it's
 19 really about having a much more nuanced picture that
 20 allows us as a country to respond to a pandemic in
 21 a much more prepared way when the next one comes on.
 22 **MS BLACKWELL:** Thank you very much, Ms Valle.
 23 My Lady, that concludes my questions.
 24 You have given permission for a question to be asked
 25 on behalf of migrants rights consortium by

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1 Ms Weeraratne, King's Counsel.

2 **LADY HALLETT:** Thank you.

3 Ms Weeraratne.

4 **Questions from MS WEERERATNE KC**

5 **MS WEERERATNE:** Thank you very much.

6 Thank you, my Lady.

7 Ms Valle, I act for the Migrants' Rights Consortium.

8 A key concern for us is understanding and the planning

9 for migrants excluded from essential services --

10 **A. (Witness nodded)**

11 **Q.** -- and subject to NHS charging and data sharing with the

12 Home Office.

13 **A.** Yes.

14 **Q.** You've just been asked about data sharing, and at

15 paragraph 236 in your witness statement you deal with

16 data sharing between the police and the Home Office.

17 **A.** Yes.

18 **Q.** You discuss a firewall --

19 **A.** Yes.

20 **Q.** -- recommended by three independent police watchdogs for

21 the purpose of preventing all communication and data

22 sharing between the police service and the Home Office

23 on migrant victims of crime, obviously including

24 domestic abuse, in the interests of bringing to justice

25 individuals breaking the law?

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1 Immigration Enforcement actually takes action against
2 the victim that is trying to come forward for whatever
3 reason.

4 So what we have found is that migrant victims are

5 generally prevented from reporting crime to police

6 because the fear of the data sharing is so high that

7 they would rather take the risk of, you know, continuing

8 in domestic abuse situations and other types of

9 situations.

10 We did some research in 2019, when it was very clear

11 that --

12 **LADY HALLETT:** I'm sorry to interrupt, could you make sure

13 we keep to the pandemic as opposed to the general

14 principle, Ms Valle. Thank you.

15 **A.** Yes.

16 So we understood that survivors who were subject to

17 immigration control were unlikely to come forward during

18 the pandemic, because of the fear of data sharing, and

19 the fact that no provision was made to stop data sharing

20 to enable these survivors to come forward.

21 **MS WEERERATNE:** And just to answer the question that my Lady

22 has just posed, and that was something you saw during

23 the pandemic, and was there a difference at that time?

24 **A.** So we saw that before, during, after the pandemic.

25 I think the biggest difference was perhaps how the data

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1 **A.** Yes.

2 **Q.** Now, this firewall recommendation was responded to by

3 the Home Office in a review that it then conducted in

4 December 2021.

5 **A.** Yes.

6 **Q.** And there's a report that you refer to. And you say

7 that the Home Office rejected this recommendation --

8 **A.** Yes.

9 **Q.** -- for a firewall, and the proposal for either a full or

10 time-limited firewall was a complete refusal?

11 **A.** Yes.

12 **Q.** So the question is this: whether your group of

13 organisations has seen or are able to say what was the

14 impact of that decision on migrant victims of crime

15 during the pandemic?

16 **A.** I think you can see from the evidence provided on the

17 lack of increase of reports to the police, there's

18 a correlation that can be made. We know that migrant

19 victims of crime generally don't come forward, because

20 it's unsafe for them to do so, because, instead of

21 having the crimes they're trying to report, like

22 domestic abuse, sexual abuse, and other criminal

23 activity, their data is shared with Immigration

24 Enforcement. And that leads to a lack of police

25 investigating the actual crime being reported, whilst

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1 sharing, kind of, compounded other restrictions at the

2 time, that made, you know, survivors less likely to

3 approach to the police as they would, you know, services

4 like ours.

5 So, I think, you know, the fact that you have more

6 or less little change in police data around reporting

7 but very high change in terms of, you know, the demand

8 for services, really talks about, you know, survivors

9 not coming forward.

10 In the case of migrant survivors, it was generally

11 understood that because the data sharing was maintained,

12 unless the situation was really high risk, they would

13 not approach statutory services. The police, first and

14 foremost, but not the only one. We know that, you know,

15 other statutory services, like healthcare services, for

16 example, also shared data with the Home Office, and we

17 know the effect that that has is that, generally,

18 migrant communities, victims of crime and otherwise,

19 will stay away from those statutory services.

20 **Q.** And just to complete that, so I think what you're saying

21 is that the fear of coming forward, the fear of

22 affecting immigration status through reporting and data

23 sharing, is one that prevented migrants from accessing

24 services? Is that --

25 **A.** That's correct, yes.

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1 **MS WEERERATNE:** Thank you very much.
 2 **LADY HALLETT:** Thank you very much.
 3 Thank you very much, Ms Valle. I appreciate you've
 4 got an awful lot to tell me, but as you know, I've got
 5 to focus on this module, and it's really important
 6 stuff, I do understand that and I do understand why you
 7 occasionally went a little bit off piste but I'll
 8 forgive you because I know how important it is.
 9 So thank you very much for your help with the
 10 Inquiry, obviously producing the report and being such
 11 a very good advocate for the cause that you and your
 12 colleagues support and it's a really worthy cause and
 13 thank you for the work you do.
 14 **THE WITNESS:** Thank you very much.
 15 **MS BLACKWELL:** My Lady, that completes this morning's
 16 evidence. May we pause for lunch, please?
 17 **LADY HALLETT:** Certainly. You probably need a break,
 18 Ms Blackwell.
 19 **MS BLACKWELL:** Yes.
 20 **LADY HALLETT:** I shall return at 2.15.
 21 **MS BLACKWELL:** Thank you very much.
 22 (1.15 pm)
 23 (The Short Adjournment)
 24 (2.16 pm)
 25 **MS BLACKWELL:** My Lady, good afternoon, can you see me and
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1 of you.
 2 For our reference it's INQ000588214.
 3 Can you each confirm, please, that that is the
 4 expert report that you have provided jointly for the
 5 purposes of Module 10?
 6 **PROFESSOR BÉCARES:** That's right.
 7 **PROFESSOR NAZROO:** Yes, it is.
 8 **Q.** Thank you. And that the facts stated in the report are
 9 true to the best of your knowledge and belief?
 10 **PROFESSOR BÉCARES:** They are.
 11 **PROFESSOR NAZROO:** Yes.
 12 **Q.** And that any opinions you have stated in your report
 13 represent your true and complete professional opinions?
 14 **PROFESSOR BÉCARES:** They do.
 15 **PROFESSOR NAZROO:** Yes.
 16 **Q.** Thank you, both, very much.
 17 By way of introduction, Professor Bécares, you are
 18 Professor of Social Science and Health at the Department
 19 of Global Health and Social Medicine in the Faculty of
 20 Social Science and Public Policy at King's College
 21 London. You have researched and published on the role
 22 of structural and societal determinants in leading to
 23 health inequities over years, and this includes
 24 examining the unequal impact of Covid-19 pandemic on
 25 LGBTQ+ populations and on minoritised ethnic groups.
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1 hear me?
 2 **LADY HALLETT:** I can, thank you, Ms Blackwell.
 3 **MS BLACKWELL:** Thank you very much.
 4 My Lady, this afternoon's witnesses are
 5 Professor Laia Bécares and Professor James Nazroo. May
 6 they be sworn, please.
 7 **PROFESSOR LAIA BÉCARES (affirmed)**
 8 **PROFESSOR JAMES NAZROO (affirmed)**
 9 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 10**
 10 **MS BLACKWELL:** Professor Bécares, will you give your full
 11 name, please.
 12 **PROFESSOR BÉCARES:** Laia Bécares.
 13 **Q.** Thank you.
 14 And Professor Nazroo, your full name, please.
 15 **PROFESSOR NAZROO:** James Nazroo.
 16 **Q.** Thank you, both, very much, and welcome back.
 17 I understand that you have both previously given
 18 evidence, in Module 2, and you have kindly agreed to
 19 provide Module 10 with reports on unequal impact of the
 20 pandemic in relation to your areas of expertise.
 21 We will begin with your joint report, please, and
 22 then move on to deal with your individual reports. Your
 23 joint report is on the impact of the pandemic on racial
 24 and ethnic inequalities across the UK.
 25 You should each have a copy of the report in front
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1 And you serve as a member of the Academic Reference
 2 Group of the NHS Race and Healthcare Observatory?
 3 (No audible answer)
 4 **Q.** And, Professor Nazroo, you are Professor Emeritus of
 5 Sociology at the University of Manchester, you were
 6 previously a fellow of the Academy of Social Sciences,
 7 a fellow of the British Academy, Professor of Sociology
 8 at the University of Manchester, and Professor of
 9 Medical Sociology at University College London. And for
 10 more than 30 years you have conducted research on issues
 11 of inequality, social justice and health, with a focus
 12 on ethnicity and race, ageing, gender and the
 13 interrelationships between all of those.
 14 **PROFESSOR NAZROO:** Yes.
 15 **Q.** Thank you very much.
 16 And finally, Professor Nazroo, amongst other roles,
 17 you were founding director of the interdisciplinary
 18 Manchester Institute for Collaborative Research on
 19 Ageing, and a member of the governing board on the NHS
 20 Race and Health Observatory and co-chair of its Academic
 21 Reference Group.
 22 The report which you have provided for Module 10
 23 builds on your Module 2 report and really continues
 24 where that left off.
 25 In the Module 2 report, you discussed the situation
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1 across the UK so far as racial and ethnic inequalities
2 were concerned, going into the pandemic.

3 And in the Module 10 report, you discuss the impact
4 of the Covid-19 pandemic on racial and ethnic
5 inequalities, and you describe the existence and extent
6 of inequalities, and discuss the causes of those
7 inequalities.

8 At paragraph 2 of your report, you say that you are
9 not consistent with terminology throughout the report,
10 because you describe a reflection of categorisation of
11 ethnicity that occurs in the evidence that you cite. So
12 you repeat the way -- or the manner in which that occurs
13 in the research papers and administrative data that
14 you've come across.

15 In Module 2 you concluded that people from ethnic
16 minority groups were at heightened risk of becoming
17 infected with Covid-19, something which you both agreed
18 was foreseeable and which the government took too long
19 to recognise.

20 You reflect a lack of data, a lack of action, and
21 you recommended a framework for each government of the
22 United Kingdom for considering those at risk in an
23 emergency.

24 The first question I want to ask, and I'll come to
25 you, please, Professor Nazroo, is in relation to race

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1 **Q.** Thank you. I'm going to remain with you, if I may,
2 Professor Nazroo, to discuss the increased risk of
3 infection and Covid-19 related mortality.

4 At paragraph 16 you tell us that in relation to data
5 gaps, prior to the Covid-19 pandemic, there were no
6 adequate sources of information on the health of ethnic
7 minority people in the constituent countries of the UK,
8 nor for the UK as a whole; is that right?

9 **PROFESSOR NAZROO:** That's correct.

10 **Q.** And it wasn't until June of 2020 that national data
11 covering England and Wales was published on the extent
12 of those inequalities?

13 **PROFESSOR NAZROO:** That's also correct. So it wasn't until
14 ONS did some quite heroic research doing data linkage,
15 and they had to use data linkage because other data
16 sources weren't available, in order to describe
17 differences in risk of mortality.

18 Can I just add a tiny bit of context, which is that
19 data sources historically have existed, in England, at
20 least, to describe ethnic differences in health across
21 different ethnic groups in the UK, but those data
22 sources effectively ended data collection in the early
23 part of the 20th century.

24 **Q.** Thank you. And do there remain serious limitations with
25 data sources?

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1 equality legislation. Is it broadly similar across the
2 nations of the United Kingdom, or are there differences,
3 and if so, are those differences significant?

4 **PROFESSOR NAZROO:** So the legislation is broadly similar
5 across the different nations of the UK. The population
6 composition varies across the different nations of the
7 UK but the legislation is similar.

8 **Q.** Thank you.

9 Within your report, do you present evidence,
10 however, mainly from England, and is that due to the
11 availability and coverage of the datasets?

12 **PROFESSOR NAZROO:** That's correct. So the majority of data
13 that are available to describe the situation of ethnic
14 minority people within our societies is broadly drawn
15 from England. There are some exceptions but broadly
16 from England. But even within England, the data, there
17 are significant data limitations.

18 **Q.** Thank you. And overall in your report, do you find that
19 there have been clear and stark ethnic inequalities in
20 infection and mortality rates, in testing, monitoring
21 and vaccination, and in health and health behaviours and
22 health care?

23 **PROFESSOR NAZROO:** Again, that's correct. In almost every
24 area that we examined we found important ethnic
25 inequalities.

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1 **PROFESSOR NAZROO:** So consequently there remain those
2 serious limitations, and they exist despite the data
3 linkages that have been made.

4 **Q.** Thank you. Proximal factors related to ethnic
5 inequalities in risk of infection and mortality, what
6 were these?

7 **PROFESSOR NAZROO:** So they are a range of factors that are
8 described as being important contributors to both risk
9 of infection and of course, following infection, risk of
10 mortality.

11 **Q.** Yes.

12 **PROFESSOR NAZROO:** So these include where people live, the
13 kind of housing they have, the various socioeconomic
14 inequalities that they face, area deprivation, types of
15 jobs, income, and so on. The types of jobs that people
16 did and how those types of jobs placed them at greater
17 or lesser extent in terms of risk of infection, and
18 crucially important also was pre-existing health
19 inequalities.

20 **Q.** So including chronic illness?

21 **PROFESSOR NAZROO:** Including chronic illnesses in effect,
22 yeah.

23 **Q.** Yes, and when you refer to those factors, are you
24 referring to the same or different elements of clinical
25 vulnerability?

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1 **PROFESSOR NAZROO:** So there could be -- some of them could
2 be described as clinical vulnerability. Clinical
3 vulnerability, as I understand it, requires a kind of
4 formal measurement of a range of conditions that people
5 might have.

6 **Q.** Yes.

7 **PROFESSOR NAZROO:** We, in some of our research, have used
8 a slightly less formal measure to try and assess the
9 extent to which people have poor health.

10 **Q.** Thank you. Taking some of those factors individually,
11 is it noteworthy that ethnic minority people were more
12 likely than white people to be employed in key worker
13 roles, and more likely to be working in client-facing
14 roles and consequently more likely, therefore, to be
15 exposed to the virus?

16 **PROFESSOR NAZROO:** Yes, again that's correct. So there are
17 a whole range of employment positions where ethnic
18 minority people are more likely to be present and led to
19 a greater exposure to the virus, and in some of those
20 employment conditions, ethnic minority people appear to
21 be less likely to have access to PPE.

22 **Q.** Thank you. We'll come on to deal with that in a moment.

23 And in terms of geographical areas was it much more
24 likely that ethnic minority people were living in
25 densely populated urban areas, rather than white people

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1 housing represent and in effect, it represents
2 deprivation.

3 **Q.** Thank you.

4 Moving, then, to deal with the risk of Covid-19
5 related mortality, you tell us at paragraph 24 and 25
6 that:

7 "It is noteworthy that prior to the Covid-19
8 pandemic, mainstream academic and policy work generally
9 ignored, or downplayed, the significance of ethnic/race
10 inequalities in health."

11 And that:

12 "The question of the risks experienced by ethnic
13 minority people emerged during the early stages of the
14 Covid-19 pandemic when anecdotal evidence reported in
15 mainstream and social media, began to indicate
16 meaningful ethnic inequalities in outcomes."

17 Is that right?

18 **PROFESSOR NAZROO:** Yes, so in the early stages of the
19 pandemic, there were some very important media reports,
20 some very important media-led investigations, as well as
21 some small-scale studies that all began to reveal the
22 extent of the ethnic inequality and risk of mortality.

23 **Q.** Thank you. And then later, towards the end of
24 April 2020, there was evidence published by The Guardian
25 and Times newspapers based on their own research which

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1 as the pandemic began?

2 **PROFESSOR NAZROO:** So ethnic minority people, geographical
3 concentration is in more densely populated areas, in
4 urban areas. It reflects the history of settlement of
5 migrant populations and then ongoing employment
6 opportunities, housing opportunities, et cetera.

7 I think in the early stages of the pandemic very
8 important was the concentration of ethnic minority
9 people in London where early exposure to the virus was
10 common. Yeah.

11 **Q.** And in addition to the urban or -- and/or deprived
12 areas, was there also a greater proportion of ethnic
13 minority people in overcrowded housing?

14 **PROFESSOR NAZROO:** Again, overcrowded housing was a risk
15 factor for infection, and for mortality. Ethnic
16 minority people are more concentrated in overcrowded
17 multi-generational housing. This type of housing was
18 particularly important when it was present in deprived
19 areas, so it's overcrowded housing in deprived areas
20 that was crucially important.

21 Importantly, once you take into account a range of
22 other factors, overcrowded housing itself did not
23 contribute to a massive extent -- did not contribute to
24 a great extent to the ethnic inequalities in risk of
25 mortality. So the question is, what does overcrowded

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1 indicated that ethnic minority people represented 19% of
2 deaths recorded in hospitals, and that areas with
3 a higher proportion of non-white, ethnic minority people
4 had experienced higher death rates.

5 **PROFESSOR NAZROO:** Yes, that's correct. That is what I was
6 referring to just now.

7 **Q.** Thank you. Then later on, still in June of 2020, the
8 ONS published their data.

9 **PROFESSOR NAZROO:** Yes, so in the period -- I'm not sure
10 when they started that research, but over a very short
11 period they then produced the linked dataset and
12 published the national figures.

13 **Q.** Thank you.

14 Could we display please, in your report, which is
15 INQ000588214, there we are, thank you, page 8, highlight
16 figure 1 at the bottom of the page.

17 This is a figure that shows ethnic and religious
18 inequalities in risk of Covid-19 related mortality in
19 England for the period 24 January 2020 to
20 11 September 2020. A adjusted -- age adjusted hazard
21 ratio comparing with white British people and
22 Christians.

23 Can you explain what we are looking at here, please,
24 Professor Nazroo?

25 **PROFESSOR NAZROO:** Yes, so because it's a hazard ratio it's
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1 risk compared with white British people.

2 **Q.** Yes.

3 **PROFESSOR NAZROO:** And so the white British group are, in
4 effect, represented by the line 1, so the horizontal
5 line 1, which in this case is at the bottom of the
6 graph.

7 **Q.** Yes.

8 **PROFESSOR NAZROO:** And any bar that is above the graph shows
9 an increased risk, an increased risk to the extent of
10 the size of that bar. You'll see there black I bars
11 that are attached to each of the bars and those
12 represent statistical confidence. So it's not certainty
13 but statistical confidence. And if that bar does not
14 cross the line 1, the horizontal bottom line, then you
15 can judge that difference to be statistically
16 meaningful.

17 Real meaning, of course, comes from the size of the
18 bars and you can see that some of those bars are very
19 high. Most of them are higher than we would expect to
20 see for most conditions, even though we were aware of
21 inequalities in health generally. So a difference of 2
22 is a very, very large difference.

23 There are two groups here where the difference is
24 not statistically significant: one is white other women,
25 and the other is white Chinese women. For every single

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1 "A crucial question, then, is how far this increased
2 risk of infection during the Covid-19 pandemic led to
3 the increased risk of mortality experienced by ethnic
4 minority people, or whether other factors were also
5 present."

6 And what did you find in relation to that question?

7 **PROFESSOR NAZROO:** So the existing research evidence makes
8 it very difficult to interpret the answer to that
9 question. So what we see are higher rates of infection,
10 and we see higher rates of mortality. They sort of
11 mirror each other. But it's very hard to make the
12 translation because we don't see the same people through
13 the pathway from pre-infection to infection to illness
14 to admission to a hospital to potential mortality. So
15 we don't have that pathway clearly laid out.

16 But it's clear that increased rates of infection
17 played an important role but it's also quite probable
18 that other factors were also -- so increased
19 vulnerability post-infection also played a role, and
20 I also argue, we also argue, that there are issues
21 around treatment that also may be important as well.

22 **Q.** Yes, thank you.

23 Could we display, please, at page 11 of your joint
24 report, and highlight table 1 .1, the top of the page.

25 Thank you very much.

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1 other group the risk is raised.

2 **Q.** Yes. And particularly so for male black African?

3 **PROFESSOR NAZROO:** Male black African is an incredibly high
4 rate but the rate for male Bangladeshi -- well, anything
5 that is at or approaching 2 is incredibly high. And
6 even ones that are 1.5, in pre-Covid research, we would
7 have considered to be very meaningful.

8 **Q.** Thank you.

9 Yes, thank you, we can take that down, please.

10 What do the studies that you have been able to
11 access tell us about the risk of infection, rather than
12 the risk of mortality?

13 **PROFESSOR NAZROO:** So the studies on risk of infection,
14 because of the nature of the science that was being
15 carried out were not really published until wave 2 of
16 the pandemic, but they did cover wave 1 of the pandemic,
17 and they were studies that were basically sending people
18 test kits and then receiving them back and analysing
19 them. And they showed only for very broad ethnic
20 groups, they didn't have enough samples to split them
21 down in the way that ONS did in that analysis, so it was
22 white versus Asian, versus black, versus mixed, versus
23 other. And they showed higher rates of infection for
24 the non-white groups compared with the white groups.

25 **Q.** Thank you. At paragraph 37 of your report you say:

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1 This shows "Ethnic difference in risk of adverse
2 Covid-19 outcomes". So what do we see here, Professor?

3 **PROFESSOR NAZROO:** Yes, so this is from one of the studies
4 that did testing and then followed people through the
5 various stages that follow testing, a large sample done
6 over wave 1 of the pandemic, and contains those
7 relatively broad ethnic groups that I described earlier,
8 in comparison with a white group. And what you can see
9 is the higher risk of testing positive for SARS-CoV-2.

10 **Q.** Yes.

11 **PROFESSOR NAZROO:** A higher risk for a hospital-related
12 admission -- sorry, admission to hospital. And then
13 a higher risk for the escalation of treatment into ICU,
14 and a higher risk for mortality.

15 So it shows a pattern where the risk is present at
16 each stage.

17 **Q.** Yes.

18 **PROFESSOR NAZROO:** Unfortunately, as I said, we don't have
19 the same people tracked across these different stages,
20 so we can't unpick what's happening at each stage.

21 **Q.** Thank you. We can take that down.

22 So, moving to your conclusions in relation to this
23 section of your report, and at paragraph 50, you say
24 that:

25 "... as for the evidence presented on inequalities

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1 in risk of ... infection, a substantial portion of
2 ethnic inequalities in risk of Covid-19 related
3 mortality is explained by ethnic differences in
4 geographical location and economic, demographic and
5 pre-existing health factors."

6 And, in summary, the evidence on ethnic inequalities
7 in risk of infection and mortality strongly suggests
8 that both are driven by geography. So, the greater
9 likelihood of ethnic minority people living in urban and
10 deprived locations, socioeconomic inequalities, and
11 occupational segregation.

12 And in relation to occupations, black African and
13 black Caribbean workers are more likely to be employed
14 in key worker roles. And, more specifically, particular
15 occupations had a high risk of mortality, including
16 social care workers, security personnel, sales and
17 retail assistants, bus and coach drivers, and chefs. Is
18 that right?

19 **PROFESSOR NAZROO:** Yes, so that's right, though I slightly
20 misused the word "explanation". As you read it out,
21 I identified that.

22 This is statistical explanation.

23 **Q.** Yes.

24 **PROFESSOR NAZROO:** And then it moves on to some of the
25 detail behind that. But it's important to remember that
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1 **PROFESSOR NAZROO:** So the height of the line shows the
2 proportion of the population who say that they have fair
3 or poor self-rated health, which is a good indicator of
4 people's quality of health.

5 And across the bottom of the chart you can see age
6 groups, and as you go from younger to older, inevitably
7 a higher proportion of people saying that their health
8 is not good.

9 What's important in this chart is the ways in which
10 the lines diverge across age groups, and so when you get
11 to 40 to 49, the lines begin to meaningfully diverge from
12 each other.

13 **Q.** Yes.

14 **PROFESSOR NAZROO:** And then that divergence increases over
15 time.

16 What you see horizontally at the 20% mark -- rather
17 coincidentally, 20% of white English people said that
18 their -- at the age 80-89 said that their health was
19 fair or poor, and if you follow that line backwards, you
20 can see the age group at which the different ethnic
21 groups cross that line. And so the authors of this
22 report, which include Laia and myself, would argue that
23 this represents premature biological ageing in ethnic
24 minority groups, which reflects a life course of
25 exposure to hazard.
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1 those inequalities in where people live, levels of
2 deprivation, types of roles, are driven by a whole host
3 of additional factors related to ethnicity, race and
4 racism.

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

6 Is it also right that ethnic minority women were
7 over-represented in, for instance, social care work and
8 were three times more likely to be in precarious and
9 insecure work?

10 **PROFESSOR NAZROO:** Yes.

11 **Q.** Yes. And the Inquiry has heard some evidence about that
12 in this morning's session.

13 Yes, thank you.

14 In fact, just before we leave this section, could we
15 display figure 3 at page 18, please.

16 Because I just want to ask you, Professor Nazroo,
17 about the ethnic differences in fair or poor
18 self-reported health by age. And this is based on
19 findings from the 2011 census, which I think was also
20 influential in the ONS figures which they were able to
21 produce, it was based on this census. Is that right?

22 **PROFESSOR NAZROO:** Yes, so the 2011 census is the data point
23 that the ONS linked to, because the 2021 census
24 obviously had not occurred at that point.

25 **Q.** Yes. And what do we see here in terms of ages?
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1 **Q.** Thank you.

2 Yes, thank you very much. Could we take that down,
3 please.

4 Professor Bécares, I'm going to come to you now to
5 discuss physical health, please. And in particular, did
6 you find that several studies have documented a number
7 of potential complications relating to Covid-19
8 infection?

9 **PROFESSOR BÉCARES:** Yes. So, we found that people who were
10 hospitalised or had Covid infection were more likely to
11 have renal complications and complications around
12 cardiovascular disease.

13 But also for women, women who had -- pregnant women
14 who were infected with Covid, with the SARS-CoV-2 virus,
15 were twice as likely to deliver a baby that was close to
16 death, that baby, compared to women who are not infected
17 with Covid.

18 **Q.** Thank you.

19 Did you find that in hospitalised patients with
20 Covid-19, South Asian and black ethnic groups had higher
21 risk of cardiovascular and renal complications compared
22 to white patients?

23 **PROFESSOR BÉCARES:** Yes.

24 **Q.** And that South Asian patients were almost twice as
25 likely to experience cardiovascular arrest and almost
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1 50% more likely to experience cardiac ischaemia rather
 2 than white patients?
 3 **PROFESSOR BÉCARES:** Yes. And this relates to pre-existing
 4 conditions around high blood pressure, diabetes, stroke,
 5 and other cardiovascular diseases.
 6 **Q.** Yes, thank you.
 7 And in terms of long-term implications of these
 8 Covid-19 related complications, were those more severe
 9 in ethnic minority people?
 10 **PROFESSOR BÉCARES:** Yes. And particularly if left
 11 untreated, these renal complications and ischaemic heart
 12 disease leads to death, and so the long-term
 13 complications are severe.
 14 **Q.** Yes, thank you.
 15 And at paragraph 128 you tell us that Long Covid has
 16 become an important public issue in the UK, and that
 17 black, mixed, and other ethnic groups have experienced
 18 increased risk of reporting Long Covid symptoms 12 weeks
 19 or more after infection?
 20 **PROFESSOR BÉCARES:** That's right.
 21 **Q.** Do you agree that protective isolation for shielding
 22 households is harder in multi-generational or crowded
 23 homes, common in some minority communities?
 24 **PROFESSOR BÉCARES:** Yes, absolutely. And as James
 25 suggested, evidence shows that people from minoritised

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1 **Q.** Finally, on this topic, I'll just look briefly at three
 2 physical health conditions that may have led to a
 3 worsening of experience during the pandemic:
 4 cardiovascular and renal complications we've already
 5 looked at; and pregnancy, and I think you've already
 6 given us some evidence about that; and finally,
 7 palliative care. Did you find studies reporting an
 8 increased inequity in palliative care with ethnic
 9 minority patients being referred later for palliative
 10 care than white patients?
 11 **PROFESSOR BÉCARES:** Yes, so ethnic minority patients were
 12 referred up to four days later than white patients but
 13 there were also difficulties around providing
 14 translation, translating services for people in
 15 palliative care but also being able to communicate with
 16 family members.
 17 **Q.** Thank you very much.
 18 The Migrant Rights Consortium have provided evidence
 19 to the Inquiry of the significant mental health
 20 challenges faced by migrant communities during the
 21 pandemic, and unfamiliar social structures, financial
 22 insecurity, travel restrictions, pre-existing conditions
 23 and trauma arising from distressing circumstances which
 24 led them to be in the UK, and barriers in accessing
 25 mental health support are issues which they have raised

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1 ethnic groups were more likely to live in overcrowded
 2 and multi-generational households, which led to
 3 difficulties in shielding.
 4 **Q.** Yes, and that exposed the risk for those communities?
 5 **PROFESSOR BÉCARES:** Right.
 6 **Q.** And did that also -- is that also reflected in an
 7 increase in mental health impact?
 8 **PROFESSOR BÉCARES:** Well, difficulties in shielding and
 9 protecting oneself from infection will have led to
 10 increased anxiety and stress, and in mental health
 11 complications, yes.
 12 **Q.** Thank you. At paragraph 132, you say:
 13 "As described in general terms in the mental health
 14 systematic evidence review ... the pandemic, and in
 15 particular non-pharmaceutical interventions implemented
 16 to control the spread of infection, including lockdowns,
 17 social distancing, and the closure of communal and
 18 social spaces, resulted in severe implications for adult
 19 mental health. For ethnic minority groups this was
 20 compounded by increased stress and anxiety about higher
 21 risk of infection for themselves and loved ones ...
 22 increased financial insecurity ... and higher rates of
 23 bereavement due to increased mortality rates ..."
 24 Is that right?
 25 **PROFESSOR BÉCARES:** That's right.

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1 which seem to chime with the evidence that you have
 2 found in your research; is that right?
 3 **PROFESSOR BÉCARES:** That's right, yes.
 4 **Q.** Yes, and this was a subject that was discussed at the
 5 Justice Roundtable event.
 6 Could we put up, please, the Justice Roundtable
 7 report which is at INQ000656301, page 39, thank you very
 8 much.
 9 And let's just have a look at what was discussed and
 10 then contained within the report:
 11 Mental health and wellbeing of migrants and asylum
 12 seekers:
 13 "The representative for Project 17, who work to end
 14 destitution among migrant families with no recourse to
 15 public funds described how the pandemic meant that
 16 migrants and asylum seekers did not have access to their
 17 usual support networks, such as ... libraries for
 18 warmth, using internet facilities at food venues, or
 19 sharing food with friends, all of which affected their
 20 mental health. They also noted that some migrants
 21 lacked access to nearby outdoor spaces for fresh air and
 22 exercise during the pandemic, negatively impacting both
 23 their mental and physical health."
 24 We can then see a quote from Project 17:
 25 "Clients were interrogated for being on the park

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1 bench because they had no garden. They were trapped in
2 their bedrooms then."

3 The report goes on to say:

4 "There was less support available for migrants and
5 asylum seekers during the pandemic, according to the
6 representatives. This included mental health support
7 and a general lack of support available in their own
8 language", which you've made reference to.

9 "Representatives said that this had a negative
10 impact on wellbeing. In particular, Project 17 found
11 that the lack of mental health support available during
12 the pandemic exacerbated migrants' fears that the
13 government would not provide assistance for them or
14 their families. Bail for Immigration Detainees
15 similarly noted that the pandemic and the treatment of
16 migrants during this time fostered a sense that they
17 were not important, reducing their sense of belonging
18 and damaging their mental health."

19 And finally:

20 "I can't remember any additional mental health
21 support [during the pandemic] for people to reach their
22 communities, families and friends."

23 Yes, thank you very much, we can take that down now.

24 What did you find, Professor Bécàres, in terms of
25 levels of physical activity during the pandemic?

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1 particularly acute?

2 **PROFESSOR BÉCARES:** Yes, that's right.

3 **Q.** Thank you. Moving to employment and economic impacts,
4 please, Professor Nazroo.

5 You tell us at paragraph 148 that the occupational
6 profile of ethnic minority workers, particularly those
7 in Bangladeshi, Pakistani, black African and black
8 Caribbean groups, made them more vulnerable to the harms
9 resulting from lockdown measures. Why was that?

10 **PROFESSOR NAZROO:** This relates to the employment sectors
11 that those particular ethnic minority groups worked in.
12 So they were more likely to work in shutdown sectors,
13 more likely to be in precarious employment, by which
14 I mean zero hours, part-time, type contracts without
15 continuity.

16 They're more likely to -- it varies across the
17 different ethnic groups but also more likely to be
18 self-employed, working as sole traders, so in very small
19 businesses that were then vulnerable. A large
20 proportion of ethnic minority workers also work in
21 industries which rely on tips as part of their salary,
22 and of course, tips aren't counted when we think of
23 furlough schemes. And importantly, for various reasons,
24 more likely to be in households where only one of the
25 adults was earning money, which then meant that that

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1 **PROFESSOR BÉCARES:** Well, minoritised ethnic groups were
2 less likely to engage in physical activity and the
3 reason for this is they're more likely, as James
4 mentioned, to live in deprived areas with reduced access
5 to green space but they also were more likely to live in
6 houses, in flats, without a garden and so their access
7 to physical activity is severely limited.

8 **Q.** Thank you. Healthcare services next, please.

9 You tell us at paragraph 144:

10 "Policies implemented to contain the spread of the
11 virus including lockdown and social distancing led to
12 changes in hospital and general practitioner care.
13 Prioritisation of Covid-19 reduced availability of
14 treatment and medical advice for non-Covid-19 care,
15 resulting in healthcare disruptions and unmet needs."

16 What did you find, in terms of ethnic minority
17 people, and in particular, people from black ethnic
18 groups?

19 **PROFESSOR BÉCARES:** Well, the more -- minoritised ethnic
20 groups and particularly people from black ethnic groups
21 were more likely to experience disruptions in
22 healthcare, in particular with GP appointments and
23 scheduled hospital appointments.

24 **Q.** Yes, thank you. And in the first eight to ten months of
25 the Covid-19 pandemic, were those disruptions

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1 particular adult and their employment was crucial for
2 the economic wellbeing of the household.

3 **Q.** Thank you. In terms of impact on ethnic inequalities
4 during the pandemic, and the amplification of those
5 inequalities, at paragraph 158 you say:

6 "The Coronavirus Job Retention Scheme helped
7 compensate for the loss of earnings [of] employed
8 workers who were furloughed."

9 But of course, what you've just told us about the
10 types of employment that many ethnic minority people
11 were employed by, may not have qualified for the
12 Coronavirus Job Retention Scheme.

13 **PROFESSOR NAZROO:** Yes, so if you're on a precarious,
14 zero-hours-type part-time-type contract then it's very
15 hard for your employer to include you in the list of
16 people who are furloughed, even if they are motivated to
17 do so, and if you rely on tips for 20% of your salary,
18 that's not counted, and -- yes, that's all.

19 **Q.** Thank you. At paragraph 163, you tell us about a local
20 study based in Bradford that you found from 2023, which
21 examined differences in the financial circumstances of
22 Pakistani and white British families during the Covid-19
23 pandemic. What did that show?

24 **PROFESSOR NAZROO:** I'm sorry, you're going to have to remind
25 me of ...

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1 Q. Okay, no problem. I can remind you that it showed that
2 early in the pandemic, in both April 2020 and June 2020,
3 Pakistani families were almost three times as likely to
4 report being financially insecure compared with white
5 British families, and were slower to recover from
6 financial insecurity than white British families, who,
7 unlike their Pakistani counterparts, had returned to
8 pre-pandemic levels of financial insecurity by October
9 to December 2020.

10 Is that a study which was surprising to you or not?

11 **PROFESSOR NAZROO:** No, so it wasn't surprising. It was
12 a local study but a very robust study. The crucial
13 thing here is that those findings point to the precarity
14 of employment and recovery post-pandemic from
15 employment. Also very important is the amount of
16 economic resources that people can rely on when they
17 don't have income. So how big your savings pot is, and
18 again, there are variations across ethnic groups in
19 terms of how big that savings pot is and how long that
20 will last for, with ethnic minority groups, except for
21 Indian people having smaller savings pots than white
22 people.

23 Q. Thank you. At paragraph 168 you also reflect upon
24 a study of migrant Polish key workers in precarious
25 employment, but noted that during the pandemic, such

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1 Finally, on this topic, we've received a TUC report
2 from 2022 suggesting that structural racism traps black,
3 Asian and minority ethnic workers in lower paid and
4 insecure work.

5 In terms of access to PPE for black, Asian and
6 minority ethnic workers, do you consider that the
7 disproportionate number of ethnic minority workers in
8 precarious work and not being given access to
9 effective PPE may have had a feature in the level of
10 infection?

11 **PROFESSOR NAZROO:** So, ethnic minority workers not in
12 precarious work were less able to access PPE. So they
13 had lower rates of access to PPE even though they were
14 in secure work.

15 Q. Right.

16 **PROFESSOR NAZROO:** And then in precarious work, of course,
17 those risks are likely to have been amplified.

18 I don't have evidence outside the TUC report on how
19 those risks were amplified, but certainly it was noted
20 in that report.

21 Q. Thank you.

22 And in terms of unequal access to the furlough
23 scheme, how can access to any furlough scheme used in
24 a future pandemic be improved for black, Asian and
25 minority ethnic workers?

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1 workers faced redundancy, pay cuts, reduced hours and
2 unpaid sick leave, with the implication that employers
3 used their precarious employment status to avoid
4 providing them with appropriate financial support. The
5 risk of unpaid sick leave, you say, or job loss, was
6 particularly problematic from a public health point of
7 view, because it incentivised employees not to take time
8 off when they may have had symptoms suggestive of an
9 infection.

10 And again, was that something which was surprising
11 or not to you?

12 **PROFESSOR NAZROO:** So it was not surprising, again. So this
13 study was a focused study, but it echoed findings in
14 more anecdotal pieces of evidence, some -- from across
15 the sector, which pointed to the ways in which
16 precarious employment led to both greater individual
17 risk but then, in order to compensate for that risk,
18 people who were ill continued to work. It's been
19 documented previously --

20 Q. Yes.

21 **PROFESSOR NAZROO:** -- in terms of influenza pandemics as
22 well. And so ethnic minority people continued to work,
23 exposing both themselves and others to the harms of
24 Covid-19.

25 Q. Thank you.

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1 **PROFESSOR NAZROO:** Yeah, so there are clear risks that
2 a furlough scheme will be exploited by bad actors, but
3 nevertheless, if we're to protect the most vulnerable,
4 then we have to be aware of those risks, and take some
5 of them with precaution.

6 In this particular case, people with precarious
7 employment should have access to furlough schemes. They
8 did not straightforwardly in the pandemic. People on
9 zero-hours contracts, again, should be able to have
10 access to those schemes. Those schemes should
11 incorporate more informal sources of income. And
12 importantly, also, people who are working in small
13 businesses, with no resources, with scepticism about
14 whether they would actually get the equivalent in terms
15 of a furlough scheme, should be -- their access to those
16 schemes should be eased.

17 Q. Thank you.

18 Professor Bécares, I'm going to come to you now to
19 discuss housing, and we'll look at five areas if we may.

20 The first, housing quality. You say at
21 paragraph 171 that:

22 "Ethnic inequalities in housing conditions during
23 the pandemic were stark across multiple domains. Ethnic
24 minority households experienced significantly higher
25 rates of damp conditions and overcrowding [which we've

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1 already discussed] than White British households."
 2 Is that right?
 3 **PROFESSOR BÉCARES:** That's right.
 4 **Q.** Thank you.
 5 Is there sufficient data in terms of this area?
 6 **PROFESSOR BÉCARES:** Yes. So, we know in England, for
 7 example, that people from black Caribbean, Bangladeshi,
 8 Pakistani ethnic groups are more likely than white
 9 people to live in houses with damp.
 10 In Scotland and Wales, we don't have the same level
 11 of evidence, but we know that minoritised ethnic groups
 12 are more likely to live in the private rented sector,
 13 which is associated with poorer housing quality.
 14 **Q.** Thank you.
 15 The second topic is overcrowding, which we've
 16 already dealt with.
 17 The third topic, multi-generational households.
 18 Some ethnic minority households, in particular Pakistani
 19 and Bangladeshi households, are more likely than white
 20 households to have older people over 65 living with
 21 children; is that right?
 22 **PROFESSOR BÉCARES:** That's right. And also Roma
 23 households.
 24 **Q.** Right. And multi-generational households experienced an
 25 increased likelihood of having a clinically vulnerable
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1 cohesion and community relationships among ethnic
 2 minority groups in the UK, with notable variations
 3 across individual ethnic groups."
 4 Is that right?
 5 **PROFESSOR BÉCARES:** That's right.
 6 **Q.** All right.
 7 Secondly, social cohesion and belonging. You say
 8 that:
 9 "In England [this is paragraph 194], studies that
 10 compare pandemic levels of neighbourhood-level social
 11 cohesion ... to those of pre-pandemic times find an
 12 overall trend for reduced levels of cohesion ..."
 13 Is that right?
 14 **PROFESSOR BÉCARES:** That's right. So this is a summary
 15 measure that captures how well people get along with
 16 people in the neighbourhood, how might they trust their
 17 neighbours, and whether they would help the neighbours
 18 or whether they would receive help from neighbours.
 19 **Q.** And you did note that the decline in levels of social
 20 cohesion was particularly high in the most deprived
 21 communities when compared to the least deprived and
 22 among people from black ethnic groups, who were more
 23 likely to experience negative changes in social
 24 cohesion?
 25 **PROFESSOR BÉCARES:** Yes. And this is something that James
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1 person cohabiting with adults who were key workers. So
 2 lots of risk involved there in that particular
 3 circumstance?
 4 **PROFESSOR BÉCARES:** Yes, both with adults who are key
 5 workers, but also with children who are attending
 6 school.
 7 **Q.** Yes, thank you.
 8 The fourth topic, area-level deprivation, which
 9 we've already covered.
 10 And access to outdoor and green spaces is the fifth
 11 area. You've touched upon this, but has there been ONS
 12 analysis conducted which showed that 12% of households
 13 in England and Wales and 13% in Scotland, had no access
 14 to a private or shared garden during the lockdown, the
 15 first lockdown?
 16 **PROFESSOR BÉCARES:** Yes. And this was more likely for
 17 minoritised ethnic groups. I think they were four times
 18 less likely than white people to have access to green
 19 space.
 20 **Q.** Thank you.
 21 Next topic, social networks and social inclusion,
 22 please -- Professor Bécàres, I'll remain with you -- and
 23 discuss, please, general findings, first of all.
 24 Paragraph 193, you say:
 25 "The Covid-19 pandemic significantly impacted social
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1 and I had done work pre-pandemic, and we had found that
 2 areas of higher deprivation are areas of lower social
 3 cohesion, and this was exacerbated in the pandemic.
 4 **Q.** Thank you.
 5 And finally on this topic, loneliness. At
 6 paragraph 97 you tell us that:
 7 "Higher levels of loneliness amongst ethnic minority
 8 groups compared to White British people have been
 9 reported by studies that combine all minority ethnic
 10 groups into one 'non-white' category ..."
 11 **PROFESSOR BÉCARES:** That's right.
 12 **Q.** And that:
 13 "The evidence is more nuanced when individual
 14 minority ethnic groups are examined independently."
 15 **PROFESSOR BÉCARES:** Yes. So we conducted a study called
 16 EVENS, which captured ethnicity in very fine-grained
 17 categories, and when we look at ethnicity in -- across
 18 subgroup categories, we find that some minoritised
 19 ethnic groups did report higher levels of loneliness, in
 20 particularly white Irish, mixed other, and black
 21 Caribbean groups, whereas others didn't.
 22 **Q.** Not so much. Thank you.
 23 And the final topic we come to before lessons
 24 learned is policing and criminal justice. And I'll
 25 remain with you, please, Professor Bécàres.
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1 In terms of general findings, at paragraph 199 you
2 tell us that:
3 "Unequal treatment by the police and law enforcement
4 agencies towards ethnic minority people was exacerbated
5 during the pandemic."

6 How so?

7 **PROFESSOR BÉCARES:** Well, minority ethnic groups were more
8 likely to be given fixed penalty notices --

9 **Q.** Yes.

10 **PROFESSOR BÉCARES:** -- which were on the spot fines given
11 by the police around violations of lockdown rules. They
12 were also more likely than white British people, and in
13 Scotland and Wales as well, to be stopped and searched
14 by the police. But there was also racialised
15 enforcement in Black Lives Matter protests.

16 **Q.** Thank you.

17 And at paragraph 207 you tell us that:

18 "The interaction between increased policing,
19 anticipation of police violence, and pandemic-related
20 fear and anxiety from risk of transmission, infection
21 and mortality from the ... virus could be associated
22 with the documented worsening of mental health. For
23 example, [you say that] analysis of the Evidence for
24 Equality National Survey (EVENS) study, showed that when
25 compared to White British people, some ethnic minority

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1 multi-generational accommodation.

2 Consider the impact that non-pharmaceutical
3 interventions to control the pandemic have on physical
4 and mental health.

5 And access [sic] digital exclusion as a factor
6 affecting access to essential services during
7 emergencies.

8 To review the financial support schemes put in place
9 during the pandemic.

10 In terms of policing and criminal justice, any
11 policies developed should consider possible
12 disproportionate impacts on minority ethnic groups.

13 Then, at paragraph 240, you say this:

14 "Ultimately, we suggest that a focus on
15 institutional racism, working in partnership with both
16 public and private institutions, must be at the centre
17 of approaches to combat all forms of racism. We
18 recommend this focus on institutions because it is
19 practices within institutions (as providers of services
20 and as employers) that can be developed to address
21 social and economic inequalities, that institutions can
22 provide anti-racist leadership and advocacy, and the
23 concrete nature of institutions makes them the
24 appropriate location of action, rather than the more
25 nebulous natures of social structures and individual

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1 groups were more likely to experience anxiety than White
2 British people."

3 **PROFESSOR BÉCARES:** That's right.

4 And it's important to say that the inequities in
5 police enforcement were really stark. So, for example,
6 in some areas of England, the minoritised ethnic groups,
7 particularly young men, were seven times more likely to
8 be given fixed penalty notices than young white men of
9 the same age group. So these are really stark
10 inequities. And the fear of being given a fixed penalty
11 notice or being stopped and searched has been -- or fear
12 of police enforcement has been associated with poor
13 mental health. So these associations, yeah, exist.

14 **Q.** Thank you.

15 I'm going to summarise your evidence on lessons
16 learned and then come to you for any additional comments
17 that you may wish to add.

18 Firstly, there needs to be a monitoring of the
19 spread of the pandemic to identify any inequalities in
20 infection and mortality.

21 A control of the spread of a pandemic can reduce
22 impact on health and mortality. This includes ensuring
23 healthcare systems avoid exacerbating ethnic
24 inequalities in health, and that clear systems are
25 developed on how to self-isolate for people living in

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1 action."

2 Professor Bécares, is there anything you would like
3 to add to that?

4 **PROFESSOR BÉCARES:** Well, I think the focus on racism is
5 crucial, but an understanding of how racism had
6 structured pre-existing inequities, that we described in
7 Module 2, and how it structured all the impacts that we
8 have described. And without this focus on racism and
9 how it structures health, social, economic and political
10 vulnerability, then there is no lessons to be learnt.

11 **Q.** Thank you.

12 Professor Nazroo?

13 **PROFESSOR NAZROO:** Yes, thank you. The focus on
14 institutional racism in that paragraph reflects
15 a broader analysis which is briefly presented in the
16 paper on the ways in which racism affects people's
17 lives. So we often think of racism as the insult or the
18 ignoring or the police surveillance, or whatever it
19 might be, but there are a whole set of other issues
20 going on that lead to disadvantage for ethnic minority
21 people.

22 We provide that, as I say, a brief summary of that
23 analysis.

24 Institutions are crucial because they become
25 vehicles for change and that's why we identify

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1 institutions as crucial here. They become vehicles for
2 change.

3 Also important in the context of the pandemic is to
4 think about the ways in which health institutions
5 operate, by which I mean the medical technologies, the
6 pharmaceutical industries, as well as things like the
7 NHS and social care.

8 And one of the things we haven't touched on is the
9 ways in which medical technology was not fit for purpose
10 during the pandemic, and how technologies were designed
11 using white people as the template. And so this relates
12 to both pulse oximetry and to PPE.

13 **MS BLACKWELL:** Yes, thank you. I hesitate to interrupt you,
14 but the reason we haven't dwelt on that today, although
15 it is in your report, is that my Lady has heard evidence
16 in Module 3 about those matters and I know that that is
17 going to be covered there, but thank you very much for
18 mentioning that.

19 My Lady, that concludes my questioning.

20 My Lady has given permission for questions to be
21 asked of Professors Bécares and Nazroo from the
22 Migrants' Rights Consortium and also the Trades Union
23 Congress.

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

25 Ms Weeraratne, I think you're first. Thank you.

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1 **PROFESSOR BÉCARES:** Yeah, can I add, it extends beyond
2 healthcare, because Liberty and Southall Black Sisters
3 had a super complaint that found that police enforcement
4 agencies were sharing immigration information with the
5 Home Office. So I agree with you and James's comment,
6 but it extends beyond health care.

7 **Q.** Thank you. We did hear about the sharing with the
8 police and immigration earlier today, and Professors, if
9 I might just follow up with this: Professor Nazroo, you
10 said you would get rid of these policies, I think you
11 said. Do you mean the hostile environment policies?

12 **PROFESSOR NAZROO:** I think the legislation that restricts
13 access to public funds should have been reconsidered
14 during the pandemic. I think that was the point I was
15 trying to make, that the hostile environment policy,
16 I think, is a broader issue that extends beyond the
17 pandemic.

18 Personally, I'm sympathetic to your view there.

19 **Q.** Thank you so much and I do have -- just to follow up to
20 be perfectly clear. Do you also agree, then, that the
21 risks posed to migrants as a result of these structural
22 barriers or these legislative barriers that you've
23 understood to be in existence, cannot be described as
24 speculative or based on a reductive and stereotyped
25 understanding of migrants' experience? And I say that

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Questions from MS WEERERATNE KC

1 **MS WEERERATNE:** Thank you.

2 Good afternoon, Professors. I act for the Migrants'
3 Rights Consortium, and a key concern for us in this
4 group are those migrants subject to immigration control,
5 and excluded from essential welfare services subject to
6 NHS charging and data sharing, and in precarious
7 employment.

8 In your report, your joint report, at paragraphs 40
9 to 71, you consider the factors leading to increased
10 risk of infection for ethnic minority people. You
11 identify five areas for analysis. And I want to ask you
12 both about immigration status in addition.

13 So would you agree that immigration laws and
14 policies that exclude people from the mainstream welfare
15 system and create barriers to accessing healthcare, such
16 as charging and data sharing, would be a further factor
17 leading to increased risk of infection for those ethnic
18 minority people who are also migrants?

19 **PROFESSOR NAZROO:** Yes. Yes, absolutely. And I think it
20 was, in my opinion, it was a mistake to not relax those
21 pieces of legislation, and to not -- not to provide
22 firewalls to prevent information being passed across
23 from health agencies to border enforcement agencies.

24 **Q.** Professor Bécares?

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1 because that's a caveat that you apply yourselves at
2 paragraph 41 to the analysis that you provide to the
3 five factors you identify in relation to ethnic minority
4 people more generally?

5 **PROFESSOR NAZROO:** Yes. So in paragraph 41, we were
6 referring to a pre-determined list. We then go on to
7 provide evidence for some elements of that list, and
8 a lack of evidence for other elements of that list.

9 In the case that you raise, I think the evidence is
10 reasonably clear.

11 **MS WEERERATNE:** Thank you so much. Thank you both.

12 **LADY HALLETT:** Thank you.

13 Ms Peacock.

Questions from MS PEACOCK

14 **MS PEACOCK:** Good afternoon. I ask questions on behalf of
15 the Trades Union Congress.

16 Professor Nazroo has explained in evidence today
17 that ethnic minority workers, whether in insecure
18 employment or not, were less likely to have access to
19 appropriate PPE. Your report at paragraph 82 states
20 that there were suggestions that more discretionary
21 elements of their employment were relevant to that
22 poorer access.

23 Could you please describe what that means and how
24 discretionary elements of work may have impacted upon
25

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1 access to PPE for ethnic minority workers?
 2 **PROFESSOR NAZROO:** If you just give me a moment to glance
 3 over the paragraph again.
 4 **Q.** I'm grateful. It's 82, on page 21.
 5 **PROFESSOR NAZROO:** So you can imagine a range of
 6 discretionary elements of employment that might be
 7 relevant here: how a line manager interacts with you,
 8 the location in which you are working, whether the PPE
 9 fits appropriately, and so on.
 10 In this case, I think I'm referring to people being
 11 in more positive employment contexts being more likely
 12 to say that they have received adequate PPE. And so you
 13 can think of the whole range of things that might be
 14 a more positive employment context. In this case it's
 15 really around the ways in which their race and ethnicity
 16 is perceived and acted upon in the environment.
 17 **MS PEACOCK:** I'm grateful. Those are my questions.
 18 **LADY HALLETT:** Thank you, Ms Peacock.
 19 **MS BLACKWELL:** My Lady, is that a convenient time for us to
 20 take our afternoon break?
 21 **LADY HALLETT:** Certainly. Just so people understand,
 22 because it took me a little while to follow, we've taken
 23 the questions before we get to the individual report for
 24 the two experts.
 25 **MS BLACKWELL:** Yes.

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1 **Q.** And that the facts stated within it are true to the best
 2 of your knowledge and belief?
 3 **PROFESSOR BÉCARES:** They are.
 4 **Q.** And that any opinions you have stated in the report
 5 represent your true and complete professional opinions?
 6 **PROFESSOR BÉCARES:** Yes.
 7 **Q.** When you were last giving evidence, in Module 2, you
 8 described those who identify within the term LGBTQ+.
 9 Could you remind us, please, of what that umbrella term
 10 encompasses?
 11 **PROFESSOR BÉCARES:** Yes. So this is a very broad umbrella
 12 term that captures people who self-identify with
 13 a sexual orientation other than heterosexual and/or
 14 a gender identity that does not align with the sex they
 15 were assigned at birth. And the letters stand for
 16 lesbian, gay, bisexual, trans, queer, and the plus
 17 captures people who identify with a label other than
 18 these categories or are not labelled at all.
 19 **Q.** Thank you.
 20 You describe within your report general patterns and
 21 trends experienced by LGBTQ+ people, but you say that
 22 there may be some variation in outcomes within each
 23 acronym?
 24 **PROFESSOR BÉCARES:** Right. So this is a very diverse
 25 group, both within and between categories of sexual

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1 **LADY HALLETT:** Right. Fortunately someone told me in
 2 a message.
 3 **MS BLACKWELL:** I'm sorry, I should have explained that
 4 perhaps at the beginning, my Lady. I'm sorry that that
 5 took you unawares.
 6 **LADY HALLETT:** No, that's absolutely fine.
 7 Very well, I shall return at 3.30.
 8 **MS BLACKWELL:** Thank you very much.
 9 **(3.14 pm)**
 10 (A short break)
 11 **(3.30 pm)**
 12 **MS BLACKWELL:** My Lady, can you see and hear me?
 13 **LADY HALLETT:** I can, thank you very much.
 14 **Questions on Professor Bécares's individual report by LEAD**
 15 **COUNSEL TO THE INQUIRY FOR MODULE 10**
 16 **MS BLACKWELL:** Thank you very much.
 17 We're now going to turn to Professor Bécares's
 18 report and evidence on inequalities experienced by
 19 LGBTQ+ groups.
 20 So, Professor, you should have in front of you your
 21 copy of the report. For our reference, it's
 22 INQ000657973.
 23 Can you confirm that this is your expert report that
 24 you have provided for the purposes of Module 10?
 25 **PROFESSOR BÉCARES:** It is.

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1 orientation and/or gender identity. There are also
 2 differences across ethnicity and migration, social
 3 class, age, all of which will be represented in
 4 differences in health, social and economic outcomes.
 5 **Q.** Thank you.
 6 Did you find different approaches to the gender
 7 across the four nations of the UK?
 8 **PROFESSOR BÉCARES:** Well, the four nations of the UK,
 9 England, Scotland and Wales have perhaps more similar
 10 approaches to gender identity, or protections around
 11 gender identity, than Northern Ireland.
 12 **Q.** Yes.
 13 And does that in any way lead to difficulties
 14 identifying relevant research, for instance, in Northern
 15 Ireland?
 16 **PROFESSOR BÉCARES:** Well, the data in Northern Ireland are
 17 more limited, both for gender identities, certainly, but
 18 also for sexual orientation.
 19 **Q.** Thank you.
 20 I'd like to have a look, please, at the beginning of
 21 your evidence, at our evidence review.
 22 Which is at INQ000659787, and page 73.
 23 Which confirms the paucity of data. And we can see
 24 that, within gaps in the evidence, there is reference,
 25 at the second bullet point down, to:

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1 "Sexual and gender minorities: Transgender and
2 gender diverse individuals are notably underexamined due
3 to data limitations (eg, the lack of specific questions
4 regarding gender identity in large population-based
5 surveys, small population samples, recoding/recording
6 studies to binary gender). In addition, sexual
7 minorities are often aggregated, masking potential
8 differences in mental health outcomes within these
9 diverse populations."

10 Does that mirror what you found in your research in
11 terms of a lack of data?

12 **PROFESSOR BÉCARES:** Yes, certainly a lack of data and data
13 gaps are one of the crucial limitations of how policies
14 were able to address or not address LGBTQ inequities
15 because there was no evidence to demonstrate either
16 inequities in infection and mortality but also in other
17 outcomes related to the pandemic.

18 **MS BLACKWELL:** Thank you. We can take that down, please.

19 At paragraph 12 of your report you say that despite
20 pre-pandemic evidence documenting that LGBTQ+ people had
21 increased exposure to social and economic risk factors
22 for Covid-19 infection and mortality compared to
23 heterosexual and/or cisgender populations, the UK lacks
24 comprehensive data on Covid-19 infection and mortality
25 outcomes for LGBTQ+ populations and that existing

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1 and bisexual women also had higher rates of obesity and
2 asthma. Gay men and bisexual people were more likely to
3 smoke than heterosexual people ... Trans people were
4 more likely to be disabled and to have chronic health
5 conditions. LGBTQ+ people were also over-represented
6 among patients with certain types of cancer ... All of
7 these factors have been documented to be associated with
8 increased risk of infection and/or mortality from
9 Covid-19."

10 Is that right?

11 **PROFESSOR BÉCARES:** Yeah, so because we don't know the
12 actual prevalence rates of infection and mortality, we
13 have to assume from pre-existing information around
14 occupation risk, and how that relates to risk of
15 infection, but also pre-existing health conditions that
16 now we know are associated with poorer prognosis from
17 Covid. So we can hypothesise that there were higher
18 infection rates and higher mortality rates.

19 **Q.** Yes. Thank you.

20 Turning to physical health, health behaviours and
21 access to health and social care services and covering
22 six brief topics, please.

23 First, pre-existing health and social inequalities
24 experienced by LGBTQ+ groups. You say at paragraphs 34
25 and 35 that these people are less likely to access key

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1 evidence confirms that people with HIV,
2 disproportionately affecting gay men and trans women,
3 faced two to three times higher Covid-19 mortality
4 compared with people without HIV; is that right?

5 **PROFESSOR BÉCARES:** Yes, so to date we don't have any
6 evidence on inequities experienced by LGBTQ people on
7 infection from Covid or mortality from Covid. So
8 five years later, we don't have any information on this.
9 We can hypothesise based on other indications like
10 increased rates of mortality of people living with HIV,
11 that there may have been increased rates of mortality.
12 Also because of pre-existing health conditions,
13 that's -- you mentioned, and that I described in the
14 report for Module 2. But it's important to say that we
15 still do not have any information on this.

16 **Q.** Thank you.

17 At paragraph 30 in your report, you list various
18 experiences of those that come within the LGBTQ+
19 umbrella: populations experiencing several risk factors
20 that put them at increased risk of infection, poorer
21 prognosis and, indeed, mortality, and I will just run
22 through a few of those if I may. You tell us this:
23 "Lesbian women were more likely to be key workers
24 compared to heterosexual women ... and in particular,
25 trans women were overrepresented in sex work. Lesbian

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1 health services compared to non-LGBTQ+ people.

2 Why is that? What's been found historically about
3 that position, please?

4 **PROFESSOR BÉCARES:** Well, historically LGBTQ people are
5 more likely to be discriminated and stigmatised against
6 in mainstream healthcare services. So in order to avoid
7 discrimination, they are less likely to seek the
8 services. When they access services, they are more
9 likely to be less satisfied and to receive lower quality
10 of care. And so LGBTQ people are therefore more likely
11 to seek services provided by LGBTQ third sector
12 organisations, which are inclusive of LGBTQ care.

13 **Q.** And so moving to what happened during the pandemic, we
14 have received a report from the LGBT Foundation entitled
15 "Hidden Figures: The Impact of the Covid-19 Pandemic on
16 LGBT Communities in the UK, May 2020."

17 Could we display this, please, it's INQ000217403.
18 Let's have a look at the first page. There we see the
19 title, and it's the third edition of this particular
20 paper. And can we go, please, to page 24.

21 We can see here that according to this report:

22 "At a time when our ability to access healthcare,
23 and the way we access healthcare has substantially
24 changed, those who faced barriers prior to the crisis
25 may be particularly affected.

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1 "The survey revealed that respondents had been
2 affected by changes to healthcare, with [black and Asian
3 minority ethnic] people, disabled people, and people
4 aged 50+ more likely to be affected (access to
5 healthcare for trans and non-binary communities is
6 covered in the next section)."

7 But looking at some of these percentages, 16% of
8 respondents had been unable to access healthcare for
9 non-Covid-related issues rising to 22% of British
10 Asian -- sorry black, Asian and minority ethnic LGBT
11 people, 26% of disabled LGBT people, and 18% of LGBT
12 people who were aged 50 plus.

13 34% of people had had a medical appointment
14 cancelled, and that rose to 39% of black, Asian, and
15 minority ethnic LGBT people, 42% of disabled LGBT
16 people, and 42% of LGBT people aged 50 plus.

17 23% of respondents said they were unable to access
18 medication or were worried that they might not be able
19 to access medication, including 37% of black, Asian,
20 minority ethnic people, 36% of disabled LGBT people and
21 21% of LGBT people aged 50 plus.

22 And 27% of people who said that there was medication
23 that they couldn't access or were worried that they
24 wouldn't be able to access mentioned access to
25 antidepressants or other medication to help manage poor

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1 paragraphs 47 and 48 of your report that the LGBT
2 Foundation received multiple reports from trans and
3 non-binary people who had been denied access to
4 prescribed and scheduled hormone injections, with some
5 being told that these were non-essential, and that there
6 was also significant financial impact from funding
7 private treatment and physical impacts from continued
8 chest binding?

9 **PROFESSOR BÉCARES:** Yes, some people who were receiving
10 gender-affirming care had their services disrupted, but
11 also people who were on the waiting list to receive
12 gender-affirming care were told that the waiting lists
13 were frozen or discontinued.

14 And so this not only, as you say, led to a change --
15 or impacts on physical health, from chest binding, but
16 also led to important -- worsening of mental health.

17 **Q.** Thank you.

18 Health behaviours, the fifth subtopic here, access
19 to food and medicine. At paragraph 51 you tell us of an
20 online study of 1,540 people, conducted between April
21 and May 2020 in the north west of England, which found
22 that LGBTQ+ people were twice as likely to report being
23 unable to access sufficient food and required medication
24 compared to non-LGBTQ+ people; is that right?

25 **PROFESSOR BÉCARES:** That's right.

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1 mental health.

2 And do those figures reflect your experience from
3 your research of how this particular aspect of access to
4 health was restricted during the pandemic?

5 **PROFESSOR BÉCARES:** Yes. And it's important to add here
6 that access to gender-affirming care was severely
7 disrupted, but -- and as was access to HIV-preventative
8 medication.

9 **Q.** Thank you.

10 We'll come to that in a moment, because the third
11 topic under this heading is "Sexual health clinics and
12 testing". Were there concerns among sexual health
13 clinics that after lockdown measures were lifted, they
14 would have difficulties coping with the increased
15 demand? And did research show that, in certain drop-in
16 services, that in fact did come to pass, and that the --
17 they have not yet caught up with the long waiting times
18 that were generated during the pandemic when services
19 weren't available?

20 **PROFESSOR BÉCARES:** Yes. So, many of the services were
21 moved to online provision, but also some services were
22 shut down. And research suggests that services have not
23 yet got up.

24 **Q.** Thank you.

25 Next, gender identity clinics. You tell us at

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1 **Q.** And finally, physical health, was there an analysis of
2 the nationally representative Millennium Cohort Study
3 which found that sexual minority young adults had poorer
4 general health than heterosexual young adults?

5 **PROFESSOR BÉCARES:** Yes. So, this is a study I conducted
6 with my colleague Dylan Kneale, and we found that sexual
7 minority young adults were four times more likely to
8 report poorer self-rated health compared to straights
9 young adults of the same age and similar socioeconomic
10 conditions.

11 **Q.** Thank you.

12 Turning to economic conditions and finances, you
13 note an increase in financial inequities, and at
14 paragraph 54 you confirm that:

15 "Trans women were over-represented in sex work ...
16 an industry that was severely disrupted by the pandemic
17 ... [that] Gay and lesbian people were more likely than
18 heterosexual people to report being a key worker (which
19 included individuals who worked in health and social
20 care, education and childcare, key public services,
21 local and national government, food services, public
22 safety and national security, transportation, utilities,
23 communications, and financial services) ..."

24 So, across the key worker spectrum?

25 **PROFESSOR BÉCARES:** Yeah, well, this is the definition in

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1 the survey, yes.
2 **Q.** Yes. And so those people who were assessed as being key
3 workers and who continued to work throughout the
4 pandemic were themselves exposed to a greater risk; is
5 that right?

6 **PROFESSOR BÉCARES:** That's right. And so there were
7 financial inequities and financial stability
8 pre-pandemic, but, as you mentioned here, trans women
9 were more likely to be over represented in sex work,
10 which was severely disrupted, but it's also an industry
11 that had increased risk of infection, as did key
12 workers.

13 **Q.** Thank you.

14 Could we put back up, please, the hidden figures
15 report, which is INQ000217403. Thank you very much.

16 And at page 22 we can see that there is reference to
17 lower socioeconomic groups, and financial impact.

18 "The crisis is having a more profound effect in
19 people on lower socio-economic groups, with lower paid
20 people more likely to be hit by the economic
21 consequences of the crisis.

22 "Although there is a lack of data on poverty and
23 deprivation levels in LGBT communities, the research
24 that exists suggests that groups within LGBT communities
25 are more likely to be worse off financially. Analysis

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1 "Not eligible for anything. I'm on my own!"

2 And:

3 "Applied for many things but have received nothing
4 at all."

5 "11% would like assistance accessing financial
6 support provided by the government."

7 Again, does that reflect your understanding of the
8 particular difficulties that LGBTQ+ people were having
9 in relation to the financial impact of the pandemic?

10 **PROFESSOR BÉCARES:** Yes. And it's also important to note
11 that, because of disruption in gender-affirming care,
12 some people had to access this privately, and because of
13 disruption to mental health support, people had to
14 access this privately, and same for fertility services
15 that were disrupted. And so this incurred further
16 financial difficulty.

17 **Q.** Thank you very much.

18 We can take that down, please.

19 Moving to housing, and three brief topics, please.

20 First is living in unsupported environments. At
21 paragraph 69 you say:

22 "A large proportion of LGBTQ+ people, and in
23 particular young and trans people, experienced lockdown
24 in housing environments where family members or
25 flatmates were not supportive of their sexuality and/or

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1 of the UK Household Longitudinal Study found that gay
2 and bisexual men experience greater material
3 disadvantage compared [to] heterosexual men while
4 bisexual women experience greater material disadvantage
5 compared to heterosexual women."

6 Thank you.

7 "The National LGBT Survey 2018 found that employment
8 rates are considerably lower for trans and non-binary
9 people. 63% of trans and non-binary respondents had
10 a job in the 12 months preceding the survey, falling to
11 56% of [black, Asian, minority ethnic] trans people.
12 This compares to an employment rate of 75% at the time.
13 Additionally 60% of trans people stated that they earned
14 less than £20,000 per year.

15 "Of our survey respondents, 9% said that the
16 Covid-19 crisis has meant that they have had to claim
17 financial support from the government that they wouldn't
18 usually claim.

19 "12% stated that they needed financial support but
20 had not received any.

21 "This includes 11% of [black, Asian, minority
22 ethnic] LGBT people, 19% of disabled LGBT people, 21% of
23 trans people and 16% of non-binary people."

24 And there are then two comments from survey
25 respondents:

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1 gender identity."

2 **PROFESSOR BÉCARES:** Yes, so people were experiencing
3 lockdown in hostile living conditions, where people were
4 either threatening or belittling. So, many people had
5 to not be themselves, in these circumstances.

6 **Q.** Yes.

7 **PROFESSOR BÉCARES:** To the extent that a charity, akt,
8 which is a national charity who support young people
9 experiencing or at risk of homelessness, cautioned young
10 people against coming out due to the threatening
11 environments they were experiencing.

12 **Q.** Thank you.

13 Second topic, domestic abuse. You refer to a lack
14 of mainstream recognition of domestic abuse occurring
15 outside of opposite sex relationships, and the way that
16 this increases barriers for LGBTQ+ people seeking
17 support.

18 The public messaging and domestic abuse services,
19 should that be clearer in terms of what is likely to
20 happen, or who can become victims of domestic abuse
21 during a pandemic?

22 **PROFESSOR BÉCARES:** Yes, during the pandemic and outside
23 pandemic times --

24 **Q.** Outside of the pandemic too -- (overspeaking) --

25 **PROFESSOR BÉCARES:** -- there is the -- perhaps the common
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1 picture of what domestic abuse looks like, which
2 excludes people not in heterosexual relationships or not
3 in cisgender relationships. And this is important,
4 because we may -- this may lead to hidden instances of
5 domestic abuse. And so, yeah, the messaging needs to be
6 reframed, not only in relation to partnerships, romantic
7 or otherwise partnerships, but also in relation to
8 family members abusing LGBTQ people.

9 **Q.** Thank you.

10 In June 2020, the Mayor's Office for Policing and
11 Crime commissioned a four-bed specialist LGBTQ+ domestic
12 abuse accommodation project, led by The Outside Project,
13 directly responsible to these needs and representing one
14 of the very few examples of specialist provision,
15 addressing critical gaps in safe accommodation and
16 protection from Covid-19?

17 Was there a lack of suitable LGBTQ+ refuge and
18 temporary accommodation placements for people fleeing
19 abuse?

20 **PROFESSOR BÉCARES:** Yes, absolutely. And because I think
21 there was an Everyone In campaign, which housed people
22 experiencing homelessness, but the same dangers or harms
23 that were experienced in households, so, for example,
24 threats and belittlement because of people's sexual
25 orientation or gender identity, there was a fear that

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1 **Q.** Thank you.

2 Discrimination and harassment. At paragraph 105,
3 you tell us that personal safety was a major concern for
4 LGBTQ+ people during the pandemic both inside the house,
5 as we've discussed, and in public settings. Increased
6 harassment due to being LGBTQ+ was reported across
7 multiple surveys. A large online survey found that
8 almost half, that's 46%, of the LGBTQ+ people sampled
9 had experienced harassment because of their identity, in
10 a public setting, during the first year of the pandemic.

11 You go on to say at paragraph 107 that:

12 "Relatedly, the LGBT Foundation experienced a sharp
13 increase in helpline calls related to discrimination
14 during the pandemic. In late March to early April 2020,
15 they received four and a half times as many calls ...
16 [and twice the amount of calls about biphobia and
17 transphobia], and a 52% increase related to homophobia
18 compared to the three weeks prior ...

19 "The nature of harassment changed slightly during
20 the pandemic", you tell us.

21 "Although the most common forms of harassment
22 remained verbal harassment ... exclusion from events or
23 activities and involuntary disclosure of LGBTQ+
24 identity, new pandemic-specific forms of discrimination
25 emerged."

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1 this would also take place in mainstream circumstances,
2 or shelters. And so there was a lack of these
3 LGBTQ-inclusive provisions, which the Outside Project
4 addressed.

5 **Q.** Thank you. Social networks, support and social
6 inclusion. You tell us at paragraph 91 that:

7 "Social networks and support for LGBTQ+ people may
8 not include people they live with, and may be more
9 geographically dispersed."

10 So LGBTQ people and in particular, you say, older
11 gay men, are more likely to live on their own and
12 therefore experience an increased level of social
13 isolation and loneliness throughout the pandemic.

14 **PROFESSOR BÉCARES:** Yeah, and I think there's a life course
15 approach here, because young people, young LGBTQ people
16 are also less likely to be close to family members as
17 compared to heterosexual young people. They are less
18 likely to be out to a family member as compared to being
19 out to a friend, and so in the early life course this
20 occurs. And then in later life course, LGBTQ people's
21 social networks are more likely to be geographically
22 dispersed. They are more likely to experience social
23 isolation, as you mentioned with gay men, but they are
24 also less likely to have the digital skills needed to
25 engage in online support.

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1 Is that right?

2 **PROFESSOR BÉCARES:** Yes. So for young people there was an
3 increase in online bullying while outside there were
4 discriminations because of the assumption that two
5 people of the same gender are not a couple and so they
6 might be breaking lockdown rules, but also when work,
7 for some people moved online, there was Zoom bombing,
8 it's called, so people disrupting Zoom events to
9 discriminate and harass LGBTQ people.

10 **Q.** Thank you.

11 Mental health and wellbeing. As a result of
12 insecure housing and homelessness, which we've touched
13 upon, that, you tell us, is likely to have had an effect
14 on the mental health and wellbeing of LGBTQ+ people.

15 **PROFESSOR BÉCARES:** Well, insecure housing, living in
16 hostile environments, disruption to gender-affirming
17 care and other healthcare, poor social networks that are
18 not -- they are not geographically dispersed, so less
19 access to social networks, increased harassment, but
20 also the disregards that LGBTQ people had in the public
21 sphere. So they were supported by the LGBTQ third
22 sector, which was in themselves experiencing strong
23 financial difficulties.

24 **Q.** Yes.

25 **PROFESSOR BÉCARES:** And the fact that there was no

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1 discussion around LGBTQ+ issues is also related to poor
2 mental health.

3 **Q.** Thank you.

4 And we'll look briefly, please, if we may, at two
5 reports. Back to the Hidden Figures Report, first of
6 all, please, and to page 11, which deals with mental
7 health. And we'll just look at the first
8 two paragraphs, please.

9 "The Covid-19 crisis is having a profound impact on
10 the general populations mental health and wellbeing. It
11 is causing significant stress, anxiety, isolation,
12 financial uncertainty, and disruption to support
13 services. The profound and lasting impact on mental
14 health is being recognised as the World Health
15 Organization has warned of a global mental health crisis
16 and stated that mental health is a 'priority to be
17 addressed urgently'.

18 "This is likely to particularly affect LGBT
19 communities as there is extensive research to show that
20 LGBT people are more likely to experience poor mental
21 health in general. For example, a 2018 study found that
22 31% of cis LGB people and 46% of trans people had
23 thought about taking their life in the previous year.
24 In comparison, NHS Digital reports that 1 in 20 adults
25 in the general population had thought about taking their
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1 there were -- it highlighted the importance of
2 socialising and having someone to talk to, and support
3 from neighbours and local community, and it also
4 identified practice and policy implications going
5 forwards.

6 So, to lessons learned, please. I'm towards the end
7 of your report.

8 You confirm in paragraphs 113 to 131, and
9 I summarise, that there is a necessity to ensure public
10 health surveillance bodies including the ONS, provide
11 equitable data and equitable access to data and linkages
12 that can document and monitor LGBTQ+ health, that there
13 should be a development and maintenance of that data,
14 and research infrastructure, which is needed to monitor
15 infections and mortality for LGBTQ+ populations going
16 forwards.

17 Just pausing on the issue of data, do you agree that
18 disaggregated data on disability is required across all
19 domains of policy making, not limited to rates of
20 infection and mortality?

21 **PROFESSOR BÉCARES:** Yes. Absolutely. But -- I agree
22 wholeheartedly, but in order to be able to disaggregate
23 across a disability, we need really large sample sizes,
24 and at the moment we have very small sample sizes which
25 don't allow for disaggregation across sexual orientation
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1 own life in the same time period."

2 So just pausing there, going into the pandemic, we
3 can see that there was considerable concern about the
4 mental health of people that fall into these categories,
5 and what you've just described as being the effects of
6 the pandemic and the lockdown restrictions, would have,
7 I think, you would agree, exacerbated the already
8 precarious mental health being suffered by some.

9 **PROFESSOR BÉCARES:** Yes, certainly, so before the pandemic
10 LGBTQ people were more likely to have higher rates of
11 anxiety, depression, than heterosexual or cisgender
12 people, more likely to self-harm and report suicidal
13 ideation, and more likely to attempt suicide than
14 non-LGBTQ people.

15 **Q.** Thank you. We can take that down.

16 And in fact we don't need to display the next
17 report. It's a report from Opening Doors London
18 entitled: "Only Connect, The Impact of Covid-19 on Older
19 LGBT+ People", and it's dated November 2020.

20 I think you've had a look at this report, haven't
21 you, Professor?

22 The headlines of which are: The impact of Covid-19
23 on the health and wellbeing of older LGBTQ+ people was
24 a negative one. There feelings of loneliness and
25 isolation, as you've already made reference to, and
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1 or gender identity to begin with. And so at the moment
2 we have this crucial gap of evidence, because of very
3 poor data infrastructure, very few surveys collect data
4 on sexual orientation, even fewer on gender identity.
5 And when they do, the numbers are so small that they
6 don't allow for a robust analysis. In order to be able
7 to disaggregate by disability and other characteristics,
8 we need an oversample, a boosted sample of sexual and
9 gender minorities.

10 **Q.** Thank you. And do you agree that where there is a lack
11 of data, this prevents community and representative
12 organisations from demonstrating the need to access
13 funding, notwithstanding the vital role played by those
14 organisations?

15 **PROFESSOR BÉCARES:** Absolutely, and this is something
16 I mention in the report, that there was evidence at the
17 beginning of the pandemic that the third sector could
18 not -- didn't have the evidence at the national level
19 required to request support. And so without the data
20 and the evidence, it's very hard to make a case for
21 policies and services. But without data infrastructure,
22 we don't have these data.

23 And I think it's important to say here that all
24 publicly funded studies, like the ONS Infection Survey,
25 the ZOE study, the Covid-19 social study, that's
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1 collected data on infection and mortality, none of them
2 included a question on sexual orientation or gender
3 identity. And these are publicly funded studies.

4 **Q.** And that needs to change?

5 **PROFESSOR BÉCARES:** Exactly.

6 **Q.** And finally, then, you also propose the condemnation of
7 any hate and harassment against LGBTQ+ people, and
8 ongoing treatment that should be funded to ensure that
9 frontline staff delivering health and social care
10 services have received training in LGBTQ+ inclusion, and
11 to support voluntary and community organisations to
12 develop flexible mechanisms to make sure that they can
13 provide ongoing care for the community?

14 **PROFESSOR BÉCARES:** Yes, and if I may add, also, to
15 increase support for the LGBTQ third sector, which was
16 already experiencing financial difficulties entering the
17 pandemic, and who were many times not able to access the
18 furlough scheme and other financial support schemes, and
19 who were supporting the LGBT community in this event.

20 **MS BLACKWELL:** Professor Bécares, thank you very much.

21 My Lady, there are no Core Participant questions for
22 Professor Bécares, so may I now move to the final report
23 of the day, and it's yours, Professor Nazroo.

24 **Questions on Professor Nazroo's individual report by LEAD**
25 **COUNSEL TO THE INQUIRY FOR MODULE 10**
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1 physical health, and the economic and employment
2 situation of older people.

3 You say at paragraph 7 of your report that the
4 primary focus of it is on those aged 65 or over,
5 although in places you draw on evidence relating to
6 adults in the 50 and older age bracket.

7 The role of ageism is highlighted in your report.

8 What do you mean by ageism, Professor Nazroo?

9 **PROFESSOR NAZROO:** So ageism has been defined as a set of
10 stereotypes and prejudices attached to older people
11 which then play out in the ways in which they're treated
12 at an individual level and at a societal level. These
13 stereotypes and prejudices largely focus on declining
14 physical ability, declining cognitive capacity,
15 vulnerability, dependency, a lack of contribution to
16 society, and therefore a devaluing of older people.

17 I just add that the characteristics that are used to
18 devalue older people are those more commonly attached to
19 poorer and frailer older people. So --

20 **Q.** Such as?

21 **PROFESSOR NAZROO:** Well, poorer and frailer older people's,
22 and so the experiences are not homogenous across the
23 older population.

24 **Q.** Thank you. The evidence from your report, you tell us
25 at paragraph 9, is drawn primarily from England,

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1 **MS BLACKWELL:** You should have in front of you your report
2 which for our reference is INQ000588213 on Inequality,
3 Later Life and Ageism.

4 Can you confirm that that is the expert report that
5 you've provided for Module 10?

6 **PROFESSOR NAZROO:** It is.

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

9 **PROFESSOR NAZROO:** They are.

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

12 **PROFESSOR NAZROO:** They do.

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

14 Your report for Module 10 continues, as with the
15 others, where your M2 report paused, and so this report
16 details the inequalities and vulnerability faced by
17 older people, including those living in care homes or
18 awaiting discharge from hospital into care, and how
19 older people, you say, became victims of the
20 prioritisation of acute hospital services and of
21 patients within acute hospital services.

22 And it covers the impact of the Covid-19 pandemic,
23 and of the policies to address the pandemic on levels of
24 loneliness and social isolation, the mental health and
25 wellbeing of older people, access to health services and

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1 although places evidence from other countries in the UK
2 as well, in combination with the evidence from England.
3 Is that because of the much greater availability of
4 evidence on inequalities in later life from England?

5 **PROFESSOR NAZROO:** Yes. So we're very fortunate within
6 England, I would say this because I'm one of the people
7 who's run this study, we have the English Longitudinal
8 Study of Ageing, which has been running for a large
9 number of years which gives us a detailed pattern of how
10 people's circumstances change as they grow older.

11 There is an equivalent study in Northern Ireland,
12 though it's younger, and so there are less data
13 available. There have been aspirations to generate
14 similar studies in Wales and in Scotland, although they
15 have not really taken off yet.

16 **Q.** And in terms of the study in Northern Ireland, has there
17 been analysis of the data collected during that
18 particular study? And if so, what's happened to that?

19 **PROFESSOR NAZROO:** Yes, so both the English study and the
20 Northern Ireland study collected data on Covid
21 experiences during the pandemic. There were some data
22 also collected in Scotland during the pandemic, though
23 that was much more partial.

24 **Q.** Yes.

25 **PROFESSOR NAZROO:** The Northern Irish data ended up included

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1 in a consortium of studies that were basically
2 longitudinal studies that had pre-Covid data and
3 during-Covid data, so it was included -- the data from
4 the Northern Ireland study were included in that
5 consortium.

6 **Q.** Thank you.

7 Intersectionality. You tell us at paragraph 20 that
8 risk is not evenly distributed across the older
9 population. As you've already made mention of,
10 socioeconomic factors strongly relate to the experience
11 of health, and particularly in older ages, and you say
12 this:

13 "Consequently, [the] socioeconomic position is
14 related to the risk of both influenza-related morbidity
15 and influenza-related mortality."

16 And was that reflected throughout the pandemic?

17 **PROFESSOR NAZROO:** Yes, so the same pattern was present
18 during the pandemic, yeah.

19 **Q.** Thank you.

20 Prior knowledge of the vulnerability of older people
21 to an influenza pandemic, you say that that was
22 recognised. And that's at paragraph 14.

23 And at paragraph 15, you say that the annual
24 influenza vaccination that was recommended for older
25 people in certain clinical groups also reflected an

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1 excluded the much larger group of older people; is that
2 right?

3 **PROFESSOR NAZROO:** Yes. So we need to consider carefully
4 about the process of recommending shielding, because
5 this obviously is a very dramatic change in people's
6 living circumstances. And, in doing that, also
7 recognise that some groups of older people are
8 particularly vulnerable. So, those living in poorer
9 areas, poorer older people, ethnic minority older
10 people, and those with chronic conditions that might be
11 summarised under the term "frailty".

12 **Q.** Thank you.

13 I want to move now to access of older people to
14 intensive care units, and noting that this is something
15 which has been previously discussed in the Inquiry in
16 earlier modules. You nevertheless have found clear
17 evidence that policies were put in place to reduce the
18 access of more vulnerable older people to intensive care
19 units; is that right?

20 **PROFESSOR NAZROO:** Yes, that's correct.

21 So a crude clinical screening tool called the
22 clinical frailty scale was used to screen people as they
23 entered hospital to determine their fitness for
24 potential ICU treatment. And if they failed that
25 screening, if their frailty level was too high, then

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1 understanding of the vulnerability that those groups
2 would have to the Covid-19 pandemic.

3 **PROFESSOR NAZROO:** Yes, correct. For some time we've had
4 a very clear understanding of the increased risk of
5 influenza serious illness and influenza mortality for
6 older people. This is particularly for people aged 75
7 and older, and particularly for older people who have
8 some other chronic illness.

9 **Q.** Thank you.

10 The Clinically Vulnerable Families group have
11 prepared and provided us with a witness statement. We
12 don't need to display this now, but at paragraph 85 of
13 that statement, which I think you've had the opportunity
14 of reading, they confirm that older age was one of the
15 strongest and most consistent predictors of severe
16 outcomes from Covid-19, and that data from the Office
17 for National Statistics showed that the risk of dying
18 among those aged over 80 was far higher than for younger
19 groups.

20 Do you agree with that?

21 **PROFESSOR NAZROO:** Yes.

22 **Q.** Yes. And that despite this, age alone was not
23 identified as a criterion for shielding, and that the
24 shielding programme focused on a narrower group of
25 conditions judged to carry exceptional risk, but

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1 they were deemed not eligible for ICU treatment.

2 **Q.** Thank you.

3 Risks faced by older people living in care homes and
4 those awaiting discharge from hospital, again, this is
5 something that has been touched upon by Module 6, but
6 you say at paragraph 55 that:

7 "People living in care homes are, therefore,
8 a population with high levels of frailty and who were,
9 consequently, at risk of complications or mortality if
10 they were infected with [Covid-19]."

11 Throughout the pandemic, beyond improving access to
12 tests for infection and improving access to personal
13 protective equipment, no additional measures were taken
14 to protect care home residents?

15 **PROFESSOR NAZROO:** Yes. So I would go slightly further than
16 that and say that care home residents were put at risk.
17 So, prior to the pandemic, it's very clear, and I've
18 detailed some of the evidence, it's very clear that
19 people living in care homes have a high risk of severe
20 illness and death from a respiratory virus such as
21 SARS-CoV-2.

22 **Q.** Yes.

23 **PROFESSOR NAZROO:** This has been very well documented. The
24 reasoning behind that has also been very well
25 documented, including by the then Deputy Chief Medical

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1 Officer.

2 **Q.** Yes.

3 **PROFESSOR NAZROO:** And consequently, that's a group of
4 people who were, in effect, identified at high risk of
5 severe illness and mortality from Covid-19 -- during
6 Covid-19 pandemic.

7 **Q.** Thank you. In terms of access to healthcare and
8 disruption to access to healthcare, at paragraph 78 you
9 say that:

10 "There is clear evidence that older people had their
11 access to healthcare disrupted, and that this disruption
12 was greater for those in greater need."

13 And the way in which you describe it is in this way:

14 "It is imperative that in the event of a future
15 pandemic policy [there should be] focus on ensuring
16 continuity of care and should target ..."

17 There should be a targeting of:

18 "... those whose care is most likely to be
19 disrupted, particularly poorer older people."

20 **PROFESSOR NAZROO:** Poorer older people and poorer older
21 people with multiple chronic conditions were the two --
22 the strongest evidence was present for in terms of
23 disruption of continuity of care.

24 Continuity of care I'm sure is a theme, indeed, Laia
25 also raised it. Continuity of care is a theme that I'm

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1 of chronic conditions, you're beginning to get to the
2 stage where you are not deemed appropriate for intensive
3 treatment.

4 Now, I stress that this tool was not used. It did
5 inform practice and other tools that were used, followed
6 similar rationale.

7 **Q.** Thank you.

8 Social exclusion, isolation, loneliness and mental
9 health. You tell us at paragraph 87 that:

10 "During the pandemic older people, and particularly
11 those identified as clinically vulnerable family and at
12 high risk, were advised to self-isolate [as we know] and
13 avoid face-to-face contact with [others]."

14 Did that lead, in your experience, from your
15 research, to higher levels of isolation, loneliness and
16 poor mental health?

17 **PROFESSOR NAZROO:** Exactly. So research conducted over the
18 pandemic showed those changes from pre-pandemic to
19 post-pandemic.

20 **Q.** Thank you.

21 **PROFESSOR NAZROO:** Sorry, to during pandemic. Pre-pandemic
22 to during pandemic.

23 **Q.** Thank you.

24 In terms of volunteering, you say that the
25 engagement of older people in volunteering activities is

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1 sure is consistent across the Inquiry, how to maintain
2 continuity of care for the most vulnerable.

3 **Q.** Thank you.

4 Would you agree that, in line with the JCVI
5 guidance, older age should be recognised as a clinical
6 vulnerability to Covid-19 due to the increase in risk
7 caused by ageing itself, including immunosenescence?

8 **PROFESSOR NAZROO:** Yes, so "immunosenescence" isn't
9 necessarily a word I would use. I tend to use the word
10 "frailty", which overlaps with "immunosenescence". But
11 nevertheless older people are at higher risk, as asked.

12 **Q.** Thank you.

13 What is the Covid-19 decision support tool?

14 **PROFESSOR NAZROO:** So the Covid-19 decision support tool was
15 a tool that ended up not being used, but was widely
16 distributed, that identified characteristics that would
17 lead people along a particular treatment pathway.

18 I think what's crucial in relation to that is that
19 if you're old, you're very likely to end up with a score
20 that leaves you onto low intensity treatment or even
21 a palliative care treatment pathway. So it captures age
22 as one criteria itself, then chronic conditions, which
23 older people are more likely to have, and level of
24 frailty, which older people are more likely to have.

25 So, you know, once you get to 65 and have a couple

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1 not only an important social contribution, it's also
2 a marker of the extent to which older people are
3 socially included. Did the pandemic affect that?

4 **PROFESSOR NAZROO:** Yes. So, levels of volunteering dropped
5 really quite dramatically during the pandemic, levels of
6 volunteering of older people. It varied slightly across
7 different groups of older people, but they were dramatic
8 declines in levels of volunteering.

9 **Q.** Thank you.

10 And factors increasing risk of social isolation and
11 loneliness. What do you say about health and level of
12 wealth? Are they usually associated with social
13 isolation and loneliness? And did that -- was that
14 reflected within the pandemic?

15 **PROFESSOR NAZROO:** Yes. So they are both strongly related
16 to levels of isolation and loneliness. The poorer you
17 are, the poorer your health, the more likely you are to
18 be isolated or lonely.

19 **Q.** Yes.

20 **PROFESSOR NAZROO:** And that persisted over the pandemic.
21 It's hard to unpick how much it changed, but it
22 certainly was consistent over the pandemic.

23 **Q.** Thank you.

24 Mental health and wellbeing, and other factors
25 exacerbating risk.

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1 The Disabled People's Organisation evidence, and
2 their submissions that the Inquiry has received, detail
3 how those with poor health, in particular disabled
4 people, faced a change in risk of social isolation
5 during the pandemic, in that the risk became
6 considerably higher due to both the decrease of caring
7 services provided within the home, but also the
8 cessation of respite and social activities for disabled
9 people outside of the home.

10 Did you find that respondents with poor health
11 experienced a large increase in the prevalence of
12 feeling socially isolate during the first Covid-19 wave,
13 albeit this percentage was decreased during the second
14 Covid-19 wave, and also that there was an increase in
15 the prevalence of high subjective social isolation with
16 a decrease in wealth?

17 **PROFESSOR NAZROO:** Yes, so that relates to my previous
18 response.

19 **Q.** Yes.

20 **PROFESSOR NAZROO:** That appeared to be the pattern. The
21 extent of that is very hard to determine with the data
22 that we had.

23 **Q.** And can you confirm, please, Professor, that the study
24 overall concluded that respondents with poor
25 self-reported health had a much higher risk of feeling

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1 vulnerable to reductions in income during the pandemic.
2 So, yes, absolutely. And many had plans to delay their
3 retirement date as a consequence.

4 **Q.** Yes. Thank you.

5 Turning, then, to lessons learned that begin at
6 paragraph 152 of your report. You confirm that your
7 research and your experience has shown you that older
8 people bore the brunt of the pandemic, that they are not
9 simply a homogeneous group, that their experience or
10 poor experience of the pandemic was influenced by
11 overcrowding. You talk about digital services and the
12 need to ensure that older people have access to such
13 services, and the ability to use them. You talk about
14 access to medical services and social care.

15 And you say, finally, at paragraph 165:

16 "... there is a need to review the adequacy of data
17 surveillance systems to inform policy development [going
18 forward]."

19 **PROFESSOR NAZROO:** Yes.

20 So, just to pick up on a -- if it's okay, if we have
21 time, to pick up on a couple of the points there.

22 **Q.** Yes.

23 **PROFESSOR NAZROO:** In relation to digital, we haven't really
24 talked about this, but older people are particularly
25 likely to be digitally excluded, particularly poorer

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1 socially isolated and lonely during the pandemic, and
2 those in the poorest wealth quintile had an increased
3 prevalence of social isolation and loneliness during the
4 second Covid-19 wave?

5 **PROFESSOR NAZROO:** Yes. So that's correct, but I'll stress
6 again that this pattern was also present pre-pandemic,
7 and how far it amplified during the pandemic is hard to
8 unpick.

9 **Q.** Thank you.

10 Economic impacts I think we have covered. Just
11 perhaps to mention adjustment to retirement plans.

12 At paragraph 133 you tell us that:

13 "The financial consequences of the Covid-19 pandemic
14 also caused concerns for older people in relation to
15 their future finances. [That] Close to half ... of
16 those who were working thought that their retirement
17 income would be lower as a result of the pandemic, and
18 14% thought it would be much lower, with very few
19 expecting their retirement income to be higher ..."

20 **PROFESSOR NAZROO:** Yes, so this is a consequence of
21 retirement income being dependent upon stock market
22 performance and stock market performance being poorer
23 during the pandemic.

24 It also relates to the amount of contribution you
25 can make, and if -- and older people were particularly

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1 older people, and older people with poorer health.

2 There are approaches to address this, and I think we
3 need to think very carefully as we move to a more
4 digitally dependent society that we begin to enable
5 older people, and particularly poorer older people, to
6 have access to digital technology.

7 As I say, there are approaches to doing this done by
8 a number of NGOs.

9 In relation to the greater vulnerability of older
10 people, just a couple of very crude statistics. More
11 than 90% of the people who died during the pandemic were
12 aged over 60. And this was particularly a significant
13 proportion in -- of those who died are in the older age
14 groups, but it is those who are poorer, ethnic minority
15 people, and those living in care homes or transferred
16 into care homes who made up a large proportion of those
17 deaths.

18 40% of the deaths during the first wave of the
19 pandemic occurred in care homes.

20 **MS BLACKWELL:** Thank you.

21 Professor Nazroo, my Lady, that concludes my -- I'm
22 so sorry, I'm just being passed a message.

23 **LADY HALLETT:** Don't worry. I think we've got Mr Wagner now
24 instead.

25 **MS BLACKWELL:** We have you're ahead of me, my Lady, as

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1 usual.
2 Clinically Vulnerable Families and Disabled People's
3 Organisations, please.

4 **LADY HALLETT:** Thank you very much, Ms Blackwell.
5 Mr Wagner.

6 **MR WAGNER:** If it's okay with you, Ms Cornaglia is going to
7 ask the question.

8 **LADY HALLETT:** Oh, back to where we were.
9 Ms Cornaglia.

10 **Questions from MS CORNAGLIA**

11 **MS CORNAGLIA:** Thank you, madam. Apologies for that.
12 Professor Nazroo, you look at economic impacts in
13 section 7 of your report. Are you aware of and could
14 you describe any examples of older people retiring early
15 because they were not safe in the workplace during the
16 pandemic?

17 **PROFESSOR NAZROO:** So there is certainly a large amount of
18 what I would describe as less formal evidence where
19 people have reported on removing themselves from work,
20 not being able to be furloughed, not being able to work
21 from home and therefore consequently removing themselves
22 from work because of their fear of clinical harm.

23 As of yet, the statistics behind this, as far as
24 I know -- you may know more than me, but as far as
25 I know, the statistics on this have not yet been

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1 your report to older disabled people accessing social
2 care and there being reduced access to sources of
3 support, poorer access to social care, a rise in unmet
4 need and intensification of caring roles and activities.
5 My question is about whether reduced social care put
6 older disabled people at greater risk of abuse,
7 including where older disabled people were receiving
8 care, potentially in the context of domestic abuse, and
9 during lockdown, the abuser may have been or newly
10 become their only carer, upon whom they may have been
11 particularly reliant or even entirely dependent.

12 **PROFESSOR NAZROO:** Yes, so just to clarify, intensification
13 of caring roles refers to informal caring roles, who are
14 largely family and friends, and hence the concern of the
15 potentially increased risk of domestic abuse in those
16 caring roles.

17 We do know that the majority of older abuse is
18 conducted by a spouse or relative. As far as I'm aware,
19 we do not know how that changed during the pandemic but
20 clearly the risk was there.

21 **Q.** Well, I think Professor Bécares has referred in her
22 evidence to -- a notion of what a common picture of what
23 domestic abuse looks like, but do we really need to take
24 into account this as well?

25 **PROFESSOR NAZROO:** To include older people? Absolutely.

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1 assessed. But it would not surprise me if we find,
2 post-pandemic, when we look at the data, that there will
3 be a proportion of older vulnerable people who have
4 retired early.

5 **MS CORNAGLIA:** Thank you very much, Professor Nazroo.
6 Madam, may I ask a very brief follow-up question in
7 relation to the use of the word "fear"?

8 **LADY HALLETT:** You may but I am going to have to get tight
9 on following-up questions, I'm afraid they don't always
10 act as follow-ups in my view. You may.

11 **MS CORNAGLIA:** Just a very brief question. The use of the
12 word "fear", how far would you say that these issues
13 with early retirement were down to fear as opposed to
14 the absence of adequate protections in the workplace?

15 **PROFESSOR NAZROO:** Well, I think the two go together. So
16 you will be concerned about -- so if you're clinically
17 vulnerable, you are concerned about your health and then
18 if you don't have adequate protection then those
19 concerns will be amplified.

20 **MS CORNAGLIA:** Thank you very much, Professor Nazroo.

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

22 And now Ms Beattie.

23 **Questions from MS BEATTIE**

24 **MS BEATTIE:** Professor Nazroo, I ask questions on behalf of
25 national Disabled People's Organisations. You refer in

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1 They're -- and I would again argue that they're
2 a data -- there are data shortages here, we do need more
3 research around the experience of elder abuse or the
4 prevalence and experience of elder abuse.

5 **MS BEATTIE:** Thank you, my Lady.

6 **LADY HALLETT:** Thank you, Ms Beattie.

7 **MS BLACKWELL:** My Lady, that completes today's evidence.
8 Perhaps it's just worth reminding ourselves that
9 although we've only highlighted certain parts of the
10 three expert reports that have been provided today,
11 provided and discussed today, by Professors Bécares and
12 Nazroo, of course the whole of the reports will be
13 published and will be taken into account by my Lady in
14 formulating our module report.

15 **LADY HALLETT:** Thank you, Ms Blackwell, a point well made.
16 Thank you.

17 Professors, I think you know that, but just to
18 reaffirm and echo what Ms Blackwell has just said, do
19 not worry if we haven't gone over everything in your
20 reports in the kind of detail you would have liked. As
21 you'll appreciate, we have to just focus on the main
22 highlights for the oral evidence but I promise you
23 I will take into account your extremely helpful report,
24 and thank you very much for the help you gave last time
25 and for the help you've given again for this module.

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1 I'm really grateful.
 2 **PROFESSOR NAZROO:** Thank you.
 3 **LADY HALLETT:** Thank you. Very well. I shall return for
 4 10.00 tomorrow, please.
 5 **MS BLACKWELL:** Thank you, my Lady.
 6 **(4.28 pm)**
 7 **(The hearing adjourned until 10.0 am the following day)**
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