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

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

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

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,

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

Q. Right.

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

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

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

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

Q. Right.

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

Q. Right.

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

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

A. Yeah.

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

A. Yes.

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

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

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

A. Yes.

Q. What might be the reason for that?

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

are multiple other intersecting factors.

Q. All right, thank you very much.

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

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

Q. Yes.

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

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

You say that significant ethnic disparities were

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

What did your research find in terms of disparities, geographical disparities across the United Kingdom?

A. We don't necessarily have broken down data on geographical disparities but I think it's important to highlight here that these impacts on pregnant women across racial lines in the UK do mirror broader risks of maternal mortality and poorer health outcomes for women across the UK in routine pregnancies outside of Covid. I mean, in the UK you're much more likely to die if you are a black woman who is pregnant than a white woman who is pregnant, and I think this mirrors broader structural inequalities in our healthcare system for pregnant women in the UK.

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

A. Yes.

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

A. Yes, absolutely.

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

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

Q. Yes.

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

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

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

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

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

That:

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

That:

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

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

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

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

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

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

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

Thank you. We can take that down.

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

paragraph 15 that in general, women tend to report healthier behaviours than men, for example healthier dietary choices and lower alcohol consumption, but that men tend to report engaging in more physical activity. Were those patterns reflected throughout the pandemic?

A. No, actually, what we saw -- what the research has shown during the pandemic is that women's diet became poorer, with women eating less fruit and vegetables in general than men and eating -- you know, being -- resorting to eating, you know, fast food and high salt and sugar food to a greater extent than that of men, and that women's physical activity also decreased compared to that of men.

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

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

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

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

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

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

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

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

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

Q. Yes.

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

Q. Interrupted, yes.

A. Yes.

Q. Thank you.

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

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

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

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

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

Q. Thank you.

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

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

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

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

because of the preventative screening efforts being suspended.

Q. Thank you.

You've mentioned menopause services. Were they also disrupted, particularly at the beginning of the pandemic, and were many routine and non-urgent services suspended for longer, including the cancellation of appointments, the redeployment of staff, and disrupted training for clinicians and other health professionals?

A. Yes, absolutely.

Q. And again, was that position across all four nations?

A. To the extent that we that have the data.

Q. Yes, right. Is there a difficulty presented by a lack of data that's split into the four nations?

A. Yes, so the ways that these are -- that all these screenings are measured and recorded is different in each of the devolved administrations, and therefore you're not always measuring exactly the same thing when you look at service disruptions. When you look at what is being counted, is it about, you know, people coming in, people being invited, samples being received? There's multiple different ways of how and what is being considered between the different administrations.

Q. Right. Thank you.

Finally on this topic, impact on elective care. Did

you find that there was a 60% increase in waiting list times during the pandemic?

A. Yes, for gynaecological services. So gynaecology was the area of medicine and clinical practice that was most disrupted in terms of wait lists during the Covid-19 pandemic, with many of the services being considered elective and therefore, you know, not urgent in the same way as the other clinical specialities, and therefore it's the area which we've seen the greatest, you know, wait times, you know, waiting lists now of over a year that still remain.

Q. So continued disruption?

A. Continued disruption, yes.

Q. Thank you.

Access to sexual and reproductive healthcare services next, please.

You tell us at paragraph 26 that the closure of sexual and reproductive health clinics disproportionately affected women, who are the biggest users of these services in the UK.

A. Yes.

Q. And that approximately one quarter of respondents to a survey -- to a national survey conducted online, including open text responses, in the summer of 2020, reported that social distancing measures had made

a difference to their access or use of such services; is that right?

A. Yes, that's correct.

Q. Changes in maternity services, care delivery, and maternal death rates in interactions with healthcare providers. You've touched upon maternal death rates already, but is it right that maternity services as a whole were significantly disrupted by Covid-19, which led to widespread changes in care delivery and reduced interactions with healthcare providers for pregnant women, and an increase in risks, therefore, for women and babies?

A. Yeah, absolutely. So, you know, it's well established in the literature that multiple antenatal appointments lead to the best possible outcomes for mother and baby, which is why, in the NHS, we have so many routine appointments offered to women. Now, during the pandemic, many of such appointments were moved to telephone consultations, and therefore women weren't getting the same level of care, arguably, than they were prior to the pandemic.

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

challenges that many women face and their kind of perinatal mental health that might experience poorer outcomes as a consequence of this lack of engaged care, face-to-face care in the antenatal period.

Q. Yes, and the Inquiry has heard, and will hear again, that also where face-to-face meetings and appointments did take place with pregnant mothers, they often had to attend those alone and without their partners?

A. Absolutely.

Q. And that had an effect on their experience?

A. Absolutely. So and I think it's important that we remind the Inquiry, it's not just those appointments that women were going to on their own but also we saw significant limitations on birth partners being present during birth and so women were having to give birth alone, and I think that is, you know, it sends shivers down my spine just thinking about these poor women who were having to give birth alone at the most vulnerable stage in their lives, arguably, and, you know, the fact that we know that -- I can't remember the exact statistics off the top of my head but, you know, 70% of birth partners or 70% of trusts reported some limitations on birth partners' participation and I think that's a really notable finding.

Q. Thank you. And just to put some figures onto the

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

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

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

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

A. Well, so, you know, the social determinants of health

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

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

Q. Yes.

A. So putting that front and centre, recognising those inequalities, I think that there's sometimes a tendency to want equality for everybody and therefore write neutral policies as if everybody experiences or everyone should have the same opportunity to the same outcome or to the same access to services, but actually recognising the limitations and the barriers of accessing those services are different between different people and therefore service provision needs to look different for different people is a really important lesson that should be learned although, indeed, health services know

this because they do it on a day-to-day basis. It's just recognising that that's not just in the routine but it's also in the emergency that, you know, case numbers aren't just case numbers. Those are people who experience life, interactions with health services, interactions with all social services, in different ways to each other.

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

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

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

tablets in their own home to try to reduce the interaction with the health service in the clinical settings and reduce the burden on the health sector at that time and it has been -- you know, it has now allowed women to have, you know, have a termination on their own terms in their own home and it's something which has continued subsequent to the pandemic, as well.

Q. Thank you.

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

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

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

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

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

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

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

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

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

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

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

Q. Yes.

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

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

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

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

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

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

Q. Yes.

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

Q. Thank you.

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

A. Yes.

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

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

evidence. It's the intersecting nature of all these issues.

Q. Yes.

A. So the compounded vulnerabilities that different women across society face, you know, create greater inequalities and discrepancies. Now, the chances of the people who were still on legacy benefits being those most vulnerable in society is high. The ones who are, you know, least likely to be able to actively move on to a new payment mechanism, for example.

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

Q. Thank you.

At paragraph 52 you tell us that for migrant women

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

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

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

Thank you very much.

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

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

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

A. Absolutely.

Q. Thank you.

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

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

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

transmission of disease.

Q. Thank you.

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

And that:

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

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

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

A. Absolutely.

Q. Thank you.

We can take that down, please.

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

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

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

Q. Thank you.

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

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

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

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

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

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

Q. Thank you.

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

A. Absolutely, yes.

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

the pandemic?

A. Absolutely.

Q. Yes.

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

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

Q. Thank you.

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

You tell us at paragraph 93 at:

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

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

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

Q. Yes.

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

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

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

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

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

to speak to this, but we know it's a very underreported issue --

Q. Yes.

A. -- and therefore we have to rely on proxy indicators, such as calls to helplines or web service traffic, or administrative data such as police records, to try to give an indication of trends that are emerging but it's very hard to get accurate statistics because of the clandestine nature of domestic violence and abuse and the challenges that women face in reporting such abuse.

Q. Thank you.

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

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

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

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

Yes, thank you very much.

At paragraph 99 you tell us that:

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

A. Yes.

Q. Thank you.

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

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

And this is where you draw together all of the evidence that we've just considered.

"Domestic violence should have been considered as a likely consequence of lockdown measures from the start."

You say:

"Recommendations for the future could include ..."

The following:

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

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

That there's:

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

That there's:

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

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

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

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

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

counterintuitive.

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

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

Q. Thank you.

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

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

So:

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

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

The pre-pandemic baseline, so:

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

Moving into the initial lockdown period, thank you. We can see that:

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

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

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

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

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

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

And that:

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

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

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

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

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

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

Q. Thank you. We can take that down, please.

You set out lessons learned, recommendations, across the whole this piece of work at paragraph 112, and many of these we have already covered during the course of your evidence. Is there anything else which you would like to add to the recommendations that you have already made about the improvement of the plight of women for next time?

A. Well, I think -- I mean, most of it is all set out and I don't want to repeat it all for the sake of repeating it but I think it's important to note that women aren't a homogeneous group and that different women are going to experience any health emergency or other crisis in different ways. But I think that the tendency towards neutral policy making obscures these differences of how women experience life in society in the UK, or indeed anywhere in the world, and that recognising the real-life implications of every policy, every action, is vital to actually understanding how such a policy will work. Because if people -- if women aren't able to, you know, survive -- to, you know, afford to eat or feed their children or, you know, not experience severe mental health outcomes, they might not then engage in the policy in the same way.

And so if you're looking to, you know, stop a health

emergency, you want everybody engaging in that policy and so recognising the limitations on people's engagement or women's engagement, is actually a good public health measure because it can lead to better adherence and uptake of future policies and future public health requirements in a health emergency.

So it's not just about gender; it's about getting better public health outcomes because you recognise the realities of people's lives in our society.

MS BLACKWELL: Thank you.

Dr Wenham, thank you very much for your evidence this morning.

My Lady, you have given permission for Mr Pezzani on behalf of Mind to ask a question, and so may I ask him to do that now.

LADY HALLETT: Mr Pezzani.

Questions from MR PEZZANI

MR PEZZANI: I'm very grateful.

Dr Wenham, good morning, I'm Roger Pezzani asking a single question on behalf of Mind. This, I think, relates to your point about supply and demand. We understand that routine mental health care and access to therapy were restricted during the pandemic, and just as many women's mental health needs increased during lockdown, different reasons for different women; as you

say, women are not a homogeneous group.

But, for example, in relation to postnatal mental health care, mental health impact of unpaid care, financial and housing insecurity, loneliness and isolation and domestic violence, as just exemplars.

The question is: based on your research, how do you consider the service disruptions and contractions impacted on women's mental health needs during the pandemic?

A. Well, I would add that I wasn't asked to comment on the mental health in particular so I haven't got a section in my report on mental health. But it would be part of the multi-faceted landscape you've just described of the different reasons of why women were experiencing poorer mental health and then their inability to access services may have compounded each and any one of those. But again, I don't have any data to back up that point; it would just be my expert opinion based on the variety of other challenges that women faced from a mental health perspective.

MR PEZZANI: I see. Thank you very much.

LADY HALLETT: Thank you, Mr Pezzani.

Dr Wenham, that concludes your evidence. Thank you so much for the help you've given to the Inquiry, both in the last module -- was it Module 2?

THE WITNESS: Yes.

LADY HALLETT: I'm losing track of time now -- and in this module. I'm really grateful to you. Some very interesting information you've provided and expert opinion, so thank you for your help.

THE WITNESS: Thank you.

LADY HALLETT: Very well, I shall break now and return at 11.55.

MS BLACKWELL: Thank you, my Lady.

(11.38 am)

(A short break)

(11.55 am)

LADY HALLETT: Ms Blackwell.

MS BLACKWELL: My Lady, can you see and hear me?

LADY HALLETT: I can, thank you.

MS BLACKWELL: May I call the next witness, Ms Gisela Valle.

MS GISELA VALLE (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 10

MS BLACKWELL: Thank you. Will you give your full name to the court, please.

A. Yes, Gisela Valle Garcia.

Q. Thank you. And Ms Valle, you should have in front of you a copy of your witness statement, which bears our reference number INQ000652188.

Can you confirm, please, that this is the witness

statement that has been provided jointly on behalf of the DA Group organisations for the purposes of Module 10?

A. That is correct.

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

A. Correct.

Q. Thank you.

I'm going to begin by providing a description of the registered charities which contribute to the Domestic Abuse Group. The first is the Southall Black Sisters, which is a black feminist organisation founded in 1979, dedicated to empowering black, minoritised and migrant women and girls, particularly those fleeing violence against women and girls. For over four decades, it has been advocating for the rights and safety of some of society's most marginalised women and provides counselling, support groups, and education classes in London, and conducts policy work, campaigning, research, professional training and community education and development.

A. Correct.

Q. Solace Women's Aid was established over 50 years ago and is one of the single largest providers of services for

victim-survivors of women and girls in the UK. It was established to prevent violence and abuse and provide services to meet the individual needs of victim-survivors, predominantly women and children. Its mission is to end the harm done through gender-based violence, and to work alongside victim-survivors to achieve independent lives free from abuse. And it is the lead agency in several partnerships across London, delivering domestic abuse services, including advice, advocacy, refuge, resettlement, counselling and therapeutic support and children's support. And it operates 24 refuges, and it adapted in the pandemic to maintain all refuge provision whilst adapting community and therapeutic services to be delivered remotely.

A. Correct.

Q. During the pandemic, Southall Black Sisters and Solace Women's Aid launched a crisis project offering safe emergency accommodation with specialist support to women and children across London during the pandemic, and it provided accommodation and support to 205 women from May 2020 to September 2021, including 73 who had no recourse to public funds.

You, Ms Valle, are Director of the Latin American Women's Rights Service, which was founded in 1983 by a group of Latin American women who saw a gap in the

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

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

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

A. That is correct.

Q. Thank you.

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

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

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

A. Yes.

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

A. That is correct.

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

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

Q. Yes.

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

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

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

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

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

A. Yes.

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

A. Yeah.

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

A. Yes.

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

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

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

to me."

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

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

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

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

A. Yes.

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

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

25:

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

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

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

And if we read on:

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

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

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

And we'll look in a moment at the impact on justice

for those who were complaining of domestic abuse.

Thank you. We can take that down now.

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

Thank you.

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

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

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

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

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

"The National Domestic Abuse Helpline logged 40,397

calls between April and June 2020, [which was] a 65% increase.

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

That:

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

And that the charity:

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

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

And finally:

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

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

restrictions on support provision processes."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

You go on to say that:

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

And that:

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

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

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

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

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

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

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

And that the:

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

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

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

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

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

Q. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

Q. Yes.

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

Q. Yes.

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

So that means that for these women, the risk of

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

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

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

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

Q. Yes.

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

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

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

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

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

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

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

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

We can see here that:

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

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

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

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

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

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

Q. Right.

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

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

Q. Yes.

A. How can we make those circumstances such that survivors

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

Q. Thank you.

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

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

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

beginning."

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

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

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

Q. Yes.

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

situation, it does become recognised.

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

Q. Yes.

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

Q. Yes.

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

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

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

A. Yes.

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

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

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

the experience of Hourglass, which is an organisation supporting older people experiencing abuse. They:

"... described how sexual abuse cases reported to [them] towards older people doubled during the pandemic. They said the majority of their calls related to familial abuse, with calls relating to abuse perpetrated by neighbours also increasing significantly during this period, doubling from 3% to 6%. There was an influx of cases involving adult grandchildren committing abuse when staying with their grandparents or great-grandparents, because their parents worked in key worker settings and tried to limit their contact with their children to avoid exposure. Restrictions on leaving the house gave more of an opportunity for perpetrators within older people's homes to commit psychological, sexual and physical abuse."

Thank you, we can take that down now.

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

A. Yes.

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

She contacted you organisation for the first time during the Covid-19 lockdown.

"She was living with her husband, their two children

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

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

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

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

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

wellbeing.

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

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

Thank you very much. We can take that down.

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

There was digital exclusion --

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

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

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

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

Q. Yes.
A. So yeah, it has a massive effect. And once -- and once, you know, the statutory services, housing and others, it might be healthcare, it might be the police, continue putting barriers in front of survivors, what will happen is that the narrative brought forward, usually by perpetrators, "Nobody cares, nobody will help you", starts become a reality for the survivors.

So it will disincentivise survivors being able to come forward because what they're seeing is that the perpetrator is correct. Nobody cares and nobody helps. So, "I'll do what I have to do in order to stay as safe as possible."
Q. Yes.
A. And that might mean remaining in abusive situations for longer.
Q. And you describe in your statement how some initiatives which were brought into force by the government such as the Everyone In initiative scheme, had many positive impacts, but of course there were challenges for, for instance, women with no recourse to public funds --
A. Yes.
Q. -- who feared losing their immigration status if they accessed the scheme.

What measures, in your opinion, would have helped to

make that scheme, taking that as an example, more effective for women with no recourse to public funds to help mitigate the impacts of the pandemic?
A. I mean, I think women with no recourse to public funds should have had that condition lifted for the duration of the pandemic, as an emergency measure in making sure that we're not putting them at risk, for the simple reason that, with schemes like Everyone In, there's a big problem with mixed accommodation, for example, so you might be able to access something but you would have to be strict homeless in order to access Everyone In, but you don't know who is going to be your neighbour in that accommodation.

If you have children, then the risk of something happening to you or your children increases as well as the mental health effects of being in an unsafe environment. So moving from a very unsafe environment to a slightly less unsafe environment, but continues to be unsafe. One of the things that we saw at the beginning of the pandemic was very simple messaging with very broad measures: stay home, stay safe, save others, you know, support the NHS. But with no recourse to public funds, well, I mean, if you fill these conditions maybe you can access this. If you -- so it's --
Q. Yes.

A. -- very complex for survivors themselves to come and ask for support as well as for statutory services to provide it because the messaging is so complicated.
Q. Confused.
A. A very broad lifting of no recourse to public funds would have had a significant effect because then both sides of the conversation would know: you have access to state support for the duration. Which was possible. We saw it with the furlough scheme. We saw it with other schemes. Resources were made available to support other areas of the population that the government knew were going to be highly impacted by the pandemic, but what I cannot, to this day still, understand is why victims of domestic abuse did not have that same level of response, of, you know, consideration from the government, which would have been, I would say, probably no more impactful on the economy than, you know, the furlough scheme.
Q. Yes, we have to be careful because we aren't a decision-making module --
A. Sorry.
Q. No, no, you don't need to apologise, but your evidence is clear on that point.

But despite the challenges, the three organisations that make up the DA Group developed innovative

approaches, didn't they, in order to maintain support? Can you tell us what those were, please.
A. Yes, I mean, for some of us it meant moving completely to online remote provision.
Q. Yes.
A. And that might have been over the phone, over chat, over websites. There were multiple innovations that were done. But I have to say that for some of us it meant going into the community and remaining within the community to make sure that those women that would have, for example, barriers to access technology would still be able to access services.
Q. Yes. Some of the challenges that were apparent related to the impact of the pandemic and lockdown on law enforcement, didn't they?
A. Yes.
Q. I'd like to turn now to look briefly at that.

And were those challenges involving both access to legal support and legal advice, and also delay in court proceedings?
A. Yes.
Q. Yes. You tell us at paragraph 228 in the statement that the pandemic caused huge delays to getting victim-survivors legal support, solicitors were working over capacity. It became challenging to find somebody

to provide that legal advice.
A. Yes.
Q. And court delays became severe. The impacts, as I'm sure everybody in the country is aware, have persisted beyond the end of the pandemic.
But I'd like to ask you in particular about family law proceedings, because at paragraph 231 in your statement, you say that, as well as criminal and civil cases, family law proceedings were affected in a similar way. There were long-term consequences of delays in those hearings that were either postponed or cancelled due to lockdowns, and that had a direct effect on, for instance, Non-Molestation Orders or child protection proceedings.
A. Yes.
Q. How were your organisations able to provide support in relation to these delays and lack of access to justice procedures?
A. Well, where it was possible, we increased our reach.
Q. Yes.
A. We work overtime, we work with others in trying to do this. In some cases, for example, we were asked to provide translation services, and case workers just did that, in order to enable that to happen. Generally, we continued doing what we have been doing for a very long

time, which is to support survivors within the existing conditions in the best way that we are able to.
But really, really, really, you know, it was a lot of case worker, frontline worker, key worker hours, put into that in order to facilitate those processes, because we knew that the longer these things were going to take place, the higher the risks for survivors, and often for their children, were going to be.
Q. Thank you.
Let's look briefly, please, at the impact of the pandemic and lockdown on health and wellbeing. You tell us that the pandemic had profound and lasting effects on the health and wellbeing of domestic abuse victim-survivors. The combination of intensified abuse, isolation from support networks, and reduced access to mental health services, all of which we've covered, created a perfect storm of psychological distress that continues to affect some victim-survivors today.
A. Yes.
Q. I'd like to display, please, the Every Story Matters mental health and wellbeing record. It's at INQ000659895, at page 35.
And we can see here that this section of the record relates to impact on victims and survivors of domestic abuse.

The Every Story Matters team heard from victims and survivors of domestic abuse who were confined with their abusers without any opportunities to escape their home for respite. They told us about how scary and stressful it was to be unable to leave their homes. Some told us about how they were unable to access support services that had previously helped them. Children's and young persons' experience of domestic abuse or living in a household with domestic abuse during the pandemic are explored further in the Module 8 Every Story Matters record.
But one contributor from England told the Every Story Matters team:
"Being on my own with no support didn't bother me at first, but when I had to deal with re-triggering domestic abuse from my youngest's father, I felt terrified, isolated, and very alone. I'd had support in place before, but couldn't access the services needed once the pandemic hit. I was scared and couldn't sleep in case my ex came around drunk. The stress was intense. I couldn't focus [on my PhD] and was also trying to balance homeschooling. I'd be scared of coming home to find my ex waiting, or worse still, in the house."
Does that chime with the experiences that your

organisation was hearing about?
A. Yes. Definitely. As this case was being read, I was thinking about the case that we put in our evidence from Mariela, where she was saying, "I work as a cleaner in St Thomas' Hospital. I am the one who cleans after they take the bodies of people who died from Covid-19, and I still feel safer than at home."
So the experiences are quite similar. I think the effects of living through domestic abuse in an isolated context, where there is a massive gap -- and we heard that from testimony earlier today from Mind -- when they gave testimony last week --
Q. Yes.
A. -- the fact that the support is just not there, and you're trying to scramble -- how to deal with the situation, without having the tools that would make it much more bearable, became a massive crisis.
And I think, for survivors of domestic abuse, we're going to continue seeing the effects of all of this happening to them at the same time for a very long time.
Q. Thank you.
Turning to lessons learned. You've covered many of them during the course of your evidence, Ms Valle. I will seek to summarise what appears at the end of your statement, and please feel free to add any which you

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

how the women that come through our services, for example, are almost always absent from this data, either from statutory services like the police, or sometimes from national charities, just because these women are not going to access those services.
At the same time, although the whole country experienced what was a really difficult, life-changing moment, the way that the women coming through our services experienced it was, if it's possible, much bigger in terms of scale and in terms of the disruption to multiple areas of their lives.
At this moment, two things that are very key are going to continue to happen. So while housing, healthcare, police, and others are almost impossible to access, the enforcement of border controls will remain intact. So you will have problems contacting the police, but the police will experience no disruption whatsoever in informing the Home Office Immigration Enforcement Team.
We know that because of lack of access to healthcare, the health situation of these survivors was much more precarious, and yet the provisions are not made in how can we take into consideration these pre-existing disadvantages that will have disproportionate effects on these populations and do

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

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

Ms Weereratne, King's Counsel.
LADY HALLETT: Thank you.
Ms Weereratne.
Questions from MS WEERERATNE KC
MS WEERERATNE: Thank you very much.
Thank you, my Lady.
Ms Valle, I act for the Migrants' Rights Consortium. A key concern for us is understanding and the planning for migrants excluded from essential services --
A. **(Witness nodded)**
Q. -- and subject to NHS charging and data sharing with the Home Office.
A. Yes.
Q. You've just been asked about data sharing, and at paragraph 236 in your witness statement you deal with data sharing between the police and the Home Office.
A. Yes.
Q. You discuss a firewall --
A. Yes.
Q. -- recommended by three independent police watchdogs for the purpose of preventing all communication and data sharing between the police service and the Home Office on migrant victims of crime, obviously including domestic abuse, in the interests of bringing to justice individuals breaking the law?

A. Yes.
Q. Now, this firewall recommendation was responded to by the Home Office in a review that it then conducted in December 2021.
A. Yes.
Q. And there's a report that you refer to. And you say that the Home Office rejected this recommendation --
A. Yes.
Q. -- for a firewall, and the proposal for either a full or time-limited firewall was a complete refusal?
A. Yes.
Q. So the question is this: whether your group of organisations has seen or are able to say what was the impact of that decision on migrant victims of crime during the pandemic?
A. I think you can see from the evidence provided on the lack of increase of reports to the police, there's a correlation that can be made. We know that migrant victims of crime generally don't come forward, because it's unsafe for them to do so, because, instead of having the crimes they're trying to report, like domestic abuse, sexual abuse, and other criminal activity, their data is shared with Immigration Enforcement. And that leads to a lack of police investigating the actual crime being reported, whilst

Immigration Enforcement actually takes action against the victim that is trying to come forward for whatever reason.
So what we have found is that migrant victims are generally prevented from reporting crime to police because the fear of the data sharing is so high that they would rather take the risk of, you know, continuing in domestic abuse situations and other types of situations.
We did some research in 2019, when it was very clear that --
LADY HALLETT: I'm sorry to interrupt, could you make sure we keep to the pandemic as opposed to the general principle, Ms Valle. Thank you.
A. Yes.
So we understood that survivors who were subject to immigration control were unlikely to come forward during the pandemic, because of the fear of data sharing, and the fact that no provision was made to stop data sharing to enable these survivors to come forward.
MS WEERERATNE: And just to answer the question that my Lady has just posed, and that was something you saw during the pandemic, and was there a difference at that time?
A. So we saw that before, during, after the pandemic. I think the biggest difference was perhaps how the data

sharing, kind of, compounded other restrictions at the time, that made, you know, survivors less likely to approach to the police as they would, you know, services like ours.
So, I think, you know, the fact that you have more or less little change in police data around reporting but very high change in terms of, you know, the demand for services, really talks about, you know, survivors not coming forward.
In the case of migrant survivors, it was generally understood that because the data sharing was maintained, unless the situation was really high risk, they would not approach statutory services. The police, first and foremost, but not the only one. We know that, you know, other statutory services, like healthcare services, for example, also shared data with the Home Office, and we know the effect that that has is that, generally, migrant communities, victims of crime and otherwise, will stay away from those statutory services.
Q. And just to complete that, so I think what you're saying is that the fear of coming forward, the fear of affecting immigration status through reporting and data sharing, is one that prevented migrants from accessing services? Is that --
A. That's correct, yes.

MS WEERERATNE: Thank you very much.
LADY HALLETT: Thank you very much.
Thank you very much, Ms Valle. I appreciate you've got an awful lot to tell me, but as you know, I've got to focus on this module, and it's really important stuff, I do understand that and I do understand why you occasionally went a little bit off piste but I'll forgive you because I know how important it is.
So thank you very much for your help with the Inquiry, obviously producing the report and being such a very good advocate for the cause that you and your colleagues support and it's a really worthy cause and thank you for the work you do.
THE WITNESS: Thank you very much.
MS BLACKWELL: My Lady, that completes this morning's evidence. May we pause for lunch, please?
LADY HALLETT: Certainly. You probably need a break, Ms Blackwell.
MS BLACKWELL: Yes.
LADY HALLETT: I shall return at 2.15.
MS BLACKWELL: Thank you very much.
(1.15 pm)
(The Short Adjournment)
(2.16 pm)
MS BLACKWELL: My Lady, good afternoon, can you see me and

hear me?
LADY HALLETT: I can, thank you, Ms Blackwell.
MS BLACKWELL: Thank you very much.
My Lady, this afternoon's witnesses are Professor Laia Bécares and Professor James Nazroo. May they be sworn, please.
PROFESSOR LAIA BÉCARES (affirmed)
PROFESSOR JAMES NAZROO (affirmed)
Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 10
MS BLACKWELL: Professor Bécares, will you give your full name, please.
PROFESSOR BÉCARES: Laia Bécares.
Q. Thank you.
And Professor Nazroo, your full name, please.
PROFESSOR NAZROO: James Nazroo.
Q. Thank you, both, very much, and welcome back.
I understand that you have both previously given evidence, in Module 2, and you have kindly agreed to provide Module 10 with reports on unequal impact of the pandemic in relation to your areas of expertise.
We will begin with your joint report, please, and then move on to deal with your individual reports. Your joint report is on the impact of the pandemic on racial and ethnic inequalities across the UK.
You should each have a copy of the report in front

of you.
For our reference it's INQ000588214.
Can you each confirm, please, that that is the expert report that you have provided jointly for the purposes of Module 10?
PROFESSOR BÉCARES: That's right.
PROFESSOR NAZROO: Yes, it is.
Q. Thank you. And that the facts stated in the report are true to the best of your knowledge and belief?
PROFESSOR BÉCARES: They are.
PROFESSOR NAZROO: Yes.
Q. And that any opinions you have stated in your report represent your true and complete professional opinions?
PROFESSOR BÉCARES: They do.
PROFESSOR NAZROO: Yes.
Q. Thank you, both, very much.
By way of introduction, Professor Bécares, you are Professor of Social Science and Health at the Department of Global Health and Social Medicine in the Faculty of Social Science and Public Policy at King's College London. You have researched and published on the role of structural and societal determinants in leading to health inequities over years, and this includes examining the unequal impact of Covid-19 pandemic on LGBTQ+ populations and on minoritised ethnic groups.

And you serve as a member of the Academic Reference Group of the NHS Race and Healthcare Observatory?
(No audible answer)
Q. And, Professor Nazroo, you are Professor Emeritus of Sociology at the University of Manchester, you were previously a fellow of the Academy of Social Sciences, a fellow of the British Academy, Professor of Sociology at the University of Manchester, and Professor of Medical Sociology at University College London. And for more than 30 years you have conducted research on issues of inequality, social justice and health, with a focus on ethnicity and race, ageing, gender and the interrelationships between all of those.
PROFESSOR NAZROO: Yes.
Q. Thank you very much.
And finally, Professor Nazroo, amongst other roles, you were founding director of the interdisciplinary Manchester Institute for Collaborative Research on Ageing, and a member of the governing board on the NHS Race and Health Observatory and co-chair of its Academic Reference Group.
The report which you have provided for Module 10 builds on your Module 2 report and really continues where that left off.
In the Module 2 report, you discussed the situation

across the UK so far as racial and ethnic inequalities were concerned, going into the pandemic.

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

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

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

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

PROFESSOR NAZROO: That's correct.

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

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

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

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

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

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

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

Q. Yes.

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

Q. So including chronic illness?

PROFESSOR NAZROO: Including chronic illnesses in effect, yeah.

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

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

Q. Yes.

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

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

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

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

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

as the pandemic began?

PROFESSOR NAZROO: So ethnic minority people, geographical concentration is in more densely populated areas, in urban areas. It reflects the history of settlement of migrant populations and then ongoing employment opportunities, housing opportunities, et cetera. I think in the early stages of the pandemic very important was the concentration of ethnic minority people in London where early exposure to the virus was common. Yeah.

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

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

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

housing represent and in effect, it represents deprivation.

Q. Thank you.

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

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

And that:

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

Is that right?

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

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

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

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

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

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

Q. Thank you.

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

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

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

PROFESSOR NAZROO: Yes, so because it's a hazard ratio it's

risk compared with white British people.
Q. Yes.
PROFESSOR NAZROO: And so the white British group are, in effect, represented by the line 1, so the horizontal line 1, which in this case is at the bottom of the graph.
Q. Yes.
PROFESSOR NAZROO: And any bar that is above the graph shows an increased risk, an increased risk to the extent of the size of that bar. You'll see there black I bars that are attached to each of the bars and those represent statistical confidence. So it's not certainty but statistical confidence. And if that bar does not cross the line 1, the horizontal bottom line, then you can judge that difference to be statistically meaningful.
Real meaning, of course, comes from the size of the bars and you can see that some of those bars are very high. Most of them are higher than we would expect to see for most conditions, even though we were aware of inequalities in health generally. So a difference of 2 is a very, very large difference.
There are two groups here where the difference is not statistically significant: one is white other women, and the other is white Chinese women. For every single

other group the risk is raised.
Q. Yes. And particularly so for male black African?
PROFESSOR NAZROO: Male black African is an incredibly high rate but the rate for male Bangladeshi -- well, anything that is at or approaching 2 is incredibly high. And even ones that are 1.5, in pre-Covid research, we would have considered to be very meaningful.
Q. Thank you.
Yes, thank you, we can take that down, please.
What do the studies that you have been able to access tell us about the risk of infection, rather than the risk of mortality?
PROFESSOR NAZROO: So the studies on risk of infection, because of the nature of the science that was being carried out were not really published until wave 2 of the pandemic, but they did cover wave 1 of the pandemic, and they were studies that were basically sending people test kits and then receiving them back and analysing them. And they showed only for very broad ethnic groups, they didn't have enough samples to split them down in the way that ONS did in that analysis, so it was white versus Asian, versus black, versus mixed, versus other. And they showed higher rates of infection for the non-white groups compared with the white groups.
Q. Thank you. At paragraph 37 of your report you say:

"A crucial question, then, is how far this increased risk of infection during the Covid-19 pandemic led to the increased risk of mortality experienced by ethnic minority people, or whether other factors were also present."
And what did you find in relation to that question?
PROFESSOR NAZROO: So the existing research evidence makes it very difficult to interpret the answer to that question. So what we see are higher rates of infection, and we see higher rates of mortality. They sort of mirror each other. But it's very hard to make the translation because we don't see the same people through the pathway from pre-infection to infection to illness to admission to a hospital to potential mortality. So we don't have that pathway clearly laid out.
But it's clear that increased rates of infection played an important role but it's also quite probable that other factors were also -- so increased vulnerability post-infection also played a role, and I also argue, we also argue, that there are issues around treatment that also may be important as well.
Q. Yes, thank you.
Could we display, please, at page 11 of your joint report, and highlight table 1 .1, the top of the page. Thank you very much.

This shows "Ethnic difference in risk of adverse Covid-19 outcomes". So what do we see here, Professor?
PROFESSOR NAZROO: Yes, so this is from one of the studies that did testing and then followed people through the various stages that follow testing, a large sample done over wave 1 of the pandemic, and contains those relatively broad ethnic groups that I described earlier, in comparison with a white group. And what you can see is the higher risk of testing positive for SARS-CoV-2.
Q. Yes.
PROFESSOR NAZROO: A higher risk for a hospital-related admission -- sorry, admission to hospital. And then a higher risk for the escalation of treatment into ICU, and a higher risk for mortality.
So it shows a pattern where the risk is present at each stage.
Q. Yes.
PROFESSOR NAZROO: Unfortunately, as I said, we don't have the same people tracked across these different stages, so we can't unpick what's happening at each stage.
Q. Thank you. We can take that down.
So, moving to your conclusions in relation to this section of your report, and at paragraph 50, you say that:
"... as for the evidence presented on inequalities

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

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

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

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

This is statistical explanation.

Q. Yes.

PROFESSOR NAZROO: And then it moves on to some of the detail behind that. But it's important to remember that

those inequalities in where people live, levels of deprivation, types of roles, are driven by a whole host of additional factors related to ethnicity, race and racism.

Q. Yes, thank you very much.

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

PROFESSOR NAZROO: Yes.

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

Yes, thank you.

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

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

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

Q. Yes. And what do we see here in terms of ages?

PROFESSOR NAZROO: So the height of the line shows the proportion of the population who say that they have fair or poor self-rated health, which is a good indicator of people's quality of health.

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

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

Q. Yes.

PROFESSOR NAZROO: And then that divergence increases over time.

What you see horizontally at the 20% mark -- rather coincidentally, 20% of white English people said that their -- at the age 80-89 said that their health was fair or poor, and if you follow that line backwards, you can see the age group at which the different ethnic groups cross that line. And so the authors of this report, which include Laia and myself, would argue that this represents premature biological ageing in ethnic minority groups, which reflects a life course of exposure to hazard.

Q. Thank you.

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

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

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

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

Q. Thank you.

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

PROFESSOR BÉCARES: Yes.

Q. And that South Asian patients were almost twice as likely to experience cardiovascular arrest and almost

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

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

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

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

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

The report goes on to say:

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

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

And finally:

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

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

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

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

Q. Thank you. Healthcare services next, please.

You tell us at paragraph 144:

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

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

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

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

particularly acute?

PROFESSOR BÉCARES: Yes, that's right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Yes.

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

Q. Thank you.

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

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

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

Q. Right.

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

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

Q. Thank you.

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

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

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

Q. Thank you.

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

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

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

already discussed] than White British households."
Is that right?
PROFESSOR BÉCARES: That's right.
Q. Thank you.
Is there sufficient data in terms of this area?
PROFESSOR BÉCARES: Yes. So, we know in England, for example, that people from black Caribbean, Bangladeshi, Pakistani ethnic groups are more likely than white people to live in houses with damp.
In Scotland and Wales, we don't have the same level of evidence, but we know that minoritised ethnic groups are more likely to live in the private rented sector, which is associated with poorer housing quality.
Q. Thank you.
The second topic is overcrowding, which we've already dealt with.
The third topic, multi-generational households. Some ethnic minority households, in particular Pakistani and Bangladeshi households, are more likely than white households to have older people over 65 living with children; is that right?
PROFESSOR BÉCARES: That's right. And also Roma households.
Q. Right. And multi-generational households experienced an increased likelihood of having a clinically vulnerable

person cohabiting with adults who were key workers. So lots of risk involved there in that particular circumstance?
PROFESSOR BÉCARES: Yes, both with adults who are key workers, but also with children who are attending school.
Q. Yes, thank you.
The fourth topic, area-level deprivation, which we've already covered.
And access to outdoor and green spaces is the fifth area. You've touched upon this, but has there been ONS analysis conducted which showed that 12% of households in England and Wales and 13% in Scotland, had no access to a private or shared garden during the lockdown, the first lockdown?
PROFESSOR BÉCARES: Yes. And this was more likely for minoritised ethnic groups. I think they were four times less likely than white people to have access to green space.
Q. Thank you.
Next topic, social networks and social inclusion, please -- Professor Bécares, I'll remain with you -- and discuss, please, general findings, first of all.
Paragraph 193, you say:
"The Covid-19 pandemic significantly impacted social

cohesion and community relationships among ethnic minority groups in the UK, with notable variations across individual ethnic groups."
Is that right?
PROFESSOR BÉCARES: That's right.
Q. All right.
Secondly, social cohesion and belonging. You say that:
"In England [this is paragraph 194], studies that compare pandemic levels of neighbourhood-level social cohesion ... to those of pre-pandemic times find an overall trend for reduced levels of cohesion ..."
Is that right?
PROFESSOR BÉCARES: That's right. So this is a summary measure that captures how well people get along with people in the neighbourhood, how might they trust their neighbours, and whether they would help the neighbours or whether they would receive help from neighbours.
Q. And you did note that the decline in levels of social cohesion was particularly high in the most deprived communities when compared to the least deprived and among people from black ethnic groups, who were more likely to experience negative changes in social cohesion?
PROFESSOR BÉCARES: Yes. And this is something that James

and I had done work pre-pandemic, and we had found that areas of higher deprivation are areas of lower social cohesion, and this was exacerbated in the pandemic.
Q. Thank you.
And finally on this topic, loneliness. At paragraph 97 you tell us that:
"Higher levels of loneliness amongst ethnic minority groups compared to White British people have been reported by studies that combine all minority ethnic groups into one 'non-white' category ..."
PROFESSOR BÉCARES: That's right.
Q. And that:
"The evidence is more nuanced when individual minority ethnic groups are examined independently."
PROFESSOR BÉCARES: Yes. So we conducted a study called EVENS, which captured ethnicity in very fine-grained categories, and when we look at ethnicity in -- across subgroup categories, we find that some minoritised ethnic groups did report higher levels of loneliness, in particularly white Irish, mixed other, and black Caribbean groups, whereas others didn't.
Q. Not so much. Thank you.
And the final topic we come to before lessons learned is policing and criminal justice. And I'll remain with you, please, Professor Bécares.

In terms of general findings, at paragraph 199 you tell us that:

"Unequal treatment by the police and law enforcement agencies towards ethnic minority people was exacerbated during the pandemic."

How so?

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

Q. Yes.

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

Q. Thank you.

And at paragraph 207 you tell us that:

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

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

PROFESSOR BÉCARES: That's right.

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

Q. Thank you.

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

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

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

multi-generational accommodation.

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

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

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

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

Then, at paragraph 240, you say this:

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

action."

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

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

Q. Thank you.

Professor Nazroo?

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

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

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

institutions as crucial here. They become vehicles for change.

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

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

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

My Lady, that concludes my questioning.

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

LADY HALLETT: Thank you very much.

Ms Weereratne, I think you're first. Thank you.

Questions from MS WEERERATNE KC

MS WEERERATNE: Thank you.

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

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

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

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

Q. Professor Bécares?

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

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

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

Personally, I'm sympathetic to your view there.

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

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

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

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

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

LADY HALLETT: Thank you.

Ms Peacock.

Questions from MS PEACOCK

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

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

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

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

LADY HALLETT: Right. Fortunately someone told me in a message.
MS BLACKWELL: I'm sorry, I should have explained that perhaps at the beginning, my Lady. I'm sorry that that took you unawares.
LADY HALLETT: No, that's absolutely fine.
Very well, I shall return at 3.30.
MS BLACKWELL: Thank you very much.
(3.14 pm)
(A short break)
(3.30 pm)
MS BLACKWELL: My Lady, can you see and hear me?
LADY HALLETT: I can, thank you very much.

Questions on Professor Bécares's individual report by LEAD COUNSEL TO THE INQUIRY FOR MODULE 10

MS BLACKWELL: Thank you very much.
We're now going to turn to Professor Bécares's report and evidence on inequalities experienced by LGBTQ+ groups.
So, Professor, you should have in front of you your copy of the report. For our reference, it's INQ000657973.
Can you confirm that this is your expert report that you have provided for the purposes of Module 10?
PROFESSOR BÉCARES: It is.

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

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

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

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

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

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

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

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

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

Q. Thank you.

At paragraph 30 in your report, you list various experiences of those that come within the LGBTQ+ umbrella: populations experiencing several risk factors that put them at increased risk of infection, poorer prognosis and, indeed, mortality, and I will just run through a few of those if I may. You tell us this:

"Lesbian women were more likely to be key workers compared to heterosexual women ... and in particular, trans women were overrepresented in sex work. Lesbian

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

Is that right?

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

Q. Yes. Thank you.

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

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

health services compared to non-LGBTQ+ people.

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

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

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

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

We can see here that according to this report:

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

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

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

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

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

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

mental health.

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

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

Q. Thank you.

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

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

Q. Thank you.

Next, gender identity clinics. You tell us at

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

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

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

Q. Thank you.

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

PROFESSOR BÉCARES: That's right.

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

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

Q. Thank you.

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

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

So, across the key worker spectrum?

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

the survey, yes.
Q. Yes. And so those people who were assessed as being key workers and who continued to work throughout the pandemic were themselves exposed to a greater risk; is that right?
PROFESSOR BÉCARES: That's right. And so there were financial inequities and financial stability pre-pandemic, but, as you mentioned here, trans women were more likely to be over represented in sex work, which was severely disrupted, but it's also an industry that had increased risk of infection, as did key workers.
Q. Thank you.
Could we put back up, please, the hidden figures report, which is INQ000217403. Thank you very much.
And at page 22 we can see that there is reference to lower socioeconomic groups, and financial impact.
"The crisis is having a more profound effect in people on lower socio-economic groups, with lower paid people more likely to be hit by the economic consequences of the crisis.
"Although there is a lack of data on poverty and deprivation levels in LGBT communities, the research that exists suggests that groups within LGBT communities are more likely to be worse off financially. Analysis

of the UK Household Longitudinal Study found that gay and bisexual men experience greater material disadvantage compared [to] heterosexual men while bisexual women experience greater material disadvantage compared to heterosexual women."
Thank you.
"The National LGBT Survey 2018 found that employment rates are considerably lower for trans and non-binary people. 63% of trans and non-binary respondents had a job in the 12 months preceding the survey, falling to 56% of [black, Asian, minority ethnic] trans people. This compares to an employment rate of 75% at the time. Additionally 60% of trans people stated that they earned less than £20,000 per year.
"Of our survey respondents, 9% said that the Covid-19 crisis has meant that they have had to claim financial support from the government that they wouldn't usually claim.
"12% stated that they needed financial support but had not received any.
"This includes 11% of [black, Asian, minority ethnic] LGBT people, 19% of disabled LGBT people, 21% of trans people and 16% of non-binary people."
And there are then two comments from survey respondents:

"Not eligible for anything. I'm on my own!"
And:
"Applied for many things but have received nothing at all."
"11% would like assistance accessing financial support provided by the government."
Again, does that reflect your understanding of the particular difficulties that LGBTQ+ people were having in relation to the financial impact of the pandemic?
PROFESSOR BÉCARES: Yes. And it's also important to note that, because of disruption in gender-affirming care, some people had to access this privately, and because of disruption to mental health support, people had to access this privately, and same for fertility services that were disrupted. And so this incurred further financial difficulty.
Q. Thank you very much.
We can take that down, please.
Moving to housing, and three brief topics, please. First is living in unsupported environments. At paragraph 69 you say:
"A large proportion of LGBTQ+ people, and in particular young and trans people, experienced lockdown in housing environments where family members or flatmates were not supportive of their sexuality and/or

gender identity."
PROFESSOR BÉCARES: Yes, so people were experiencing lockdown in hostile living conditions, where people were either threatening or belittling. So, many people had to not be themselves, in these circumstances.
Q. Yes.
PROFESSOR BÉCARES: To the extent that a charity, akt, which is a national charity who support young people experiencing or at risk of homelessness, cautioned young people against coming out due to the threatening environments they were experiencing.
Q. Thank you.
Second topic, domestic abuse. You refer to a lack of mainstream recognition of domestic abuse occurring outside of opposite sex relationships, and the way that this increases barriers for LGBTQ+ people seeking support.
The public messaging and domestic abuse services, should that be clearer in terms of what is likely to happen, or who can become victims of domestic abuse during a pandemic?
PROFESSOR BÉCARES: Yes, during the pandemic and outside pandemic times --
Q. Outside of the pandemic too -- (overspeaking) --
PROFESSOR BÉCARES: -- there is the -- perhaps the common

picture of what domestic abuse looks like, which excludes people not in heterosexual relationships or not in cisgender relationships. And this is important, because we may -- this may lead to hidden instances of domestic abuse. And so, yeah, the messaging needs to be reframed, not only in relation to partnerships, romantic or otherwise partnerships, but also in relation to family members abusing LGBTQ people.

Q. Thank you.

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

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

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

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

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

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

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

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

Q. Thank you.

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

You go on to say at paragraph 107 that:

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

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

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

Is that right?

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

Q. Thank you.

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

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

Q. Yes.

PROFESSOR BÉCARES: And the fact that there was no

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

Q. Thank you.

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

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

"This is likely to particularly affect LGBT communities as there is extensive research to show that LGBT people are more likely to experience poor mental health in general. For example, a 2018 study found that 31% of cis LGB people and 46% of trans people had thought about taking their life in the previous year. In comparison, NHS Digital reports that 1 in 20 adults in the general population had thought about taking their

own life in the same time period."

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

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

Q. Thank you. We can take that down.

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

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

The headlines of which are: The impact of Covid-19 on the health and wellbeing of older LGBTQ+ people was a negative one. There feelings of loneliness and isolation, as you've already made reference to, and

there were -- it highlighted the importance of socialising and having someone to talk to, and support from neighbours and local community, and it also identified practice and policy implications going forwards.

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

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

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

PROFESSOR BÉCARES: Yes. Absolutely. But -- I agree wholeheartedly, but in order to be able to disaggregate across a disability, we need really large sample sizes, and at the moment we have very small sample sizes which don't allow for disaggregation across sexual orientation

or gender identity to begin with. And so at the moment we have this crucial gap of evidence, because of very poor data infrastructure, very few surveys collect data on sexual orientation, even fewer on gender identity. And when they do, the numbers are so small that they don't allow for a robust analysis. In order to be able to disaggregate by disability and other characteristics, we need an oversample, a boosted sample of sexual and gender minorities.

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

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

And I think it's important to say here that all publicly funded studies, like the ONS Infection Survey, the ZOE study, the Covid-19 social study, that's

collected data on infection and mortality, none of them included a question on sexual orientation or gender identity. And these are publicly funded studies.

Q. And that needs to change?

PROFESSOR BÉCARES: Exactly.

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

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

MS BLACKWELL: Professor Bécares, thank you very much.

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

Questions on Professor Nazroo's individual report by LEAD COUNSEL TO THE INQUIRY FOR MODULE 10

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

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

PROFESSOR NAZROO: It is.

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

PROFESSOR NAZROO: They are.

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

PROFESSOR NAZROO: They do.

Q. Thank you very much.

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

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

physical health, and the economic and employment situation of older people.

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

The role of ageism is highlighted in your report. What do you mean by ageism, Professor Nazroo?

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

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

Q. Such as?

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

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

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

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

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

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

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

Q. Yes.

PROFESSOR NAZROO: The Northern Irish data ended up included

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

Q. Thank you.

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

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

And was that reflected throughout the pandemic?

PROFESSOR NAZROO: Yes, so the same pattern was present during the pandemic, yeah.

Q. Thank you.

Prior knowledge of the vulnerability of older people to an influenza pandemic, you say that that was recognised. And that's at paragraph 14.

And at paragraph 15, you say that the annual influenza vaccination that was recommended for older people in certain clinical groups also reflected an

understanding of the vulnerability that those groups would have to the Covid-19 pandemic.

PROFESSOR NAZROO: Yes, correct. For some time we've had a very clear understanding of the increased risk of influenza serious illness and influenza mortality for older people. This is particularly for people aged 75 and older, and particularly for older people who have some other chronic illness.

Q. Thank you.

The Clinically Vulnerable Families group have prepared and provided us with a witness statement. We don't need to display this now, but at paragraph 85 of that statement, which I think you've had the opportunity of reading, they confirm that older age was one of the strongest and most consistent predictors of severe outcomes from Covid-19, and that data from the Office for National Statistics showed that the risk of dying among those aged over 80 was far higher than for younger groups.

Do you agree with that?

PROFESSOR NAZROO: Yes.

Q. Yes. And that despite this, age alone was not identified as a criterion for shielding, and that the shielding programme focused on a narrower group of conditions judged to carry exceptional risk, but

excluded the much larger group of older people; is that right?

PROFESSOR NAZROO: Yes. So we need to consider carefully about the process of recommending shielding, because this obviously is a very dramatic change in people's living circumstances. And, in doing that, also recognise that some groups of older people are particularly vulnerable. So, those living in poorer areas, poorer older people, ethnic minority older people, and those with chronic conditions that might be summarised under the term "frailty".

Q. Thank you.

I want to move now to access of older people to intensive care units, and noting that this is something which has been previously discussed in the Inquiry in earlier modules. You nevertheless have found clear evidence that policies were put in place to reduce the access of more vulnerable older people to intensive care units; is that right?

PROFESSOR NAZROO: Yes, that's correct.

So a crude clinical screening tool called the clinical frailty scale was used to screen people as they entered hospital to determine their fitness for potential ICU treatment. And if they failed that screening, if their frailty level was too high, then

they were deemed not eligible for ICU treatment.

Q. Thank you.

Risks faced by older people living in care homes and those awaiting discharge from hospital, again, this is something that has been touched upon by Module 6, but you say at paragraph 55 that:

"People living in care homes are, therefore, a population with high levels of frailty and who were, consequently, at risk of complications or mortality if they were infected with [Covid-19]."

Throughout the pandemic, beyond improving access to tests for infection and improving access to personal protective equipment, no additional measures were taken to protect care home residents?

PROFESSOR NAZROO: Yes. So I would go slightly further than that and say that care home residents were put at risk. So, prior to the pandemic, it's very clear, and I've detailed some of the evidence, it's very clear that people living in care homes have a high risk of severe illness and death from a respiratory virus such as SARS-CoV-2.

Q. Yes.

PROFESSOR NAZROO: This has been very well documented. The reasoning behind that has also been very well documented, including by the then Deputy Chief Medical

Officer.
Q. Yes.
PROFESSOR NAZROO: And consequently, that's a group of people who were, in effect, identified at high risk of severe illness and mortality from Covid-19 -- during Covid-19 pandemic.
Q. Thank you. In terms of access to healthcare and disruption to access to healthcare, at paragraph 78 you say that:
"There is clear evidence that older people had their access to healthcare disrupted, and that this disruption was greater for those in greater need."
And the way in which you describe it is in this way:
"It is imperative that in the event of a future pandemic policy [there should be] focus on ensuring continuity of care and should target ..."
There should be a targeting of:
"... those whose care is most likely to be disrupted, particularly poorer older people."
PROFESSOR NAZROO: Poorer older people and poorer older people with multiple chronic conditions were the two -- the strongest evidence was present for in terms of disruption of continuity of care.
Continuity of care I'm sure is a theme, indeed, Laia also raised it. Continuity of care is a theme that I'm

sure is consistent across the Inquiry, how to maintain continuity of care for the most vulnerable.
Q. Thank you.
Would you agree that, in line with the JCVI guidance, older age should be recognised as a clinical vulnerability to Covid-19 due to the increase in risk caused by ageing itself, including immunosenescence?
PROFESSOR NAZROO: Yes, so "immunosenescence" isn't necessarily a word I would use. I tend to use the word "frailty", which overlaps with "immunosenescence". But nevertheless older people are at higher risk, as asked.
Q. Thank you.
What is the Covid-19 decision support tool?
PROFESSOR NAZROO: So the Covid-19 decision support tool was a tool that ended up not being used, but was widely distributed, that identified characteristics that would lead people along a particular treatment pathway.
I think what's crucial in relation to that is that if you're old, you're very likely to end up with a score that leaves you onto low intensity treatment or even a palliative care treatment pathway. So it captures age as one criteria itself, then chronic conditions, which older people are more likely to have, and level of frailty, which older people are more likely to have.
So, you know, once you get to 65 and have a couple

of chronic conditions, you're beginning to get to the stage where you are not deemed appropriate for intensive treatment.
Now, I stress that this tool was not used. It did inform practice and other tools that were used, followed similar rationale.
Q. Thank you.
Social exclusion, isolation, loneliness and mental health. You tell us at paragraph 87 that:
"During the pandemic older people, and particularly those identified as clinically vulnerable family and at high risk, were advised to self-isolate [as we know] and avoid face-to-face contact with [others]."
Did that lead, in your experience, from your research, to higher levels of isolation, loneliness and poor mental health?
PROFESSOR NAZROO: Exactly. So research conducted over the pandemic showed those changes from pre-pandemic to post-pandemic.
Q. Thank you.
PROFESSOR NAZROO: Sorry, to during pandemic. Pre-pandemic to during pandemic.
Q. Thank you.
In terms of volunteering, you say that the engagement of older people in volunteering activities is

not only an important social contribution, it's also a marker of the extent to which older people are socially included. Did the pandemic affect that?
PROFESSOR NAZROO: Yes. So, levels of volunteering dropped really quite dramatically during the pandemic, levels of volunteering of older people. It varied slightly across different groups of older people, but they were dramatic declines in levels of volunteering.
Q. Thank you.
And factors increasing risk of social isolation and loneliness. What do you say about health and level of wealth? Are they usually associated with social isolation and loneliness? And did that -- was that reflected within the pandemic?
PROFESSOR NAZROO: Yes. So they are both strongly related to levels of isolation and loneliness. The poorer you are, the poorer your health, the more likely you are to be isolated or lonely.
Q. Yes.
PROFESSOR NAZROO: And that persisted over the pandemic. It's hard to unpick how much it changed, but it certainly was consistent over the pandemic.
Q. Thank you.
Mental health and wellbeing, and other factors exacerbating risk.

The Disabled People's Organisation evidence, and their submissions that the Inquiry has received, detail how those with poor health, in particular disabled people, faced a change in risk of social isolation during the pandemic, in that the risk became considerably higher due to both the decrease of caring services provided within the home, but also the cessation of respite and social activities for disabled people outside of the home.

Did you find that respondents with poor health experienced a large increase in the prevalence of feeling socially isolate during the first Covid-19 wave, albeit this percentage was decreased during the second Covid-19 wave, and also that there was an increase in the prevalence of high subjective social isolation with a decrease in wealth?

PROFESSOR NAZROO: Yes, so that relates to my previous response.

Q. Yes.

PROFESSOR NAZROO: That appeared to be the pattern. The extent of that is very hard to determine with the data that we had.

Q. And can you confirm, please, Professor, that the study overall concluded that respondents with poor self-reported health had a much higher risk of feeling

socially isolated and lonely during the pandemic, and those in the poorest wealth quintile had an increased prevalence of social isolation and loneliness during the second Covid-19 wave?

PROFESSOR NAZROO: Yes. So that's correct, but I'll stress again that this pattern was also present pre-pandemic, and how far it amplified during the pandemic is hard to unpick.

Q. Thank you.

Economic impacts I think we have covered. Just perhaps to mention adjustment to retirement plans.

At paragraph 133 you tell us that:

"The financial consequences of the Covid-19 pandemic also caused concerns for older people in relation to their future finances. [That] Close to half ... of those who were working thought that their retirement income would be lower as a result of the pandemic, and 14% thought it would be much lower, with very few expecting their retirement income to be higher ..."

PROFESSOR NAZROO: Yes, so this is a consequence of retirement income being dependent upon stock market performance and stock market performance being poorer during the pandemic.

It also relates to the amount of contribution you can make, and if -- and older people were particularly

vulnerable to reductions in income during the pandemic. So, yes, absolutely. And many had plans to delay their retirement date as a consequence.

Q. Yes. Thank you.

Turning, then, to lessons learned that begin at paragraph 152 of your report. You confirm that your research and your experience has shown you that older people bore the brunt of the pandemic, that they are not simply a homogeneous group, that their experience or poor experience of the pandemic was influenced by overcrowding. You talk about digital services and the need to ensure that older people have access to such services, and the ability to use them. You talk about access to medical services and social care.

And you say, finally, at paragraph 165:

"... there is a need to review the adequacy of data surveillance systems to inform policy development [going forward]."

PROFESSOR NAZROO: Yes.

So, just to pick up on a -- if it's okay, if we have time, to pick up on a couple of the points there.

Q. Yes.

PROFESSOR NAZROO: In relation to digital, we haven't really talked about this, but older people are particularly likely to be digitally excluded, particularly poorer

older people, and older people with poorer health.

There are approaches to address this, and I think we need to think very carefully as we move to a more digitally dependent society that we begin to enable older people, and particularly poorer older people, to have access to digital technology.

As I say, there are approaches to doing this done by a number of NGOs.

In relation to the greater vulnerability of older people, just a couple of very crude statistics. More than 90% of the people who died during the pandemic were aged over 60. And this was particularly a significant proportion in -- of those who died are in the older age groups, but it is those who are poorer, ethnic minority people, and those living in care homes or transferred into care homes who made up a large proportion of those deaths.

40% of the deaths during the first wave of the pandemic occurred in care homes.

MS BLACKWELL: Thank you.

Professor Nazroo, my Lady, that concludes my -- I'm so sorry, I'm just being passed a message.

LADY HALLETT: Don't worry. I think we've got Mr Wagner now instead.

MS BLACKWELL: We have you're ahead of me, my Lady, as

usual.

Clinically Vulnerable Families and Disabled People's Organisations, please.

LADY HALLETT: Thank you very much, Ms Blackwell.

Mr Wagner.

MR WAGNER: If it's okay with you, Ms Cornaglia is going to ask the question.

LADY HALLETT: Oh, back to where we were.

Ms Cornaglia.

Questions from MS CORNAGLIA

MS CORNAGLIA: Thank you, madam. Apologies for that.

Professor Nazroo, you look at economic impacts in section 7 of your report. Are you aware of and could you describe any examples of older people retiring early because they were not safe in the workplace during the pandemic?

PROFESSOR NAZROO: So there is certainly a large amount of what I would describe as less formal evidence where people have reported on removing themselves from work, not being able to be furloughed, not being able to work from home and therefore consequently removing themselves from work because of their fear of clinical harm.

As of yet, the statistics behind this, as far as I know -- you may know more than me, but as far as I know, the statistics on this have not yet been

assessed. But it would not surprise me if we find, post-pandemic, when we look at the data, that there will be a proportion of older vulnerable people who have retired early.

MS CORNAGLIA: Thank you very much, Professor Nazroo.

Madam, may I ask a very brief follow-up question in relation to the use of the word "fear"?

LADY HALLETT: You may but I am going to have to get tight on following-up questions, I'm afraid they don't always act as follow-ups in my view. You may.

MS CORNAGLIA: Just a very brief question. The use of the word "fear", how far would you say that these issues with early retirement were down to fear as opposed to the absence of adequate protections in the workplace?

PROFESSOR NAZROO: Well, I think the two go together. So you will be concerned about -- so if you're clinically vulnerable, you are concerned about your health and then if you don't have adequate protection then those concerns will be amplified.

MS CORNAGLIA: Thank you very much, Professor Nazroo.

LADY HALLETT: Thank you very much.

And now Ms Beattie.

Questions from MS BEATTIE

MS BEATTIE: Professor Nazroo, I ask questions on behalf of national Disabled People's Organisations. You refer in

your report to older disabled people accessing social care and there being reduced access to sources of support, poorer access to social care, a rise in unmet need and intensification of caring roles and activities. My question is about whether reduced social care put older disabled people at greater risk of abuse, including where older disabled people were receiving care, potentially in the context of domestic abuse, and during lockdown, the abuser may have been or newly become their only carer, upon whom they may have been particularly reliant or even entirely dependent.

PROFESSOR NAZROO: Yes, so just to clarify, intensification of caring roles refers to informal caring roles, who are largely family and friends, and hence the concern of the potentially increased risk of domestic abuse in those caring roles.

We do know that the majority of older abuse is conducted by a spouse or relative. As far as I'm aware, we do not know how that changed during the pandemic but clearly the risk was there.

Q. Well, I think Professor Bécares has referred in her evidence to -- a notion of what a common picture of what domestic abuse looks like, but do we really need to take into account this as well?

PROFESSOR NAZROO: To include older people? Absolutely.

They're -- and I would again argue that they're a data -- there are data shortages here, we do need more research around the experience of elder abuse or the prevalence and experience of elder abuse.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Beattie.

MS BLACKWELL: My Lady, that completes today's evidence. Perhaps it's just worth reminding ourselves that although we've only highlighted certain parts of the three expert reports that have been provided today, provided and discussed today, by Professors Bécares and Nazroo, of course the whole of the reports will be published and will be taken into account by my Lady in formulating our module report.

LADY HALLETT: Thank you, Ms Blackwell, a point well made.

Thank you.

Professors, I think you know that, but just to reaffirm and echo what Ms Blackwell has just said, do not worry if we haven't gone over everything in your reports in the kind of detail you would have liked. As you'll appreciate, we have to just focus on the main highlights for the oral evidence but I promise you I will take into account your extremely helpful report, and thank you very much for the help you gave last time and for the help you've given again for this module.

I'm really grateful.

PROFESSOR NAZROO: Thank you.

LADY HALLETT: Thank you. Very well. I shall return for 10.00 tomorrow, please.

MS BLACKWELL: Thank you, my Lady.

(4.28 pm)

(The hearing adjourned until 10.0 am the following day)

I N D E X