Witness Name: Lara Wong on behalf of
Clinically Vulnerable Families
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IN THE PUBLIC INQUIRY INTO THE UK COVID-19 INQUIRY

MODULE 10

WITNESS STATEMENT OF
LARA WONG
ON BEHALF OF CLINICALLY VULNERABLE FAMILIES ('CVF')

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I, Lara Wong, on behalf of Clinically Vulnerable Families, will say as follows: -

1. I am writing this statement in response to the UK Covid-19 Inquiry's request, dated 9 April 2025, for evidence under Rule 9 of the Inquiry Rules 2006 in respect of Module 10. I provide this written response on behalf of Clinically Vulnerable Families ('**CVF**') which I founded and lead with the support of deputy leaders, expert advisors, and dedicated team members. Others have contributed to the information and detail within this statement to whom I am grateful for their assistance. This statement gives a voice to our members and throughout, where appropriate, I have provided quotes, examples and case studies from many of our members to assist the Inquiry in understanding their real life lived experience and in doing so, have not sought to correct any spelling or grammatical errors, and have presented the quotes as they have been provided by our members to maintain the authenticity. In addition, the names associated with some quotes have been randomised to protect the identity of the member, save for where they have already given evidence to the Inquiry.

2. In order to prepare this statement, I have drawn on my own experience and knowledge, including from my professional training and understanding, as well as the knowledge and experience of CVF members. CVF is a primarily volunteer group with an online membership base, as set out in paragraph [9]. I am aware of many

members' experiences and perspectives because CVF has sought to advocate for members' rights, has provided peer support for members and we routinely discuss the challenges faced both individually and as a group during the Inquiry's defined pandemic period.

3. It is noted that for the purpose of this Rule 9 request, the date range of the pandemic is set as the period between 1 January 2020 and 28 June 2022. Where we refer to the pandemic within this statement we do indeed refer to that prescribed time period. However, we do not agree that the pandemic came to an end on 28 June 2022. With ongoing virus evolution and continued hospitalisations, as a consequence of continued health risks, for many of our members the pandemic remains a very real and live issue, and in some cases still curtails their fundamental freedoms. We highlight throughout this statement examples of our members' lived experiences, stressing that those experiences have not improved since 28 June 2022 but remain unchanged to this day. This situation will likely continue unless immediate action is taken to address their needs. We therefore respectfully urge the Chair to consider the impact of the pandemic upon Clinically Vulnerable people and their families during the defined period, recognising that for many, those challenges persist, as they did at the height of the pandemic.

4. Throughout my statement, I will be using various terms and abbreviations when describing the population that CVF represent and I set out descriptions of those abbreviations below to assist the reader:

Clinically Vulnerable	Used when referring to the whole group, including the original Covid-19 vaccine priority group 4, group 6, and people aged over 65, as defined in the 2020 JCVI vaccination priority list.
clinically extremely vulnerable ('**CEV**')	Individuals classified as Group 4 under the original Covid-19 vaccine priority list. These individuals were formally advised to shield due to severe clinical risk.
clinically vulnerable ('**CV**')	Individuals classified as Group 6 under the original Covid-19 vaccine priority list. These individuals were not formally advised to shield but are considered at high clinical risk.

CV families / CV households	Households that include at least one member who is either CV or CEV. The CV or CEV member may be a child or an adult.

PART A – Clinically Vulnerable Families

History, purpose and membership

5. CVF is a grassroots organisation founded in August 2020. It was incorporated as a Community Interest Company (a private company limited by guarantee) on 16 October 2024 with me serving as the Chief Executive Officer. CVF currently represents those who are CV, those who had been identified as CEV (before this terminology was retired), including people who are Severely Immunosuppressed; and those in their households across all four UK nations.

6. CVF's mission is to support, inform and advocate for those in CV households as they face an ongoing threat posed by Covid-19. Our vision is that one day we will have sufficient protections to restore the freedoms of society's most vulnerable.

7. CVF has multiple purposes, and these have evolved since its foundation. CVF primarily aims to support, educate, assist, advocate and campaign for CV families in the UK due to the risks posed by Covid-19. To further understand the work of the group I have set out how CVF fulfils its functions below:

    a. Support

    CVF supports its members, in part through an active social media presence, that is firmly rooted in our four core principles:

    i. To be scientific and evidence based;
    ii. To provide peer support and practical assistance (e.g., drafting letters, helping with other correspondence and communications for our members);
    iii. To address the mental health needs of members by offering weekly check-ins with members; and
    iv. To operate exclusively for the CV and their households.

Through communication with our members, CVF are able to identify and address any additional needs that arise from a member's circumstances, such as the need for legal advice and advocacy.

b. Education

Due to my background, along with a number of other expert members, CVF is able to offer a variety of resources to help its members and actively share good quality scientific publications, with possible interpretations, to help assist members to access the information. This includes, but is not limited to, sharing how to assess individual risk and advice on how to reduce risk of Covid-19 infection, providing information on eligibility for additional vaccines and antiviral treatment (including advice on any processes involved and commonly experienced difficulties), and regular updates on government policy documents relating to CV families.

c. Assist

CVF aims to identify those members with urgent needs and help them by offering peer support. For example, we have helped members access antiviral treatments within the tight 5-day timescales by providing basic explanations of how to apply, as well as directly making representations to healthcare professionals and members' MPs in some exceptionally challenging cases. We also help draft letters, correspondence and other communications for our members.

CVF has supported members who have faced fines and/or prosecutions, or have been threatened with the above, for Covid-19 related absences in school. CVF also supports those who are at risk of losing their jobs or of being made redundant for Covid-19 related reasons. CVF has assisted members in making requests for risk assessments and reasonable adjustments within school and employment settings.

d. Advocate and Campaign

CVF has, and continues to, work collaboratively with various other charities and organisations pursuing shared and unique goals. The key issues we seek to address include, or have included:

i. Reasonable adjustments
ii. Ventilation standards and air quality

iii. Safety of indoor spaces
iv. Access to Covid-19 vaccinations and treatment
v. Covid-19 Infection Prevention and Control measures
vi. Protection of the right to wear a mask
vii. Maintenance of test, trace and isolate policies
viii. Maintenance of Covid-19 data collection
ix. Inequalities faced by Clinically Vulnerable children and children in CV households in education
x. Recognition of Clinical Vulnerability as a protected characteristic under the Equality Act 2010

8. To date, CVF has driven policy change through various methods and has:

a. Shared members' case studies with the local and national media.
b. Developed and maintained strong links with parliamentarians who have asked questions in Parliament on behalf of CVF.
c. Taken part in relevant All-Party Parliamentary Groups ('**APPGs**'), for example, the Coronavirus APPG chaired by Layla Moran MP.
d. Joined forces with other campaign and educational groups, such as Covid-19 Bereaved Families for Justice, Clean Air Classrooms, Long Covid groups, and Independent SAGE (for example, in relation to 'The Covid-19 Safety Pledge'). CVF has brought its unique perspective to these collaborations, a perspective which is not available from any other organisation;
e. Made connections, established awareness, and raised CVF's profile through social media platforms, aiming always for a better future for the CV and their families.
f. Contributed to the National Institute for Health and Care Excellence ('**NICE**') appraisal for Evusheld and call for evidence: [LW10/001 - INQ000408806] is demonstrative of the submissions made by CVF to NICE.
g. Advocated against recent changes to the UK's Covid-19 vaccination policy proposed by the Joint Committee on Vaccination and Immunisation ('**JCVI**'), which may significantly narrow eligibility for booster doses and risk excluding many individuals who remain Clinically Vulnerable to Covid-19.

9. CVF's membership is open to all Clinically Vulnerable people and those living in CV households. Entry questions are used to determine whether applicants to the group meet the criteria. At present, the combined membership and following of CVF is

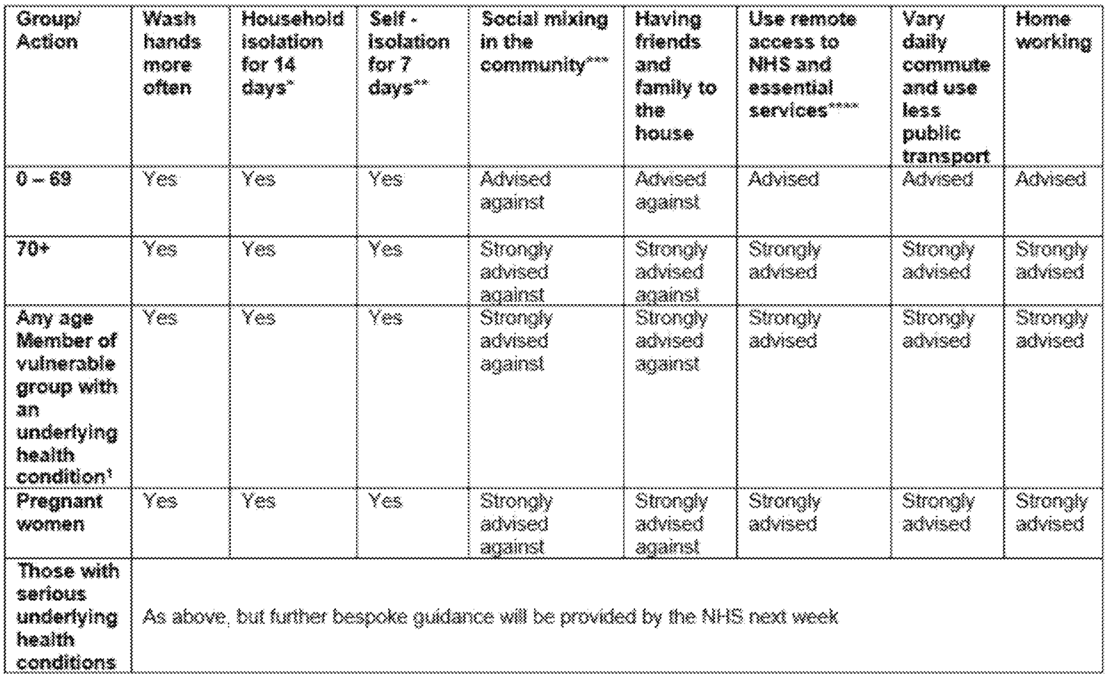
approximately at 66,453 and is continuing to grow. The group have a significant online presence, through which most of their work is achieved. As at the date of the drafting of this statement, there are 2,676 members of CVF's private Facebook group, 13,719 followers on Twitter (now known as X), and 5,756 BlueSky followers. Each member or follower in the figures cited above tends to represent a family or household and we can therefore reasonably assume that CVF's reach is at least three times the number of actual members and followers to account for multiple occupancy households.

10. More information about the group and the work that we do can be found by accessing CVF's website, images of which can be found at [LW10/002 - INQ000408817].

The CV, CEV, and Severely Immunosuppressed population

11. The names of some of these groups were created by the government during the early pandemic, along with the term '*shielding*'. These terms have continued to be removed and changed by the government over the period of the pandemic to the current day. Although the term CEV is no longer used by the government, many who were designated CEV continue to describe themselves as such.

12. For the purposes of this statement, I adopt the definitions of Clinically Vulnerable, CV and CEV as set out above at paragraph 4. I would however like to note in this respect that the terms "clinically vulnerable" or "clinically extremely vulnerable" were not a self-identified category or a community-defined label – these were new names which were JCVI or government defined. Clinically Vulnerable people were not consulted with respect to these definitions. As demonstrated in the below table at figure 1, Public Health England advice from as early as March 2020 identified 'clinically vulnerable' groups (people with certain underlying health conditions, aged over 70, or pregnant women), in recognition of their increased risk of severe illness from Covid-19, but placed huge responsibility on individuals to take precautions without offering any reasonable adjustments. This meant that people with underlying conditions who fell outside the government's defined terms for those considered to be CEV (i.e. those with "*serious underlying health conditions*" in the table below) were left uniquely exposed, especially in employment, healthcare, education and access to support and services.



Group/ Action	Wash hands more often	Household isolation for 14 days*	Self - isolation for 7 days**	Social mixing in the community***	Having friends and family to the house	Use remote access to NHS and essential services****	Vary daily commute and use less public transport	Home working
0 – 69	Yes	Yes	Yes	Advised against	Advised against	Advised	Advised	Advised
70+	Yes	Yes	Yes	Strongly advised against	Strongly advised against	Strongly advised	Strongly advised	Strongly advised
Any age Member of vulnerable group with an underlying health condition[1]	Yes	Yes	Yes	Strongly advised against	Strongly advised against	Strongly advised	Strongly advised	Strongly advised
Pregnant women	Yes	Yes	Yes	Strongly advised against	Strongly advised against	Strongly advised	Strongly advised	Strongly advised
Those with serious underlying health conditions	As above, but further bespoke guidance will be provided by the NHS next week							

(Figure 1), [LW10/003 - INQ000176654]

13. While the number of Clinically Vulnerable individuals in the UK is not publicly available, we can use vaccination and other data to provide some reference points. For instance, as of February 2021 [LW10/004 - INQ000408872], the total number of persons identified in the top priority groups in 2020/2021 totalled approximately 20.5 million, and March 2022 estimates suggested that almost 11 million people were CV due to age (aged 65 and over) [LW10/005 - INQ000408850]. Estimates of numbers of severely immunosuppressed people vary (NICE estimates that 1.8 million are severely immunosuppressed and eligible for Evusheld [LW10/006 - INQ000339319], while Government estimates have ranged between 1.7 and 1.2 million: [LW10/007 - INQ000474557_0053, §200]; [LW10/008 - INQ000417415-0002]). While helpful, these figures are likely underestimates; for example, they exclude Clinically Vulnerable young people under the age of 16.

14. These individuals have always been at highest risk of poorer outcomes from Covid-19 infection, despite vaccination, and continue to be so [LW10/009 - INQ000408828, p.60]. This is especially true for immune suppressed individuals, some of whom may not mount a response, or an effective response, to Covid-19 vaccination and

therefore remain at incredibly high risk from Covid-19. These increased levels of risk are well known to government: for instance, Office of National Statistics ('**ONS**') data confirms that people who have 'underlying conditions' versus 'healthy people' have a 9.2 times increase in death from Covid-19 [LW10/010 - INQ000408875]. People who identify as 'activity limited by health a lot, by health conditions' versus 'healthy people' have a 5.4 times increase in developing Long Covid [LW10/011 - INQ000408796].

Recognition of clinical vulnerability

15. Despite being among those most medically at risk from Covid-19, Clinically Vulnerable people were frequently invisible in data collection, and excluded from protections. The structural failure to identify, protect, or represent Clinically Vulnerable people must be recognised as a distinct and serious omission. While there was, initially, limited data collected regarding those who were CEV, once this classification was removed, no further systematic data was gathered about their experiences or outcomes.

16. Furthermore, Clinically Vulnerable people are not recognised as a protected group in law and had no equivalent legal status or protection, unlike those recognised as being disabled under the Equality Act 2010 [LW10/012 - INQ000377698]. The Equality Act guidance is clear that having a medical condition alone does not mean that one qualifies as disabled. As clinical vulnerability is based solely on medical risk, not functional impairments, people who are at increased risk from infections do not necessarily meet the criteria for "disability" under the Equality Act and consequently may have no associated legal rights and protections, such as the right to 'reasonable adjustments', even when the risk to their health or life is high. Indeed, conditions may be well-managed, treatments that increase risks may be temporary, and some people may have risk factors that are independent of any underlying health conditions, such as those related to pregnancy or age. As a result, guidance from public bodies like the Health and Safety Executive ('**HSE**') made no reference to legal protections under the Equality Act when advising employers on how to manage risk for CV or CEV workers. Rather, for CV workers (or 'workers in higher-risk groups'), the guidance simply stated:

> "There are currently no expectations of additional controls specifically for these groups. But make sure your existing controls (social distancing, good hygiene and cleaning, ventilation, supervision etc) are applied strictly." [LW10/013 – INQ000652697]

17. For CEV workers, HSE suggested slightly stronger measures in guidance such as enabling home working or adjusting duties, but without reference to enforceable rights under the Equality Act. Measures were framed as what is "reasonably practicable" [LW10/013 – INQ000652697], stopping well short of offering "reasonable adjustments" under the Equality Act. This stands in stark contrast to how groups with recognised protected characteristics were treated under the same guidance. For instance, employers were required to carry out specific individual risk assessments for pregnant workers, and where safety could not be ensured, were obligated to suspend the worker on paid leave. The guidance, [LW10/013 – INQ000652697] explicitly acknowledged the risks to pregnant workers and set out legal mechanisms to protect them - a level of protection not offered to other Clinically Vulnerable people, despite their similarly high health risks. Similar enforceable rights were not available to CV or CEV workers and CVF feels that this highlights a key structural failing. As a consequence, Clinically Vulnerable people were often left without suitable protection, and found themselves dependent on employer discretion.

18. Our lived experience is that Clinically Vulnerable people were left in something of a legal vacuum. Highly at risk, but without formal protection or even the right to refuse unsafe work. Unlike disabled people, CV and CEV workers could not rely on the Equality Act to request adjustments or protection based on their Clinically Vulnerable status and found they frequently had no route for legal recourse if denied safety measures.

PART B – Impact on Mental Health and Wellbeing

19. See Annex A for two separate case studies that share the experience of living in a CEV household and the experience of a CEV person.

20. The pandemic created sustained psychological pressures for Clinically Vulnerable people that went beyond the immediate threat of infection. Extended shielding (formal or informal), repeated disruption to healthcare access, and prolonged

exclusion from everyday activities meant that risk management became a constant feature of daily life. Many experienced the erosion of protective measures as a signal that their safety was no longer a public priority, amplifying feelings of isolation and abandonment. Their challenges were often compounded by pre-existing health conditions which created new barriers to social connections, and disrupted access to sources of emotional support.

21. An important factor in this has been the way ongoing medical risks have been deprioritised or ignored in public policy and service planning. For Clinically Vulnerable people, the knowledge that exposure to airborne infections may cause severe illness or death is not hypothetical. The removal of mitigations in healthcare and public spaces has forced many to choose between protecting their physical health and participating in essential activities, including medical appointments, and attending education or workplaces. The persistent threat to physical safety has, in turn, been a significant driver of legitimate anxiety, social withdrawal, and loss of trust in systems.

22. CVF gathered insight from its members, through our recent 'Impact on Society' survey [LW10/014 - **INQ000657072**]. The survey ran in the summer of 2025 and received 125 responses from people in Clinically Vulnerable households across the UK, capturing experiences over multiple stages of the pandemic. It combined structured questions on specific impacts (e.g. healthcare access, mental health, community participation) with open-text accounts that provided rich qualitative detail. The responses illustrate both the scale and persistence of the mental health toll, showing how it evolved through different phases of the crisis.

Survey Findings

23. Responses showed that impacts were multi-layered, often combining social, emotional, and practical challenges. Participants described both the direct strain of living with increased health risks and the secondary effects of prolonged exclusion from safe public spaces, healthcare, and social contact. Key themes emerging from the data included:

    i. Social isolation was reported as a major factor for most respondents, associated with shielding, ongoing risk from airborne infections, and the withdrawal of mitigations (e.g. masking in public and healthcare settings) leaving many finding it harder to return to their former lives.

ii. A large proportion described their concerns linked to increased infection risks, particularly in healthcare environments, workplaces, and high population density public spaces without ventilation or masking.

iii. Many experienced depression and a sense of hopelessness when mitigations were lifted without protections for high-risk individuals.

iv. Grief and trauma were compounded by circumstances such as being unable to visit dying relatives, restricted funerals, or lack of post-bereavement support due to shielding.

v. Reports of loneliness were particularly acute in households not only where the CV/CEV individual lived alone, but also where they were the only vulnerable member, creating divisions within families about acceptable risk and behaviours.

<u>Patterns over time</u>

24. In the early shielding period (March–July 2020), respondents to CVF's survey, cited extreme isolation, anxiety about the unknown risks of Covid-19, and distress over being unable to access routine medical care. The results of the survey also showed that, in mid-2020 and early 2021, anxiety remained high despite some easing of restrictions, due to continued vulnerability and concerns about inconsistent public compliance with safety measures. There was a slight decrease in anxiety following vaccinations between Nov - Dec 2020 and Jan - Mar 2021 (first vaccinations for CEV individuals), where the proportion reporting high anxiety decreased from 86.4% to 82.4% (-4%). A further decrease was observed between Jul - Oct 2021 ("Freedom Day" / shielding ending) and Nov 2021 - Jan 2022 (rise of Omicron / booster period), from 92.0% to 86.4% (-5.6%). Loneliness rose from 38.4% during the first lockdown to 54.4% by June 2022, following the introduction of the "Living with Covid" policy [LW10/014 - **INQ000657072**].

25. Reported rates of depression were around one-third during the first lockdown, rising to just over 45% when shielding was paused and initiatives such as the return to work and Eat Out to Help Out were introduced. Rates remained relatively stable thereafter, with notable peaks around "Freedom Day" and the "Living with Covid" policy, reaching a high of 53.6%, mirroring the rise in loneliness over the same period [LW10/014 - INQ000657072].

26. By "Freedom Day" (July 2021) and thereafter, for some people, mental health impacts might be considered to have shifted towards chronic stress and long-term social withdrawal as protections were removed, leaving individuals to navigate their own risks alone.

27. Many respondents described feeling that their lives were undervalued:

Quote 1 – Kath, 31
"This [pandemic period] showed me and my family that society views disabled and chronically [ill] lives like mine as disposable".

28. Others spoke about the destabilising impact of changing shielding advice on their families' mental health:

Quote 2 – Heather, 50
"The constant pausing / unpausing and uncertainty of when to shield really affected us all - we felt safer shielding and would rather have just been supported to do thus throughout".

29. Some accounts illustrated the severe mental health toll of prolonged isolation and unmitigated medical risk:

Quote 3 – Dorota, 53
"Five years on my mental health is still in tatters from the extremes of isolation, depression, anxiety, and fear I experienced. I had a full suicide plan in place [if] I caught the virus, so terrified was I of being put on a ventilator and dying in terror that I planned to end my life painlessly and peacefully if I tested positive."

30. Some respondents described the harm caused when mental health support failed to acknowledge the legitimacy of their ongoing Covid-19 risk, treating it instead as an irrational fear to be overcome.

Quote 4 – Jayden, 32

"I was referred to a clinical psychologist in the hospital's mental health team after I'd had my maximum Macmillan counselling sessions. I think they felt I wasn't making any progress. I told the psychologist that the Macmillan counsellor had treated my concerns like a phobia and kept trying to get me to do things I didn't feel were safe. Like going to a restaurant. I remember saying I felt like she was trying to rehabilitate me into something completely wrong for me. Her response was "You don't have a phobia. A phobia is an irrational fear and I can see that Covid is a real, legitimate concern." I realised I was not mad. I was completely right to feel as concerned as I did, as a vulnerable cancer patient."

31. Our data suggests that these serious mental health harms were not simply short-term responses to lockdowns but that they are ongoing consequences of prolonged exclusion from their former lives. Indeed, for some people, particularly those who are immunosuppressed or immunocompromised and who may not have responded to their vaccinations, the medical risk from Covid-19 and other airborne infections remains as high as at the start of the pandemic. Yet this is now compounded by greater community prevalence of the virus. This continued elevated risk is still recognised in current UK Heath Security Agency ('**UKHSA**') and Department of Health and Social Care ('**DHSC**') guidance [LW10/015 – INQ000652400] which continues to advise additional precautions for "people whose immune system means they are at higher risk".

32. The availability of vaccinations has reduced the level of risk for most of the population, however, underlying health conditions and immunosenescence (age-related decline and dysfunction of the immune system) from ageing still increase the risks faced by Clinically Vulnerable groups compared to healthy people. The persistent and now unmitigated threat to health has been a major source of chronic stress, undermining mental wellbeing and forcing particularly vulnerable people to remain isolated long after the majority of society returned to normal life. The result is a public health equity gap: while most of the population have resumed all normal activities, Clinically Vulnerable people continue to face increased risks that undermine recovery in terms of both their physical and, for some, their mental health.

The closure and subsequent reopening of cultural, leisure, and recreational facilities.

33. The closure and reopening of cultural and leisure spaces had a profound and lasting impact on Clinically Vulnerable people. While initial closures brought anxiety, loss of work, and isolation, reopening without protections was often more damaging, amplifying exclusion, risk, and psychological harm.

Case Study (iii) – An actress who is CEV due to Cancer

"By the autumn of 2020, when theatres were tentatively reopening and I was starting to do remote auditions, I was diagnosed with cancer and started 18 months of chemo and immunotherapy. I was severely immunocompromised, and I had to shield. So, ironically, if I thought my life felt dispensable before, with those appalling government adverts suggesting ballet dancers simply abandon their hard-won careers to 'Retrain in Cyber' [LW10/016 – INQ000652699], then it was nothing compared to how I felt my life looked now. Not only had I been shut out of my workplaces since March, but the door to every aspect of public life now appeared firmly locked.

My day-to-day became much rockier to navigate. Suddenly the narrative became 'if you're scared just stay at home then'. This was the same in theatre. I have actor friends who were told not to test so that they wouldn't know they had Covid. Some theatre producers were basically saying if you don't know then you can come to work and you don't have to feel guilty about it. That wasn't the kind of environment I could safely return to, despite the fact that my hair was growing back and I was starting to feel ok, despite still being on treatment. But the big issue was that I was still immunocompromised – but no-one can see that, can they? People expect those who are going through cancer to look emaciated and sick. But immunocompromise doesn't 'look' poorly. It's an invisible health problem."

Anonymous, CVF Member

Survey Data and Industry Findings

34. The Big Freelancer Survey ('**BFS**'), conducted in June 2020 shows that freelancers were "70% of the total theatre workforce" and disabled workers were disproportionately affected. This survey addressed concerns of freelancers and the financial issues which drove many to consider leaving completely, including 42% of

disabled workers reported at the time as likely to leave the theatre industry, although no data was collected on Clinically Vulnerable groups [LW10/017 – INQ000652700].

35. In CVF's members' experience, Clinically Vulnerable performers, many of whom are not formally classified as disabled, faced increasing professional exclusion as safety measures were rolled back. Basic protections such as mask-wearing became grounds for questioning their ability to work.

Quote 5 - Ash, Opera Pianist
"I was (and still am) the only one masking at work… My boss asked me 'how are you going to manage act 2 of this opera when everyone is in the room?'… I felt uncomfortable that it was being suggested that I'm now unable to do my job to the best of my ability, that my reluctance to catch Covid is affecting my employment."

36. This pattern of exclusion extended beyond the workforce to audiences themselves. The Association of Leading Visitor Attractions ('**ALVA**') conducted a series of public attitude surveys in 2020. Their Wave 4 report, dated July 2020 [LW10/018 – INQ000652701], found that older people were among the least confident about returning to indoor attractions, in circumstances where it is well understood that older people are likely to be Clinically Vulnerable:

> *"Younger people are more likely to be the earliest returners, with those from older age groups less confident about a quick return especially to indoor attractions."*

37. An earlier report by the ALVA highlighted widespread concern around indoor venues and a strong public preference for visible safety measures, such as face masks and those with better ventilation. As early as May 2020, an ALVA report [LW10/019 – INQ000652702] noted:

> *"Outdoor, open spaces are increasingly recognised by the public as safer than indoor, enclosed spaces."*

38. Despite this awareness, support for mitigations (e.g., ventilation, masking, reserved times with limited entry) was largely abandoned after reopening, and there was a shift toward personal responsibility for managing Covid risk. As a result, culture and

leisure spaces became less accessible, embedding long-term social exclusion for Clinically Vulnerable people, which is evident from many CVF members testimony, such as the ones below.

Quote 6 – Tam, 45
"I have not seen any local public spaces take any steps to make themselves safer for vulnerable people. I contacted several local arts venues... asking about ventilation or adjustments under the Equality Act 2010... Typically I got no response... Eventually I gave up even trying to participate in a society so eager to exclude me."

Quote 7 – Lesley, 50
"We could barely do anything with other people. (We still can't.) When everything reopened, the risks were actually higher for us, and there were no mitigations... We couldn't even go to the library, let alone to the theatre, or to community groups. We were excluded because masks were... vilified and sneered at... Still the case, we are still excluded from most of society because of this."

Quote 8 – Aisha, 38
"I felt a great deal of grief at missing out on events that were part of my identity, such as gigs and comic cons. When places opened, family and friends assumed I'd attend... The lack of information to the public about CV people meant so many went back to pre-pandemic lifestyles... I feel guilty that my child has missed out on wonderful experiences, like visiting museums."

39. The failure to provide even minimal accommodations – such as support for those who mask, or outdoor events – was exclusionary. For Clinically Vulnerable people, it is about the right to participate in public and cultural life on equal terms. Reopening (particularly following 'Freedom Day' and 'Living with Covid') without protections effectively denied many their rightful safe access to society - and continues to do so.

The closure and subsequent reopening of places of worship

40. The closure and reopening of places of worship had a deeply emotional and often traumatic impact on many Clinically Vulnerable people. While many religious institutions initially adapted well to the challenges of the pandemic—offering online services and socially distanced alternatives—the subsequent withdrawal of

mitigations and digital access created lasting harm. For Clinically Vulnerable individuals, these shifts were not simply inconvenient; they represented exclusion from spaces of spiritual significance, social connection, and emotional support.

41. Survey data from CVF shows that while nearly half of respondents did not regularly attend religious services, the majority of those who would normally attend religious or faith-based activities reported their ability to participate was either significantly (54.6%) or somewhat (35.9%) affected by their clinical vulnerability. Only a small minority (9.4%) said their participation was unaffected.

42. This exclusion had profound consequences. Many respondents experienced grief, trauma, and isolation as they were unable to attend key rites of passage, such as funerals and memorials. Rituals intended to bring people together, to reinforce social support networks surrounding the bereaved and comforting them in their grief, in many cases had the opposite effect: reinforcing isolation, fracturing relationships and obstructing the normal processes of grieving and healing. The loss of these moments for collective mourning compounded isolation and disrupted normal grieving processes. Members were grateful for the efforts made by religious institutions and faith communities to include vulnerable people and families in services and social events through online provision, especially at the beginning of the pandemic. However, others described how the return to "normal" within faith communities made them feel abandoned or even betrayed.

Quote 9 – Morgan, 43

"I hadn't realised until it stopped how much my weekly services meant to me in terms of my mental health. The community and social aspect of going to church is very important to me and when this stopped it was very hard. Unfortunately two significant events happened during the timeframe that greatly challenged my Christian faith and without the weekly face-to-face support, I felt very isolated. All this has made me turn my back on organised religion and I am no longer a practicing Christian."

Quote 10 – Taylor, 45

"We were regular attendees at our village church and our children loved messy church. I felt our church were unsupportive and unchristian! We no longer attend church and I no longer feel part of that community."

43. The psychological toll of this exclusion extended beyond the duration of restrictions. Members spoke of feeling displaced, their place in the community diminished. Others reported that even when they could attend online, the loss of in-person connection led to a lasting damage to their spiritual wellbeing.

Quote 11 – Katty, 38

"We used to attend in person every week, but when we returned to some face-to-face worship, we attended once a month, and it remains more or less that. Online attendance is brilliant to have, but not quite the same as attending in person."

Quote 12 – Leah

"We felt like our faith-based values - caring for the vulnerable - were completely abandoned. It hurt more coming from people we trusted."

44. The loss of mitigations like masking, clean air, or dedicated services created an environment that excluded Clinically Vulnerable people both physically and spiritually.

Quote 13 – Sarah

"Our church refused to consider improving ventilation due to perceived discomfort for other worshipers, which was prioritised over the safety needs of vulnerable people. We offered to fundraise for HEPA filters to make the worship space safe for elderly and vulnerable people, but the PCC obstructed this. They prioritised the comfort of others over our safety, even knowing our son had nearly died from Covid. It was a moral injury."

45. The failure to maintain accessibility, or to uphold even basic principles of equity and inclusion, left many feeling disposable within their faith communities. As one member put it:

Quote 14 – John

"It flies in the face of everything we know from the Bible about Jesus's special concern and care for the most vulnerable."

46. Places of worship have a vital role to play in community resilience, particularly in times of crisis. Ensuring they remain inclusive, safe, and accessible to all - especially those most at risk - is not only a public health concern, but a matter of moral and spiritual responsibility.

The closure and subsequent reopening of hospitality, retail, travel, and tourism venues and services

47. Those working in the retail, travel and tourism, or hospitality sectors who were Clinically Vulnerable were often forced to withdraw from their roles, leading to financial insecurity. Some experienced job losses when they were unable to return to unsafe in-person roles and were excluded from furlough schemes due to leaving "voluntarily" for safety reasons, similarly to other sectors.

48. When society reopened, the removal of safety mitigations (masking, ventilation, occupancy limits) meant that many people could not safely re-engage. For many high-risk people, these remained 'non-essential', and society felt increasingly closed off to them. As protections were removed, the risks increased, and this added to psychological pressures, further impacting the mental health of Clinically Vulnerable individuals. People who lived alone were particularly impacted:

Quote 15 – Robin, 67
"I was unable to attend my daughter's wedding abroad as it was too risky for me to fly or stay in a hotel and my consultant advised against it. This was heartbreaking for me. […] I felt very lonely (I live alone) - phoning or texting friends and family is not as emotionally fulfilling as meeting in person. No hugging or physical contact with my close family was difficult to cope with, especially when my first grandchild was born."

Eating in Enclosed Spaces

49. Eating is an inherently social activity, shaped by millions of years of cultural evolution. For those who needed to wear masks to remain safe, however, dining in public spaces became fundamentally inaccessible. Food and drink are often central to rites of passage, celebration, and even mourning. Declining to participate in shared meals or drinks is widely interpreted as a social faux pas.

50. Clinically Vulnerable people and families were frequently pressured by friends, colleagues, and even loved ones to remove their masks in order to "join in." This pressure intensified during the government's "Eat Out to Help Out" initiative, which effectively excluded or risked Clinically Vulnerable people by incentivising indoor,

unmasked public dining at a time when no vaccines or treatments were widely available. The message appeared to be that public life was reopening, but only for the healthy majority.

51. CVF's survey confirms that the reopening without appropriate support for vulnerable people created significant psychological harm, including:

a. Anxiety over the lack of measures

Quote 16 – Fatima, 23
"I was terrified about the reopening. I felt safer during the lockdowns as more people were being careful. But when the government reopened everything again, people were less careful and places were less safe for me to go."

b. Grief over missing milestones and communal events

Quote 17 – Gayle, 60
"Socially we have been very affected by being unable to meet in person or attend any events such as weddings, funeral, birthday celebrations etc. Emotionally, living in isolation is very difficult having only contact by remote means, mental health, in normal circumstances living in such isolation would be considered as a cruel and unusual punishment for a situation wholly outside our control it is there for to be expected that poor mental health are to be expected, we feel completely abandoned by the state who's primary duty is to keep us safe."

c. Trauma from being forced to choose between safety and participation

Quote 18 – Helen, 59
"My mum lives 400 miles away. I was terribly concerned for her. When I did fly down to visit I had to weigh up the high risk to both of us of my making that journey against our desperation to see each other. I couldn't have lived with myself if I'd brought infection to her house and she had become ill. It's been like that every time we've seen each other since. As you can imagine, having to make such choices takes a terrible toll on mental health and wellbeing."

d. Loneliness and exclusions due to inaccessible or unsafe environments

Quote 19 – Rachel, 43
"We stopped many of the social events we had done: music group playing, pub, restaurants, theatres, museums - these were all big parts of our life and we just had to stop completely. We avoid holidays which require plane travel, which means I've only seen my US family once since 2020."

52. What was celebrated publicly as a return to normality was experienced by many Clinically Vulnerable people, particularly those who were immunosuppressed or immunocompromised, as a new phase of exclusion. Without clear safety measures, the reopening effectively signalled that their participation and their wellbeing was not important. It contributed to emotional distress and social isolation, with long-term consequences for both accessibility and mental health.

<u>The restrictions on carers, family visits, or access to advocates during lockdowns.</u>

53. Restrictions placed on access to carers, family members, and advocates during the pandemic had severe, wide-ranging impacts on the mental health, autonomy, safety, and sometimes dignity of individuals who were both high-risk as CEV or CV and a carer or also disabled themselves – particularly if they lived alone.

54. CVF would agree that infection control policies necessitated the changes in how services and visitations operated at that time, but there was a widespread failure to ensure safe alternatives that could have enabled greater continuity of care, or advocacy, for those most affected. The restrictions often did not address how to support people facing sometimes severe isolation in a time of crisis facing long-term harm due to unmet physical or medical needs and harms to their psychological wellbeing.

55. This was particularly evident where:

   a. Social care services were withdrawn without replacement or proper communication;
   b. Families (including children and young people) were left to deliver complex care needs without training, PPE, or respite;
   c. Carers were furloughed / unable to safely attend;

d. Clinically Vulnerable people remained concerned about receiving family visitors, even after wider reopening, due to ongoing infection risks;

e. Professional advocates (such as MacMillan nurses, health visitors, or disability support workers) became unavailable or unreachable during critical periods.

Quote 20 – Alice, 63

"Not having access to carers made my physical health deteriorate which knocked on to mental health. My mother had just died […]. I wasn't able to access advocacy support."

Quote 21 – Aria, 30

"No health visitor care. Not even on the telephone. No respite care, no MacMillan care. No help at all was given ever."

56. In guidance from June 2020, 'Coronavirus Job Retention Scheme: people receiving direct payments', it is clear that the government recognised the additional pressures on unpaid family carers and the increased cost of PPE but did not address these issues directly. Example scenarios all appeared to assume that family carers of disabled people who were also shielding would be willing and able to fill the gap for in-person care – this did not always work out and put considerable pressure on family members (including children and young people) [LW10/020 – INQ000652741].

Lack of information and training on airborne mitigations

57. An avoidable driver of harm was the near-total lack of public information on airborne risk and how to manage it safely at home and in care settings. National communications focused on hand-washing and the cleaning of surfaces, while offering little advice on simple airborne measures. This gap was one that CVF consistently sought to address by providing members with clear, practical information on how to reduce airborne risk.

58. Domiciliary care workers, who were often on zero-hours contracts, move between multiple households and were not trained, equipped or supported to use high-grade respirators (FFP2/FFP3). There was no or no suitable guidance on matters such as basic fit-testing for a suitable mask, donning/doffing, storage between visits, and support for mask use in their own daily lives to lower onward transmission.

59. A continuing barrier to safe care provision is the persistent refusal of some carers to wear masks, often justified on the basis of "personal responsibility" being interpreted as "personal choice." This presents a particular risk to those who are not only disabled but also immunocompromised or immunosuppressed, including older people who experience immunosenescence. For these groups, exposure to respiratory pathogens can have severe and/or life-threatening consequences.

60. Where carers do agree to mask, there is frequently a lack of understanding about the difference between basic face coverings and PPE. Public discourse often conflated cloth or surgical masks with respirators, obscuring the fact that FFP2/FFP3 masks are specifically designed to filter airborne particles and provide a high level of protection to the wearer while also serving as source control to protect those who cannot mask. This misunderstanding has left Clinically Vulnerable clients at heightened risk. A lack of consistent training, reinforced by mixed government messaging and misinformation in the media, has contributed to this situation. CVF members continue to report instances where requests for high-grade mask use during care visits are met with resistance, indifference, or claims that it is "no longer necessary."

61. CVF was also concerned to learn from one CVF member that PPE for domiciliary care workers had been downgraded from higher-grade respirators mask (such as FFP2) to fluid-resistant surgical masks. This change increased risks both for Clinically Vulnerable care workers who moved between multiple households, as well as for shielding households relying on their support.

62. The British Occupational Hygiene Society ('**BOHS**') has since highlighted these exact failings. In its guidance "COSHH and Healthcare – Respiratory Protection" (July 2025) [LW10/021 – INQ000652703], BOHS confirmed that surgical masks (FRSMs) are medical devices intended only for source control and cannot lawfully be supplied or used as respiratory protective equipment. The guidance makes clear that providing FRSMs to healthcare or care workers in place of respirators constitutes a breach of COSHH, as they do not protect the wearer from inhalation of hazardous bioaerosols. By contrast, suitable PPE, such as fit-tested FFP3 respirators (or equivalent), is legally required where there remains a risk of airborne exposure. BOHS emphasised that substitution with surgical masks is neither adequate nor suitable protection under COSHH. This reinforces CVF's position that

the downgrading of PPE in healthcare and domiciliary care settings left Clinically Vulnerable people without required protections, amounting not only to a policy failure but also a breach of existing health and safety law.

63. Public information should have included how to improve natural ventilation by cross-venting for short bursts, using trickle vents, or use of the stack effect to improve airflow without losing thermal comfort. Also, the public was not informed of the benefits of portable air filters (with additional information on how to calculate appropriate units for the room using CADR, placement, and with consideration for noise) and also the monitoring CO_2 as a proxy for rebreathed air in a space - and therefore airborne transmission risk.

64. Clinically Vulnerable families were never provided with clear, accessible instructions on how to combine effective ventilation, air filtration, and high-grade masking with a simple "clean-air routine" during care visits. This omission forced Clinically Vulnerable households and their carers to improvise infection control measures. CVF submits that this reflects a systemic lack of planning for those dependent on care and advocacy. Many of the harms could have been mitigated through direct engagement with those most affected - people relying on others to maintain a basic quality of life. The failure to provide this information, and appropriate PPE, was a missed learning opportunity and has left many, to this day, without a safe or reliable support system.

65. The combined effect of the withdrawal of care, lack of safe alternatives, insufficient communication on airborne risks and mask use has left a lasting legacy of reduced safety, and continued exclusion for many Clinically Vulnerable households. These were not inevitable outcomes of the pandemic but the result of policy gaps, poor communication, and a distinct failure to prioritise the needs of those most at risk. CVF urges that future planning must embed airborne infection-control measures, safe care pathways, and meaningful engagement with affected communities to prevent such harms from recurring.

Any other significant feature of the pandemic/measures put in place which impacted the mental health and wellbeing of clinically extremely vulnerable and clinically vulnerable people.

66. Prolonged isolation had significant mental health impacts, leading to anxiety, depression, and loneliness. These psychological challenges made some individuals less likely to comply with isolation requirements, particularly if they felt unsupported or if isolation exacerbated pre-existing mental health conditions, as reported in an article on loneliness and social isolation during the Covid-19 pandemic [LW10/022 – INQ000505931].

67. The social isolation experienced during self-isolation periods, particularly for those living alone or without a strong support network, led to resistance against complying with test, trace and isolate regulations. This was especially true among vulnerable populations who relied on social interactions for daily support.

68. It was clear to me that people were struggling with significant mental health challenges when I founded CVF. As early as September 2020, I began to share a weekly mental health post. This allowed members to 'check-in' by posting a coloured heart to indicate how they were feeling, and hopefully a comment. If people only posted a heart, and the heart indicated that they were struggling or starting to struggle, I encouraged them to elaborate, whilst fostering a supportive environment. I actively encouraged other members to respond because many of their issues were commonly shared, and supportive discussions frequently developed. This approach not only created a sense of community but also enabled me to identify key issues experienced by the group, provide individual support, and work with others towards addressing them.

Unequal impact on clinically extremely vulnerable and clinically vulnerable people, compared to the rest of the population.

69. The extended periods of shielding (formal and informal) that were imposed on Clinically Vulnerable households produced unique and unequal mental health consequences compared to the wider population. While most of society experienced lockdowns of a limited duration, many Clinically Vulnerable households remained

isolated for years, often without adequate support. This produced prolonged stress, social isolation, and loss of resilience.

70. The lack of government recognition for CEV households outside the official shielding lists, or once shielding status was withdrawn, meant people were left to manage risk alone. This created feelings of abandonment and invisibility, contributing to anxiety, hopelessness and depression. These harms were not distributed evenly across society but concentrated in those managing pre-existing health conditions and associated risks.

71. The absence of specific mental health provision to meet their needs compounded their disparities. Many high-risk people could not safely access mental health services in person, and remote provision was frequently unavailable. For those already managing long-term health conditions, the loss of mental health support exacerbated their difficulties.

72. The psychological toll was also compounded by the additive effect of risks and challenges. The impact of long-term shielding for households was devastating. Many felt like a burden to their loved ones, that society had turned its back on them, and that the government had abandoned them. For Clinically Vulnerable people who were also carers, parents, or in insecure employment balancing work, education and household safety led to a constant state of heightened stress. Families also experienced long-term impacts on relationships, identity and their day-to-day life.

73. Social exclusion was another major driver of disparity. Clinically Vulnerable households were disproportionately excluded from social and cultural life, including community networks, volunteering, religious practices and public services. The message that life was back to “normal” marginalised them further, leaving people feeling that they no longer belonged.

74. Stigma and hostility towards risk reducing behaviours (masking, opening windows, or limiting contact) further harmed their wellbeing. When the population at large was encouraged by the government to move on, Clinically Vulnerable households were frequently criticised for maintaining their own precautions, reinforcing their experience of being “othered”.

75. Underlying health conditions and other intersecting disadvantages heightened disparities. For example, those on low incomes or without digital access could not so easily compensate for lost in-person contact. Individuals with multiple vulnerabilities faced compounded psychological harm, as policies were developed in silos that failed to consider or address their realities.

76. In the long-term, these disparities have not been resolved. Some people in Clinically Vulnerable households continue to remain extremely cautious and socially restricted due to their health being an ongoing high-risk. This has meant their isolation has no clear endpoint and the mental health strain is considerable as wider society has resumed normal life. The lack of recognition, support, and safe access to services has meant that for Clinically Vulnerable people, the mental health impact of Covid-19 is not in the past but continues to endure.

<u>Unequal impact for various socio-demographic groups of clinically extremely vulnerable and clinically vulnerable people (including, but not limited to age, gender, race/ethnicity, socioeconomic status, and LGBTQ+).</u>

77. CVF only has minimal data to rely on for this topic. Some of the responses we received (e.g., from a member who is a foreign national and parent to a CEV child, or from a member of mixed ethnic heritage who identified as non-binary and described their traumatic complex grief experience following the loss of a parent who had been abusive) suggest that further research is needed to investigate such intersectional experiences and their associated mental health impact disparities. Other than that, elderly people suffered similar disproportionate impacts to other Clinically Vulnerable people. One person reported being labelled "over anxious" by faith leaders when raising concerns and felt their concerns relating to issues around airborne risks were downplayed. Members described alienation, grief, and loss of belonging.

78. CVF also wishes to flag that, as Callum Phillips (2021) writes in the British Medical Journal (BMJ) [LW10/023 – INQ000652704], the UK, at the time, was still failing to adequately collect data on LGBTQ+ individuals and their health outcomes, although available data suggested that LGBTQ+ people tend to have worse Covid-19 outcomes. CVF agrees that the lack of visibility and inclusion of LGBTQ+ people's

experiences in national data collection remains a serious concern.[1] These gaps not only limit understanding of how intersecting identities shape risk and access but also perpetuate the marginalisation of already underserved communities within healthcare and public health policy.

Unequal impact for clinically extremely vulnerable and clinically vulnerable people with specific conditions (including, but not limited to severe respiratory conditions, specific cancers, those on immunosuppression therapies and pregnant women)

79. Some people with suppressed immune systems, respiratory illness, and other high-risk conditions faced intensified fear, exclusion, and lack of bureaucratic oversight. Some were missed from the shielding list, compounding their sense of abandonment.

Quote 22 – Jo, 54
"I have been immune suppressed for 44 years due to an organ transplant... I have multiple co-morbidities... Yet somehow, I was missed, forgotten & left to fend for myself... When we got an emergency food delivery I cried... because at least I had been remembered."

80. Even patients who were formally shielded were required to attend essential healthcare services such as cancer treatments, dialysis, and immunosuppressant infusions. These were unavoidable and created significant disparities in exposure risk. Unlike the general population, who could reduce exposure by staying at home, many of the highest-risk patients had no choice but to enter healthcare environments during peaks of transmission. Paragraphs 81 - 98 address what many CVF members reported as their experience:

81. **Dialysis patients** often had to travel multiple times per week to shared hospital units, sitting in close proximity to others for extended periods, whilst eating and drinking next to other (often unmasked) patients. A study found that people receiving in-centre haemodialysis were at substantially higher risk of contracting Covid-19, and mortality rates among dialysis patients were far higher than in the general population [LW10/024 – INQ000652705].

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[1] CVF's own survey included 22 respondents who identified as LGBTQ+, and six who identified as non-binary, transgender, or gender neutral. Consequently, CVF did not receive sufficient data to draw conclusions about the specific experiences of LGBTQ+ members during the pandemic.

82. **Cancer patients** undergoing chemotherapy and radiotherapy reported being placed in crowded waiting rooms or wards without adequate infection-control measures.

83. **Immunosuppressed patients** receiving hospital-based treatments (e.g. biologics, monoclonal antibodies, or transplant follow-up) had to routinely attend healthcare appointments.

84. Despite their suppressed immunity, many of these patients found that they were not always prioritised for isolation rooms, and they sometimes found themselves next to symptomatic Covid-infected patients.

85. **Older Age** was one of the strongest and most consistent predictors of severe outcomes from Covid-19. 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; in January 2021 [LW10/025 – INQ000652742], when Covid-19 deaths were at their peak, deaths from Covid-19 were nearly 32 times higher than deaths from flu and pneumonia among people aged 40 to 59 and 60 to 79. Older people were also significantly more likely to require hospitalisation and intensive care, and age remained an independent risk factor even after accounting for other underlying conditions.

86. Despite this, age alone was not identified as a criterion for shielding. The shielding programme focused on a narrower group of conditions judged to carry exceptional risk, but excluded the much larger group of older people - even though they accounted for the majority of Covid-19 deaths. Instead of being offered formal protections, older people were largely left to manage their own risks, relying on general lockdown measures or informal isolation. This policy gap meant that healthier older adults, including those living independently but at very high risk, were not supported through mechanisms such as priority food and pharmacy deliveries, or targeted financial support nor were they ever fully informed of their risks.

87. The exclusion of age as a stand-alone shielding factor highlights how even the most powerful risk predictor was not incorporated into protective frameworks, leaving older people disproportionately exposed to the pandemic's worst outcomes.

88. **Obesity and Diabetes.** People with underlying conditions such as obesity, and diabetes were among the most likely to die from Covid-19. For example, the U.S. Centers for Disease Control and Prevention ('**CDC**') reported that those with such underlying conditions had substantially higher hospitalisation and ICU admission rates compared to individuals without these comorbidities [LW10/026 – INQ000652706].

89. Although diabetes and obesity were consistently recognised as among the strongest predictors of severe Covid-19 outcomes and mortality, most people within these groups were excluded from the formal shielding list. CVF believes that, because they represented a large segment of the population, including them may have been ruled out as impractical.

90. **Obesity**. Public Health England's review found that a BMI ≥ 40 was a strong independent risk factor for Covid-19 hospitalisation and death. However, only people at the most extreme end of obesity (BMI ≥ 40) were included in the vaccine priority Group 6 and even then, they were not shielded. Millions of people with obesity below this threshold - who still faced a significantly increased risk - received no additional protections or guidance, except from advice simply instructing them to lose weight:

> *"The report highlights that supporting people to achieve and maintain a healthy weight may reduce the severe effects of COVID-19 on the population, especially among vulnerable groups that are most affected by obesity."* [LW10/027 – INQ000652707].

91. **Diabetes**. NHS data showed that people with diabetes were at significantly higher risk of Covid-19 death - with analysis from NHS England in 2020 showing that one in three deaths in hospital with Covid-19 involved someone with diabetes [LW10/028 – INQ000652708]. Later studies confirmed that poor outcomes were linked to both type 1 and type 2 diabetes, and that risk was only partly mitigated by vaccination [LW10/029 – INQ000652709].

92. A limited number of diabetics were eventually given CEV status but mostly after the majority of the CEV group were vaccinated and therefore they did not qualify for shielding support (e.g. paid leave, food delivery, or workplace protections).

93. In her oral evidence to the UK Covid-19 Inquiry on 23 November 2023, then-Minister for Equalities Kemi Badenoch acknowledged that, in the context of disability and ethnic minorities, *"So where we discovered that diabetes, for example, was a significant risk factor in terms of whether people died from the disease or not, those sorts of things we looked at."* She also said: "*The main factors behind the higher risk of COVID-19 infection for ethnic minority groups include […] or a pre-existing health condition (such as diabetes) ..."* [LW10/030 – INQ000587289].

94. **Learning Disabilities**. In November 2020, a report by the government ('Covid 19 deaths of people identified as having learning disabilities: summary' report published 12 November 2020) [LW10/031 - INQ000408816] showed that the death rate for people with learning disabilities ('LD') with Covid-19, adjusted for under-reporting, was 369 per 100,000 adults, which is 3.6 times the rate in the general population. Deaths in hospital settings, which the report noted were likely to be an under-estimate, were 3.1 times those of adults without disabilities. Recognition of people with LD as a group at increased risk from Covid-19 and requiring specific protective measures was delayed. In particular, CVF understand that the disparity in deaths between the LD and wider public was known before Christmas 2020 but that LD people were only added to the shielding list on 19 February 2021 and thus were not initially prioritised for vaccination in early 2021.

95. In February 2021, it was announced by the BMJ that 'local groups of GPs have decided to deviate from national guidance and said they will prioritise all patients with learning disabilities for vaccination given the disproportionate impact on them', and suddenly added LD onto the priority list at the time of vaccination. In fact, it was only in the week of 19th February 2021 that an extra 1.7 million people in England, including some with severe learning disabilities were added to list of CEV people, as evidenced within a BMJ article published 19 February 2021 [LW10/032 - INQ000408800].

96. The heightened Covid-19 risk for people with learning disability was not solely a result of disability status, although that may have increased their exposure risk, but was due to the underlying clinical conditions that are more prevalent in this population. Many people with LD live with:

a. **Respiratory conditions** (e.g. aspiration pneumonia due to swallowing difficulties, chronic lung disease).
b. **Congenital heart disease and other cardiac problems**, which are significantly more common in people with conditions such as Down's syndrome.
c. **Endocrine and metabolic conditions**, including thyroid disorders, diabetes, and obesity.
d. **Weakened immune systems** can be caused by genetic conditions or long-term treatments.
e. **Epilepsy**, which is more prevalent among people with learning disability.

97. These conditions overlap directly with the categories of clinical vulnerability already recognised by government and the JCVI, yet people with profound LD were not included in early shielding despite having higher rates of these conditions. Their exclusion highlights the failure to recognise how multiple vulnerabilities can compound risks.

98. This policy gap meant that large groups with well-established elevated risk continued to face high-risks, work in public-facing roles, or living without support during high-transmission periods, unlike those on the shielding list. Many CV and CEV CVF members reported feeling abandoned, being forced to manage their own health risks, and excluded from schemes designed to protect people.

PART C – Impact on Access to Key Services/Support

99. CVF has already provided the Inquiry with extensive evidence on this topic within our Module 3 Rule 9 statement, including detailed accounts of barriers, unsafe environments, and systemic failures to provide accessible healthcare for those at high risk from Covid-19. We do not repeat that evidence here in full but instead highlight new insight drawn from our 2025 "Impact on Society" survey [LW10/014 - INQ000657072], which reinforces and updates our earlier findings. For instance, CVF's evidence discussed the barriers to safe healthcare faced by Clinically Vulnerable people. As of 28 June 2022, a poll of CVF's membership (to which over 500 members responded) indicated that 54% of members had already delayed or cancelled healthcare appointments due to Covid-19 risks. Polling form October 2022 and November 2023 indicated that respectively 91% and 90% of CVF's members were saying that they had or would delay or cancel a healthcare appointment due to

Covid-19 risks. CVF's evidence explained that many of the issues around access to services, and especially healthcare services, could have been addressed via appropriate air filtration systems (e.g., HEPA units), as well as via the implementation of simple measures such as mask-wearing in healthcare settings and the provision of remote consultations where appropriate. CVF's evidence highlighted that the unresolved issues of access to healthcare services meant that some of the most vulnerable members of society were unable to receive suitable and much-needed care.

Barriers to safe healthcare

100. CVF's 2025 survey responses indicate that, as awareness of airborne transmission increased among Clinically Vulnerable people and those in their households, their assessment of risk in shared clinical settings changed. With the subsequent withdrawal of measures such as universal masking, attention to ventilation, and isolation of potentially infectious patients, many respondents reported that even though clinical services were technically "open", they were often inaccessible in practice because environments were not made safe for those at heightened risk from airborne pathogens.

101. CVF members frequently described choosing between treatment and safety and the psychological toll of navigating environments recognised as hazardous. Members have previously likened attending hospital without protections to "*playing Russian roulette*" with their lives. Their sense of exclusion was heightened by a lack of safe alternative pathways, such as safer places in clinics with 'clean air' or, where appropriate, continued remote appointments.

102. As one group of healthcare professionals noted, "*At-risk patients have entirely legitimate concerns that they may endanger their health by visiting their GP or hospital*". CVF fail to understand why protections are not linked to the ongoing needs of the Clinically Vulnerable patients who frequently use the service, leaving them without consistent, safe access to essential care [LW10/033 – INQ000652711].

Masking to protect healthcare systems

103. On 27 May 2022, the English Government removed the requirement for masks in healthcare settings except where there was a known Covid-19 risk – this was

especially concerning for CVF and our members. In a letter sent out on 1st June 2022, NHS England updated its guidance to indicate that patients entering general practices no longer need to wear a face mask unless they had respiratory symptoms.

104. Across England, NHS providers have repeatedly reintroduced universal masking during periods of winter pressure or rising respiratory admissions, after relaxing policies in steadier periods. Acute and specialist hospitals announced temporary returns to masks in clinical areas during periods in 2022–23, 2023–24 and 2024–25, not just during the winters, due to increased Covid-19 or influenza, or "*pressure on services*," then stood them down again when pressures eased [LW10/034 – INQ000652712]

105. Unlike England, Scotland retained the use of fluid resistant face masks (FRSM) until May 2023 when they moved to risk assessments for PPE, as can be read in this article from The Pulse [LW10/035 - INQ000408849]. This change followed the World Health Organization's declaration on 5th May 2023, that the Covid-19 global health emergency was over. CVF members are concerned that despite calls to reinstate masks this winter, as of mid-January 2024, NHS Scotland have not done so, as demonstrated in this article in The Scotsman, 'NHS Scotland winter crisis: Calls to reintroduce Covid 'pandemic-style' measures, including mask wearing, to save NHS' published 3rd November 2022 [LW10/036 - INQ000408851]. While the legal requirement to wear face coverings in most indoor public places moved to guidance on 18 April 2022 (after a short delay from March), health and care settings continued to advise mask use until 16 May 2023, when the Scottish Government formally withdrew the "extended use" guidance and services reverted to the National Infection Prevention and Control Manual (risk-based PPE rather than universal masking).

106. The mandatory requirement to wear masks in health and social care settings in Wales was removed on 30 May 2022. Mask mandates were also reinstated in Wales at a local level on several occasions. For example, Hywel Dda University Health Board [LW10/037 - INQ000408853] confirmed in July 2022 that mask-wearing was reinstated at Glangwili Hospital, and in November 2022 Betsi Cadwaladr University Health Board [LW10/038 - INQ000408852] reintroduced mandatory face masks in hospitals and GP surgeries. These reinstatements underline the inconsistent and reactive nature of mask policy across Wales.

107. The legal requirement for wearing face coverings in healthcare settings was revoked on 15th February 2022 as set out in the Statutory Rules of Northern Ireland 2022 No.47 Public Health, The Health Protection (Coronavirus, Restrictions, Wearing of Face Coverings)(Revocation) Regulations (Northern Ireland) 2022 [LW10/039 - INQ000408854]. This change was part of the broader lifting of Covid-19 legal measures in the region, shifting all remaining protections from mandatory requirements to guidance overnight. Unlike other nations, CVF are not aware of masks ever being reinstated by any of the six Health and Social Care Trusts in Northern Ireland, which has been a particular source of concern for CVF members whenever cases rise.

108. These periods of reinstatement have often coincided with media attention and public-health focus on so-called "twindemics," "tripledemics" and "quaddemics" – where multiple respiratory viruses circulate at once, such as influenza and Covid-19 (Sept 2022) [LW10/040 – INQ000652713] , RSV, influenza and Covid-19 (Dec 2022) [LW10/041 – INQ000652714] or Covid-19, influenza, RSV and norovirus (Feb 2024) [LW10/042 – INQ000652715]. While such peaks rightly raise concerns about healthcare capacity, they also underline that the need for respiratory protection is now only framed as a short-term crisis measure to protect the system, rather than year-round as a preventative safety measure to protect high-risk patients.

109. Vulnerable people with a higher risk from Covid-19 infection would benefit from, but are not provided with, protective masks (FFP3). Such masks can be expensive and absent provision for Clinically Vulnerable people, who remain exposed to Covid-19 related risks, can create a health inequality for those who cannot afford them.

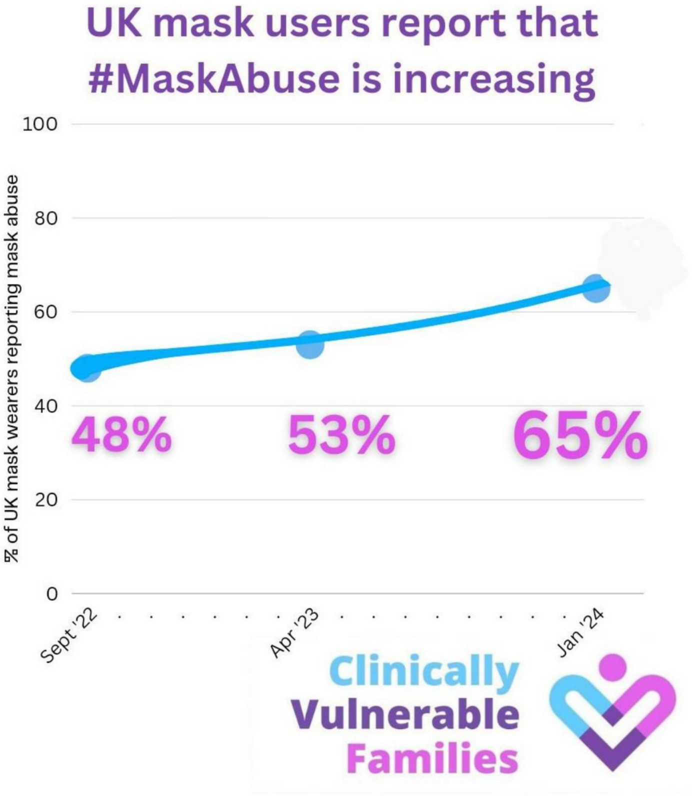
110. Despite clear evidence from bodies such as the European Centre for Disease Prevention and control that FFP2 and FFP3 respirators are significantly more effective than surgical masks against airborne Covid-19 [LW10/043 - INQ000408841], these were not widely used in general healthcare. Some hospitals even required patients to downgrade from higher-grade respirators to surgical masks, a practice criticised in the BMJ as particularly harmful for those who were CEV [LW10/044 - INQ000408842]. A study carried out by Cambridge University showed that FFP3 masks were highly effective in reducing Covid-19 infection in healthcare workers. In fact, *"Healthcare workers working on red wards faced an approximately 31-fold (and at least fivefold) increased risk of direct, ward-based*

infections. Conversely, after changing to FFP3 respirators, this risk was significantly reduced (52-100% protection)" [LW10/045 - INQ000408843].

111. CVF members were acutely aware that respirators offered superior protection, however, this understanding was frequently not shared by staff. They were also local and regional variations in attitudes towards, and support for, Clinically Vulnerable individuals in relation to mask-wearing.

112. CVF has previously identified a rise in hostility towards mask wearers. We believe this stems from the failure to clearly communicate the protective benefits of high-grade masks, which left their use open to stigma and misunderstanding, which is particularly problematic for Clinically Vulnerable people.

113. CVF polling, as shown in figure 2 below, suggests there has been an increase in mask aggression / abuse over time, with the proportion of respondents reporting mask abuse rising from 48% in September 2022, to 53% in April 2023 and to 65% in January 2024.



(Figure 2)

114. Subsequently, mask wearing and enforcement in healthcare was almost uniformly dropped (with a few exceptions), and this was despite evidence showing that staff wearing upgraded face masks cut ward-based infections by up to 100% as seen at Addenbrooke's Hospital [LW10/046 - INQ000408844]. CVF remain concerned that such protections were both possible and, in later stages, widely available - yet the public, including high-risk populations, were never informed about them.

115. CVF believes that the rise in hostility reflects a combination of factors: the removal of legal protections, confusing and sometimes stigmatising government communications, and the lack of public education about the benefits of high-grade masks. Together these created a climate in which mask use was increasingly seen as unnecessary or even provocative by some, leaving Clinically Vulnerable people particularly exposed to aggression when protecting themselves.

Local improvements to Air Quality

116. Air quality standards in healthcare vary significantly across the UK, with some providers taking proactive steps to reduce airborne infection risks while others making no comparable changes. For example, Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's) undertook a programme of installing portable HEPA filtration units on selected wards [LW10/047 – INQ000652743], following their research [LW10/048 – INQ000652716] showing they could substantially reduce airborne Covid-19 and other bioaerosols in healthcare settings. These improvements were funded and implemented locally, meaning patients in that setting benefit from cleaner air as part of standard care, while others elsewhere rely solely on existing ventilation provision, which often may be inadequate. Such disparities create a postcode lottery for protection from airborne pathogens, leaving Clinically Vulnerable patients in some areas with far less safe environments despite having the same underlying needs.

117. CVF believe that safety in healthcare should not depend on local perceptions of seasonal or system pressures. Clean indoor air (improved ventilation and / or HEPA air filtration) and appropriate respiratory protection should be regarded as routine infection-prevention controls, not temporary measures. Just as hand gel is available year-round at entrances, on hospital wards, and at the end of every bed to reduce fomite transmission, measures to control airborne transmission should be a standard

feature of safe care. With appropriate controls, it is possible to reduce transmission of multiple airborne infections (e.g. Covid-19, influenza, RSV, measles), whilst supporting safe access for all patients and ensuring equitable access for Clinically Vulnerable people, thereby improving our resilience against future surges of all airborne infections.

118. Nothing really changed when shielding was paused; the unaddressed risks around healthcare settings remained and consequently our community felt exposed to high-risks with limited options available to them or the protections in place to mitigate their vulnerabilities. For them, Covid-19 still represented a significant and serious threat to their lives or the health of their families and wider communities.

Accessing social care services and support during the pandemic

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

120. Frequently, these changes had profound consequences on their mental health, physical wellbeing, and capacity to remain safe while shielding or self-isolating.

Withdrawal or suspension of home support services

121. Several respondents reported that home care support was paused or unavailable, even for those with severe disabilities or high dependency.

Quote 23 – Alex, 45 (England)

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

Lack of communication or substitutes

122. Where services were withdrawn, families were often not given alternative solutions or clear communication about when services would resume.

Quote 24 – Jay, 38 (England)
"No health visitor care. Not even on the telephone. […] No respite care, no MacMillan care. No help at all was given ever!"

123. For others, the lack of appropriate care altogether meant they were forced into full-time, unsupported caregiving roles. Another CVF member in Scotland, provided a detailed account of how the withdrawal of formal care, administrative challenges, and lack of PPE combined to create lasting harm.

Case Study (iv) – Inadequate Home Care Support

"We had to suspend the care workers from coming into our home as they were visiting multiple homes and did not have adequate PPE. My husband and I carried out all my son's personal care as his PA also had to stop coming in for a while. When we had risk assessed and things looked a bit safer and people could test and we had better PPE, the care company told us they no longer had capacity.

We were mentally and physically exhausted as by the time we felt it would be safer to have care workers back in, the care company told us they no longer had capacity, leaving my son with 1 part time personal assistant. We managed to source another company, but social work absolutely dragged their heels in agreeing the additional funding. We were left with 1 PA and struggled to find alternative care for my son.

There was a large surplus in my son's [SDS option 1] budget, but social work said … we could not utilise this on another company as they were planning on recouping the funds, despite the existing funding being enough to pay a care team for 6 months. This had a massive effect on our mental health due to the stress it caused.

Social work were quite happy for my husband, myself and the PA to save the government thousands of pounds in care costs while my husband and I were on our knees with physical, mental and emotional exhaustion.

> *They eventually agreed on another company, but they really dragged their heels and the stress they caused was immense. I had to retire 3 months earlier than planned due to lack of mitigations at work and inadequate care provision for my son. Social work did not take back the funding they said they would recoup. The needless trauma this caused us was unforgivable. We were really messed about until I told them I had contacted my MSP"*
>
> Anne, 57

124. This family's case stands out not only for its clarity and detail, but the themes it raises - infection risk, withdrawal of support, bureaucratic inflexibility, and the long-term impact on caregivers' wellbeing - are representative of many CVF members' experiences. Many families within CVF who use care services reported having to suspend care due to infection risk, particularly in the absence of suitable PPE or other mitigations to protect the households. Some described long delays in restarting services, local authorities were overwhelmed refusing or delaying funding approvals, and a general inflexibility in the system that failed to respond to the unique pressures faced by Clinically Vulnerable households which may have put them at the back of the queue when services restarted.

Exclusion from services due to risk or Shielding

125. As discussed above, exposure to risk, combined with inadequately tailored policy measures, meant that, for many Clinically Vulnerable individuals, access to care services was not just limited - it became unsafe. This reflects a wider failure: public systems were not designed to account for those who experienced both clinical vulnerability and service dependency. There was little to no strategic planning to adapt care delivery models for those at heightened risk. As a result, CV and CEV people were often effectively systemically excluded from services due to the absence of viable safe access routes.

Accessing benefits and/or financial support during the pandemic

126. Financial safety nets sometimes appeared to be inaccessible or inadequate for Clinically Vulnerable people. Those who resigned from their work for safety reasons (due to the failure of employers to provide reasonable adjustments) were not eligible

for furlough once it was announced. Not all Clinically Vulnerable people in work were eligible in any case), and so job losses due to resignations became common, with Clinically Vulnerable people disproportionately forced to rely on Universal Credit. Even where applying for Universal Credit was their only option, the system was initially overwhelmed, subject to delays, and ultimately unsafe due to changes in requirements for in-person appointments.

Case Study (v) - Accessing Universal Credit as a Clinically Vulnerable Keyworker

"I was a keyworker on a zero-hours contract when I rapidly became very aware that I was also at high-risk from Covid, every day that I worked before I locked myself down felt like living with a ticking timebomb. Planning each move to avoid risks. The risk of working became too high. My employer was aware of my health risks – as I was explicit early on and asked to not be put anywhere where I was covering sick staff. However, they repeatedly and knowingly put me into hazardous situations. I found out through others that I had been used to replace a staff member pulled out only minutes before because they had symptoms. In the end, I made the difficult decision to leave my job a week before the first lockdown, because it simply wasn't possible to continue in-person work without risking my health as I had been surrounded by symptomatic people and was struggling with increasing stress daily despite doing everything I could to mitigate my risks by opening windows and doors, cleaning hands and surfaces, and eating alone in my car.

Initially I was ineligible for furlough, or any other financial support. I had a family and children, but I felt completely on my own. My employer refused to offer me furlough because, as a keyworker, there was work still available and in their view it was my choice not to take it.

*Without an income, I had to apply for Universal Credit (ESA) which was a demeaning experience. By the time I had applied, there was a huge backlog. I ended up at the back of a *very* long queue, and it took months to get a payment. When ESA finally started, they made errors and overpayments, followed by deductions. Nothing was stable.*

Later, the Jobcentre began demanding in-person appointments, even though Covid cases were rising again. I begged them to continue telephone meetings, but my work coach told me that although they understood my situation, they had to follow the guidance. I felt completely trapped – I was again expected to put myself at risk just to keep receiving a really low and basic form of financial support.

In the end, I had to cancel my ESA in November (I can't remember if it was 2020 or 2021) because I couldn't cope with facing unnecessary health risk and the significant stress of being told to return to face-to face work in the middle of a wave. The process had already taken a *huge toll on me and my family. Choosing to step away from the only financial support I could get added even more pressure, but it felt like the only way to protect my health.*

We have not recovered financially from that time. The support my family needed just wasn't there. We are now living with financial insecurity and owe money to our extended family who had to help us out. Our future feels unstable and I haven't made the savings I need to retire one day. All of this happened not because I chose to not work, but because there was no safe option available to someone like me."

Phil, 43

127. Many individuals faced significant financial challenges when asked to self-isolate, particularly those without access to sick pay or those in precarious employment. Although the UK Government introduced financial support packages, such as the Test and Trace Support Payment, these were often perceived as insufficient. Access was difficult, and the limited availability of these funds, combined with delays in processing payments, discouraged compliance with the need to self-isolate, as many people simply could not afford to miss work.

128. To assist the Inquiry, here is a brief timeline of key events/decision:

March 2020	In-person Jobcentre appointments were suspended due to the start of pandemic measures. [LW10/049 – INQ000652717]
Throughout 2020	Most appointments were conducted by phone or online. By November 2020, Jobcentres were open to provide essential services to those who could not be assisted remotely, even to some in tiered lockdowns. Disabled people - who may not have been Clinically Vulnerable, but were statistically more likely to be - were not required to attend in-person appointments, as disability benefit assessments remained suspended. However, this policy still left many Clinically Vulnerable claimants without adequate protection. [LW10/050 – INQ000652718]
May 2021 onwards	Claimants began receiving letters calling them back to in-person Jobcentre appointments. In theory, remote options remained for some cases. By late 2021, CVF members reported being routinely asked to attend Jobcentres in person, even during rising case numbers with work coaches citing that it was "policy" or "guidance" they could not override. [LW10/051 – INQ000652719]

Exclusion from employment protections

129. Some Clinically Vulnerable individuals were excluded from support mechanisms like the furlough scheme due to their keyworker roles, or because they had to leave work voluntarily to protect their health. Yet this "voluntary" decision was rarely a true choice, it was a forced decision driven by a lack of choice in the face of unsafe working conditions.

Quote 25 – Mandy, 41

"Reasonable adjustments were denied in my workplace, despite having HR and union involvement. This resulted in me having to leave my job. This was somewhere I'd worked for 18 years and worked hard to build my career. The feeling of grief was overwhelming. In addition, the stress during this time leading up to leaving my employment, the meetings, the hostility from my workplace etc was also hugely damaging to my mental health. In leaving my job I had to take a £12k per annum pay cut and my career has never recovered."

130. In other cases, Clinically Vulnerable people were dismissed outright when employers refused to accommodate work-from-home adjustments.

Quote 26 – Rae, 45

"I was dismissed due to work saying that they could no longer offer me reasonable adjustments citing the fact there was no other work to do work at home which I know was lies as they'd recently employed others to work at home. They stated my role was not work at home and couldn't be made to be work at home. Because my role was inspecting other people's premises one risk assessment they had done for non CV was irrelevant as my workplace was other people's businesses to assess compliance of Covid rules and food and health safety legislation."

Gaps in recognition

131. CVF evidence indicates that benefit systems often failed to recognise the complexity of clinical vulnerability in real-world contexts. For many, the system did not reflect the realities of risk, isolation, or caregiving pressures during the pandemic.

132. While there were efforts to target financial support to low-income households, the reach and effectiveness of these programs were inconsistent. Gaps in support led to some individuals choosing not to isolate due to financial necessity.

133. One CVF member described how the sudden withdrawal of professional care and the lack of flexibility in support systems forced her separated co-parent to leave his job in a care home and move back into the family home to care for their medically complex daughter. Despite the clear need, it took months of legal proceedings to establish him as a paid carer:

Quote 27 – Amy, 45 years old

"[My] daughter received a high care package due to medically complex health needs, I have a physical disability that made some care tasks impossible. Her carers were furloughed. My daughter's dad (separated and lived away from family home) worked in a care home and gave up his job to support my daughter. We faced a lengthy legal battle for him to be a paid carer to my daughter - he needed financial income for his own home. He moved back into the family home to support daughter. This was great for daughter and children. The stress of lack of money etc was huge and unnecessary. We relied on food donations and weekly food packages from the council. Where we had been self-sufficient we were then reliant on others and financially disadvantaged as children's dad had no income for three months. Caused mortgage pressures on top of caring for my complex daughter."

134. Rigid frameworks and a lack of discretion or emergency responsiveness left many Clinically Vulnerable families without timely access to appropriate support. Another respondent pointed to systemic issues with the way PIP operated, noting that severe risk was not recognised within the system's design:

Quote 28 – Jackie, 61 years old

"There [was] no acceptance [..], or understanding of how high risk […] cause[d] severe and real functional limitations relevant to PIP, or what this means for public service design and delivery."

135. CVF believes that during the crisis phase of the pandemic, there was a societal and UK Government failure to recognise and respond to a distinct group: those who were Clinically Vulnerable, including those designated as CEV, but not disabled as

defined under benefit systems like PIP. This lack of recognition had serious consequences, leaving many without appropriate protection, support or accommodation for their needs, and resulting in avoidable hardship, exclusion and long-term disadvantage. While there is some overlap between disability and clinical vulnerability, the two are not the same thing: not all CV/CEV individuals are disabled, or eligible for disability-related benefits, and not all disabled people were considered clinically vulnerable to Covid-19.

136. Despite this, government support mechanisms operated within a binary model and did not make any provisions for people facing serious health risks, but who were otherwise not considered “disabled.” The failure to account for a new, urgent risk category left many without access to adequate support.

137. Even for those Clinically Vulnerable people who *were* disabled, accessing PIP was already extremely difficult before the pandemic. During the peaks of the pandemic, no meaningful adjustments were made to account for their increased financial pressures. The additional needs of CEV people whose personal independence was suddenly severely restricted by government guidance, and CV people who faced heightened risk and needed financial support to work safely (for example by purchasing FFP2/3 masks, hand gel, air filters etc.) were not considered within PIP payments. Pre-existing awards remained unchanged even though care needs and living costs increased.

138. CVF’s survey data revealed significant reliance on benefits at that time among Clinically Vulnerable households. For instance, 25.6% of all CV/CEV household respondents reported receiving benefits or financial support during the pandemic. Among households that included a disabled person, that figure rose to 35.2%.

139. CVF members who were on legacy benefits were excluded from the £20 uplift that was applied to Universal Credit [LW10/052 – INQ000652720]. One respondent put it plainly:

Quote 29 – Connie, 48

“Being on Legacy benefits, Pip and Contribution ESA I didn't get any uplifts.”

140. In addition to the experiences outlined above, CVF has documented further structural barriers and systemic oversights that compounded the financial precarity

of CV/CEV individuals during the pandemic. These themes emerged consistently across survey responses, and member testimonies at the time, and are detailed in the following sections.

Delays and errors in CEV classification and access to support

141. A number of people were either incorrectly excluded from the shielding list or faced long delays in being added. This omission had direct consequences for their access to Statutory Sick Pay ('**SSP**'), Workplace protections (e.g. remote working or shielding leave), priority food delivery slots and access to wider support networks.

Quote 30 – Catharine, 55 years old

"We started shielding a couple of weeks prior to lockdown as it was obvious what was going to happen, and I knew I was highly vulnerable. I was happy to shield but I was not happy to be erroneously missed off the shielding list. It took me about 3 weeks and many emails to the GP and consultants to finally get on it, despite an absolutely cut and dried reason."

142. Those who were not officially listed would have had to continue with potentially public-facing work without suitable protections, or to resign with no access to furlough or SSP.

143. The ability to access food, medicine, and other essential supplies during isolation was constrained. While local authorities and volunteer networks provided some support, not everyone could access these services effectively. This was particularly problematic in rural areas and among individuals without access to online services.

144. People who were clinically vulnerable, but not classified as CEV, faced considerable challenges in accessing essential medicines. Whilst local authorities set up networks of volunteers to support CEV people, those who were CV were very much left to fend for themselves. This was a serious problem for those who relied on life giving treatments, such as those who were high-risk insulin dependent T1 diabetics.

145. Due to the general lack of availability of pharmacy deliveries or external support, many CV and CEV people (or their household contacts) were forced to make

incredibly difficult decisions between essential medicine and attending high exposure risk locations such as pharmacies or supermarkets.

PART D – Impact of Government Rules and Guidance

Confusion and exclusion from Government messaging

146. CVF found there were significant challenges that Clinically Vulnerable people faced in understanding and interpreting government-issued Covid-19 rules and guidance. One of the most pressing concerns was that official communication often failed to reflect or address the particular needs of those at highest risk of severe illness or death from Covid-19.

147. A key issue was the lack of tailored guidance for Clinically Vulnerable people, particularly during periods of policy transition. As national messaging encouraged the public to return to workplaces, hospitality, and public transport, many were left with unclear or non-existent advice about how to protect themselves in environments that no longer enforced basic mitigations.

148. This was especially visible during government campaigns like 'Eat Out to Help Out', which ran from 3 to 31 August 2020, coinciding with the end of formal shielding on 1 August. The scheme incentivised public indoor mixing at a time when many Clinically Vulnerable people remained informally shielding and had received no updated clinical guidance.

149. This financial incentive increased the social pressure to return to pre-pandemic norms, whilst leaving vulnerable people behind. The scheme's design failed to accommodate those who could not safely dine indoors and offered no alternative such as home delivery. As such, it was discriminatory by rewarding risky behaviour that was inaccessible or unsafe for high-risk groups and widening disparities in social participation during a public health emergency.

Problematic framing of public health measures

150. Government communications frequently framed essential public health protections, such as mask-wearing and remote working, as "restrictions" rather than basic safety

measures. This language culminated in the naming of “Freedom Day” which took place on 19 July 2021, when nearly all Covid-19 protections were lifted in England. Though promoted as a return to normality, this framing excluded and endangered those who remained Clinically Vulnerable.

151. Despite rising cases driven by the Delta variant, and ongoing concerns about harm, [LW10/053 – INQ000652744 and LW10/054 – INQ000652721] the government pressed ahead with lifting protections after a four-week delay. “Freedom Day” had originally been scheduled for 21 June 2021, but was postponed to 19 July to allow more adults to receive second vaccine doses. Prime Minister Boris Johnson maintained that the country must “*learn to live with this virus*.” [LW10/055 – INQ000652722]

152. For many Clinically Vulnerable people, the lifting of protections did not represent liberation but rather a loss of safety and social inclusion during a highly precarious period. While the public were encouraged to return to pre-pandemic norms, Clinically Vulnerable people faced increased risk of exposure and a reduction in their freedoms – where they had to choose between participation and protection in a society that no longer recognised their needs.

Quote 31, Nicola, 38
“The isolation of having to stay indoors to stay alive was made worse by the public’s reactions to mask wearing, freedom day etc.”

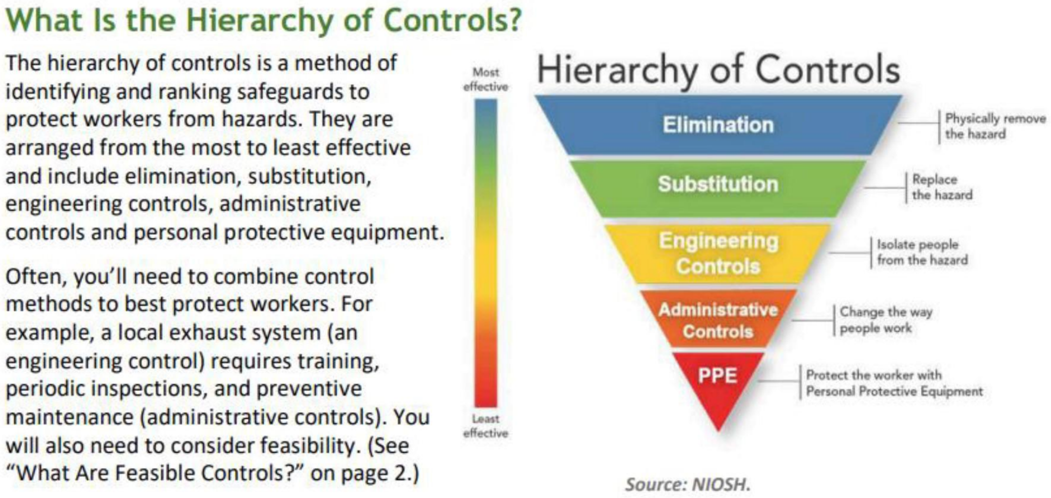
Quote 32, Samir, 45
“Public messaging was disastrous. At first it encourages empathy but that quickly changed, with eat out to help out and freedom day, to encouraging the public to ignore covid and to resent vulnerable people who became unpleasant reminders and a burden.”

‘Living with Covid’

153. On 21 February 2022, during a statement in the House of Commons outlining the government's "Living with Covid" strategy, Prime Minister Boris Johnson stated: *"We can now deal with [the virus] in a very different way, moving from government restrictions to personal responsibility".* [LW10/056 – INQ000237518] This marked a significant policy shift, moving away from legally mandated protective measures

towards encouraging individuals, businesses, and public institutions (ultimately including high-risk locations such as healthcare) to make their own judgements and decisions regarding Covid-19 precautions.

154. CVF believes the framing of Covid-19 protections as a matter of “personal responsibility” was fundamentally flawed from the outset. As BMJ experts warned in July 2021: ““*Personal responsibility” does not work in the face of an airborne, highly contagious infectious disease. Infectious diseases are a matter of collective, rather than individual, responsibility*.” [LW10/054 – INQ000652721] Public health guidance should never have placed the burden of protection onto individuals, particularly when the main controls - such as adequate ventilation or air filtration - are measures that cannot be managed by individuals. In terms of the hierarchy of controls [LW10/057 – INQ000652746] (as shown in figure 3 below), which used in health and safety, CVF found that Clinically Vulnerable people were left with only the lowest tier of protection: PPE, often without support or recognition.



What Is the Hierarchy of Controls?

The hierarchy of controls is a method of identifying and ranking safeguards to protect workers from hazards. They are arranged from the most to least effective and include elimination, substitution, engineering controls, administrative controls and personal protective equipment.

Often, you’ll need to combine control methods to best protect workers. For example, a local exhaust system (an engineering control) requires training, periodic inspections, and preventive maintenance (administrative controls). You will also need to consider feasibility. (See “What Are Feasible Controls?” on page 2.)

Source: NIOSH.

(Figure 3)

155. Public messaging increasingly emphasised a return to the old "normal " sending the implicit message that the safety of Clinically Vulnerable people was no longer a concern, which was particularly problematic for those whose high risks may not have changed, or changed significantly, since vaccination. For some, this exacerbated feelings of abandonment and invisibility. As protective policies were rolled back, so

too was the public's recognition of their importance. CV families became increasingly marginalised, and in some cases socially stigmatised, despite their higher risks.

Quote 33 – Guy, 58 (Wales)

*"A common experience in [CVF] at this time [following the living with Covid policy] was that people were constantly told "you don't need to wear *that* anymore", meaning that we shouldn't wear a mask. To begin with I brushed it off, but even months later people were still telling us this, even though we clearly knew that others weren't masking, because it made them uncomfortable. UK Government messaging didn't explain that some people might still be at risk, or even that decent masks might protect us without everyone else masking. It also meant that many of us started to experience abuse, people shouting at [CVF members] aggressively or coughing in our faces and even more frequently, and often difficult to prove or spot, many people subtly walking next to you and then coughing hard and walking off."*

156. Left without protections, and in the face of such public messaging, Clinically Vulnerable people continued to rely on basic precautions like masks. But with no legal framework to defend those choices, they were often left isolated or unsafe. Many CVF members reported being bullied or harassed for wearing masks in public since measures were dropped. Even in healthcare settings, the refusal to accommodate basic safety requests such as mask-wearing was common. Further, as many CV/CEV people were not visibly vulnerable, they sometimes felt compelled to disclose private medical information in order to justify basic precautions.

Quote 34 – Abigail, 44

"In Scotland [we] were given lanyard[s] that said we were vulnerable but felt like instead of people understanding when they saw it they would go so what's wrong with you. Like they had a right to know."

Quote 35 – Elizabeth, 68

"As a cancer patient I know I have the right under the Equalities Act 2010 to be treated in a safe environment but this has not been delivered by the NHS. I wear a mask when I go to a healthcare setting and I wear a lanyard saying I'm CEV and would the person treating me wear a mask. This is consistently ignored."

157. Rather than protecting mask-wearing, laws were brought in, for instance, to restrict mask use in protest settings, putting even greater pressure on those trying to protect themselves. Indeed, the Public Order Act 2023 introduced new powers that allowed police to challenge or remove protestors for wearing 'face coverings'. CVF has worked with Liberty to raise awareness of this issue, highlighting the discrimination and exclusion caused by the legislation [LW10/058 – INQ000652747]. Clinically Vulnerable people were both expected to take personal responsibility for their safety, whilst also being restricted from doing so in protests.

158. Overall, following "freedom day," the removal of free testing, accurate data, and the lack of targeted guidance and support left Clinically Vulnerable people without the necessary tools to assess their risk and protect themselves effectively. Poor communication created confusion about what CV and CEV individuals (or those in their households) should or could do under evolving rules. It also forced many to make painful choices, as discussed elsewhere, between risking exposure by following general rules, or self-imposing stricter measures at the cost of wellbeing, social participation, and impacts on access to healthcare, employment, and education. The withdrawal of protections and the failure to protect the right to mask created a hostile environment for those at risk - and effectively excluded some people in CV households from full participation in society. This has had lasting consequences for Clinically Vulnerable people, impacting participation in public life, a growing stigma, and often expectations to disclose private health information, or simply risking exposure. Public health policy must acknowledge that vulnerability is not a personal choice, and safety should not have become a personal burden of responsibility. Without structural protections, Clinically Vulnerable people remain systemically excluded, and their rights to health, dignity, and inclusion have been quietly abandoned.

Timing and clarity of official guidance

159. From the outset, official communications to CEV individuals were frequently delayed. CVF members felt that initial shielding instructions were issued with insufficient detail and often reached vulnerable individuals too late. The communication breakdown meant some people were unaware they were on the shielding list until weeks into the lockdown.

160. Others, who were CV, were not formally recognised at all, despite being at higher risk. As the pandemic progressed, the speed and clarity of updates deteriorated further: Guidance was often released with little notice, leaving CV households scrambling to adjust. Public briefings rarely addressed our specific concerns, leaving individuals to interpret whether broader rule changes applied to them.

161. When formal shielding ended, the messaging failed to provide any kind of transition plan, risk assessment tools (even wastewater testing was ultimately abandoned), or appropriate measures to improve airborne transmission safety to provide ongoing protection.

162. Communication gaps created significant uncertainty, causing many to continue isolating far beyond official mandates due to the lack of reassurances or alternatives. Some people, particularly those who are severely immunosuppressed, are still shielding, or living limited lives on the periphery of society, to this day. They were certainly not the main beneficiaries of the reopening of society, and their unique needs were swiftly forgotten.

<u>Lack of targeted information for 'Clinically Vulnerable' people</u>

163. While some official support was offered to those identified as CEV, CVF highlights that most Clinically Vulnerable people fell outside of that narrow definition, and many CEV people were not identified until very late on. This group was often left without guidance, support letters, or eligibility for services like priority shopping, food deliveries, or support to work from home. The failure to provide suitable information to the whole group forced people to attempt to make risk-based decisions on their own to mitigate airborne transmission. As a result, many faced dilemmas such as:

a. Whether to return to unsafe workplaces.
b. How and when to mix with others.
c. How to manage risks in enclosed indoor environments.
d. Which masks were most protective.
e. How to manage children returning to school.
f. How to access healthcare services safely in person.

164. This absence of specific guidance placed an enormous burden on vulnerable households to self-advocate and seek information through informal networks such as CVF itself. Many of these issues continue, for all Clinically Vulnerable people, but particularly for those who were severely immunosuppressed or immunocompromised, or those who have health conditions that placed them at high-risk from Covid-19 but that also prevented them from receiving any vaccines

165. During her oral evidence on 29 November 2023, Professor Dame Jenny Harries, former Deputy Chief Medical Officer for England and Chief Executive of the UKHSA, acknowledged shortcomings in how the government communicated effectively with the broader Clinically Vulnerable population. When asked why support and messaging were not sent to all Clinically Vulnerable people (beyond those formally identified as CEV), Dame Jenny Harries stated:

> *"For those who are in the clinically vulnerable group, the wider one, then there was the -- obviously it's a much wider group, we recognised that we couldn't contact all of those people centrally. It wasn't feasible. And for the reasons which I've just said, that intersectionality of risks was very much something for local government. So it's not something that was handled in that way"* [LW10/059 – PHT000000051]

166. This shows that the lack of centralised communication or support to the wider clinically vulnerable group was not due to a lack of risk, but rather a result of inadequate infrastructure, planning, and coordination. She claimed that the system simply was not equipped to identify or engage with all high-risk individuals, despite many facing comparable levels of risk from Covid-19.

167. For CVF, this reflects what our members have consistently reported: that many people at high clinical risk were left unsupported not because they did not need protection, but because the government lacked the systems to deliver it. As a result of the failure to develop targeted communication strategies for high-risk populations there was a gap that left many people without the information necessary to make informed, safe decisions at key stages of the pandemic.

168. While the CEV group received some targeted communications and a supposed 'catch-all' approach through self-identification, no comparable effort was made for the CV group -

until the formal Covid-19 vaccination programme began. At that point, those in the CV group were suddenly identifiable and contactable, raising questions about why similar outreach had not occurred earlier.

169. CVF believes that the significant overlap between the CV group and the NHS flu vaccine eligibility dataset could have been effectively used to contact clinically vulnerable people earlier in the pandemic. This could have included a simple advisory message with a caveat that not everyone contacted would be considered vulnerable – similar to the approach used when people were contacted about potential eligibility for Covid-19 antiviral treatments, which was a much more complex dataset to identify as set out in this NHS England blog by Darren Hickling published on 16 February 2023 [LW10/060 – INQ000652724].

> “This letter has specific instructions for patients who have been identified by a specialist team as potentially being able to benefit from COVID treatments. Please ignore this letter if you have already been contacted by NHS England.” [LW10/061 – INQ000655685].

170. CVF subsequently found that not all individuals who received the NHS letter about Covid-19 treatments met the formal clinical criteria to qualify for antiviral access.

171. Failing to use existing flu vaccine risk group data to inform and support the CV population earlier in the pandemic was a missed opportunity with serious implications for both safety and trust.

Flu vs Covid-19 Vaccine Eligibility Comparison

Condition / Risk Group	**Included in Flu Vaccine (Green Book)** [LW10/062 – INQ000652748]	**Included in Covid-19 Vaccine (Green Book)** [LW10/063 – INQ000652726]
Chronic respiratory disease	Yes	Yes
Chronic heart disease and vascular disease	Yes	Yes
Chronic kidney disease	Yes	Yes
Chronic liver disease	Yes	Yes
Chronic neurological disease	Yes	Yes
Diabetes and adrenal insufficiency	Yes	Yes
Immunosuppression	Yes	Yes

Asplenia or dysfunction of the spleen	Yes	Yes
Body Mass Index ≥40 kg/m²	Yes	Yes
Pregnant women	Yes	Yes
Aged over 65	Yes	Yes
Severe mental illness	No specific mention	Yes
Younger adults in long-stay nursing and residential care settings	No specific mention	Yes
Medical discretion for clinicians to apply clinical judgment to identify others	Yes	Yes

172. The UK government's pandemic response should have been better prepared to address the needs of large groups of vulnerable people, and these failings must be addressed to prevent similar avoidable harms in future health crises.

<u>Reliance on Social Networks for information</u>

173. Due to these systemic failures, CVF became a critical hub for peer-to-peer support, interpretation of complex and evolving guidance, and practical risk management. The group filled the vacuum left by inadequate official communications and public health planning by helping its members in the ways set out above at paragraphs 9 and 10.

174. Through our multifaceted work, CVF has not only supported its own community but also helped to expose broader gaps in the UK's pandemic response - particularly the lack of a coordinated plan to protect and enable Clinically Vulnerable people. However, it was neither sufficient nor appropriate for volunteer-led organisations to carry the burden of filling communication gaps left by government.

<u>CVF's concerns in relation to test, trace and isolate systems ('**TTI**')</u>

175. CVF's membership was often more impacted than other groups by decisions relating to TTI systems due to the heightened risks faced by its members. In the UK, public health responsibilities are devolved so each of the devolved nations had different testing and tracing policies – these are discussed below in para 199, 204, 212, 219-220.

176. Overall, however, there were issues with TTI policies across devolved nations affecting CVF members generally. For instance, the definition and categorisation of the *'most vulnerable'* was flawed from its inception. As explained in a publication by The Health Foundation in 2021 [LW.10/64 – INQ000505898], the NHS derived data sets could only initially identify less than half of those (approximately 900,000) ultimately categorised as most vulnerable. This meant that not all those people who actually qualified for antiviral treatments were offered a 'priority PCR', although this group needed rapid testing and results (which are time critical) in order to be allowed prescriptions for potentially life-saving treatments.

177. Furthermore, the government did not take into account the family and work units in which people lived and worked when considering TTI policies. A false belief that children were not particularly affected by Covid-19 meant that school policy development reinforced this, and it continues to this day. Children who were either themselves vulnerable or lived within a household with Clinically Vulnerable members were treated as a homogenous group with all children. Little consideration was given to their different risks or vulnerabilities. Multigenerational households were also poorly understood at national level, even though they often contained a large number of individuals, including vulnerable and elderly members or younger members with clinical risk factors.

Shielding, Isolation and the psychological and physical impacts

Experiences of Shielding and Isolation

178. While many people considered shielding as an important protective measure, many others also experienced it as isolating, psychologically harmful, and economically damaging. The impacts were not uniform. Experiences varied significantly depending on the support of those around them, including families or households, social networks of friends, workplaces and education settings.

179. Based on CVF members' experience, shielding was not inherently harmful, but its implementation, and the withdrawal of support at the end of formal shielding, often left people feeling abandoned. Shielding succeeded where it was accompanied by practical assistance on risk management, support for households, and societal recognition. Without these, many faced deep and lasting harms to their mental and physical wellbeing.

180. Future public health planning must take seriously both the benefits and costs of shielding, and design protections that do not isolate Clinically Vulnerable people from society. The experiences of shielding during the Covid-19 pandemic offer critical lessons - both in what worked, and what must be done differently.

181. See Case Studies (vi) and (vii) in Annex A where CVF members share their experience of what it was like as a CEV person and what it was like living in a CEV household.

Gaps and Inequalities: Formal and Informal Shielding

182. Although formal shielding guidance applied to a government defined group of clinically extremely vulnerable people, CVF's members reported that even within this group, support was inconsistent and often inadequate. Many CEV people were left without the protections needed to shield safely - in their homes and healthcare environments, or when shielding guidance was paused or ended in workplaces, public places or education settings.

183. Many unshielded clinically vulnerable people, were not formally recognised, but chose to shield or self-isolate to protect themselves. Family members of Clinically Vulnerable people frequently also changed their behaviours to shield alongside the vulnerable person or to isolate from them. Their decisions were based on awareness of their heightened risks, but without state support or access to employment protections. As a result, significant disparities emerged: both during periods when shielding was in place and after it was paused; between those who were formally recognised and those who were not; and between policy design and lived experience:

   a. When formal shielding guidance was paused or ended, many CEV people were left without workplace protections or practical support and were exposed to unnecessary risks, particularly in employment and education settings.

   b. Many CV people, who were not officially included in the shielding programme, chose to isolate for safety but received no government recognition or support. Informal shielding decisions were medically informed based on risk but not respected by employers or other organisations.

c. In both cases, individuals and households were frequently forced to self-fund or self-manage prolonged periods of isolation, leading to unequal access to safety and growing mental, financial, and physical strain.

d. The design of shielding policies focused on individuals rather than households and excluded family members and carers from support, even though their actions directly affected the ability of CV and CEV people to remain safe.

e. There was significant uneven access to food, with Clinically Vulnerable people suffering disproportionately from access restrictions. For instance:

   i. older people could not access the internet for food deliveries and continued to shop in person, even if clinically or clinically extremely vulnerable;

   ii. some people were delayed being added to the shielding list, and there were inconsistencies and lack of transparency with respect to the shielded persons details held by supermarkets, which meant that some CVF members could not access a supermarket delivery slot or secure a supermarket priority slot;

   iii. some supermarkets would only accept those who had previously had an account with them, for example, Sainsburys and Ocado;

   iv. local food services such as Milk Delivery Companies were overwhelmed (see e.g., [LW10/065 - INQ000408805], showing that one of CVF's members was caller 27,005 in the queue for placing orders); and

   v. Clinically Vulnerable individuals with food allergies or conditions requiring a specific diet, e.g., coeliacs or people with dairy allergy, kidney patients etc., struggled specifically to access necessary food items, including in circumstances where supermarkets were limiting numbers of food and other items given issues with panic-buying (see [LW10/066 - INQ000408829]).

Quote 36 – Catharine, 55 years old

"Thankfully we had the foresight to stock up a bit on pasta, dried and tinned food, long life milk etc. I was unable to access the priority slots (as I was delayed being added to the shielding list) or the shielding food deliveries for several weeks which was a bid issue. Neither of us have any family in the area, mine are over 100 miles away and my partners over 200 miles away."

Psychological and emotional impact

184. Isolation was widely understood by members as necessary for survival - but also deeply traumatic and psychologically costly. From CVF's recent survey 95.2% of respondents described negative mental or emotional impacts linked to shielding or cautious living - including stress, depression, anxiety, loneliness, suicidal thoughts, burnout, and other trauma [LW10/014 - **INQ000657072**]. These effects were often felt not only by the person shielding but by other household members including children, partners, and carers. Shielding, especially when unsupported, resulted in significant psychological fallout.

Quote 37 – Emily, 54

"Myself, my husband and my two adult sons all shielded to protect my CEV husband, as a result of this we lost friends, I lost my job affecting my confidence and self-worth, my eldest sons metal health has been severely affected and he is now on medication and awaiting counselling."

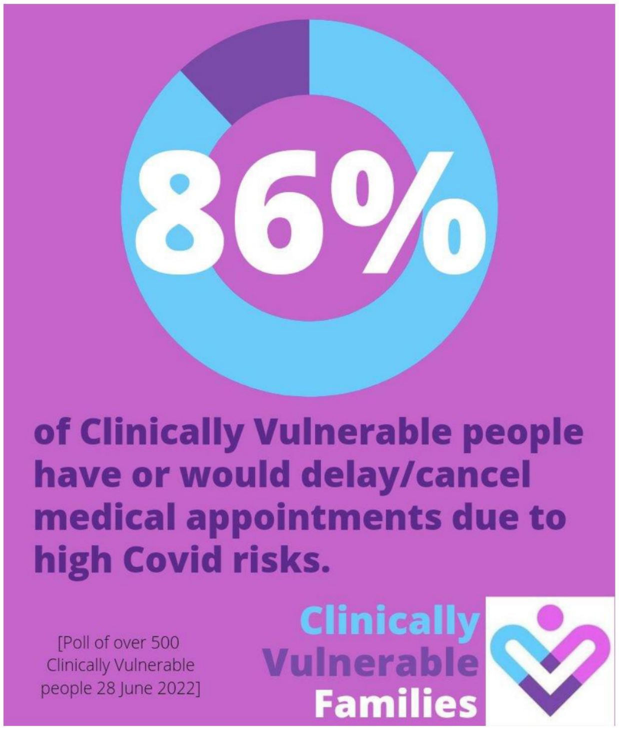
Quote 38 – Vivian, 62

"In short it has ruined our lives. One person had to give up working as a GP. Both suffered emotionally and socially and continue to do so. Winters are unbearable, we are locked away. We can't go into any dining or entertainment venues, nor to friends' and families' houses. We spend Christmas alone. It is not living, it is existing."

Physical health impact

185. The mental health toll was closely linked with deteriorations in physical wellbeing due to lack of safe access to healthcare, including cancelled appointments and fear of infection in unmasked clinical settings, reduced mobility and exercise, especially for those who did not feel safe anymore, and the exacerbation of existing chronic conditions due to prolonged isolation or stress.

186. Polls of CVF members in June 2022 and October 2022 found 86% and 91% respectively delayed or cancelled medical appointments when community Covid -19 risk was high (figures 4 and 5 below). These figures help explain the high rates of unmet need described by Clinically Vulnerable people, with 93.4% of respondents of this survey saying they had struggled to safely access healthcare, including dentistry, or support services during the timeframe.



of Clinically Vulnerable people have or would delay/cancel medical appointments due to high Covid risks.

[Poll of over 500 Clinically Vulnerable people 28 June 2022]

(Figure 4)

(Figure 5)

187. For many Clinically Vulnerable people, self-managing risks in the absence of safe healthcare environments often means avoidance of healthcare.

188. CVF members also described the conditions that led many to avoid or delay care, including:

> **Quote 39 – Jack, 73**
>
> *"Lack of mask-wearing by staff or patients, poor ventilation or crowded settings, refusal to accommodate simple safety requests (e.g. masks, remote appointments), increased risk of exposure to Covid-19 due to lack of safety measures."*

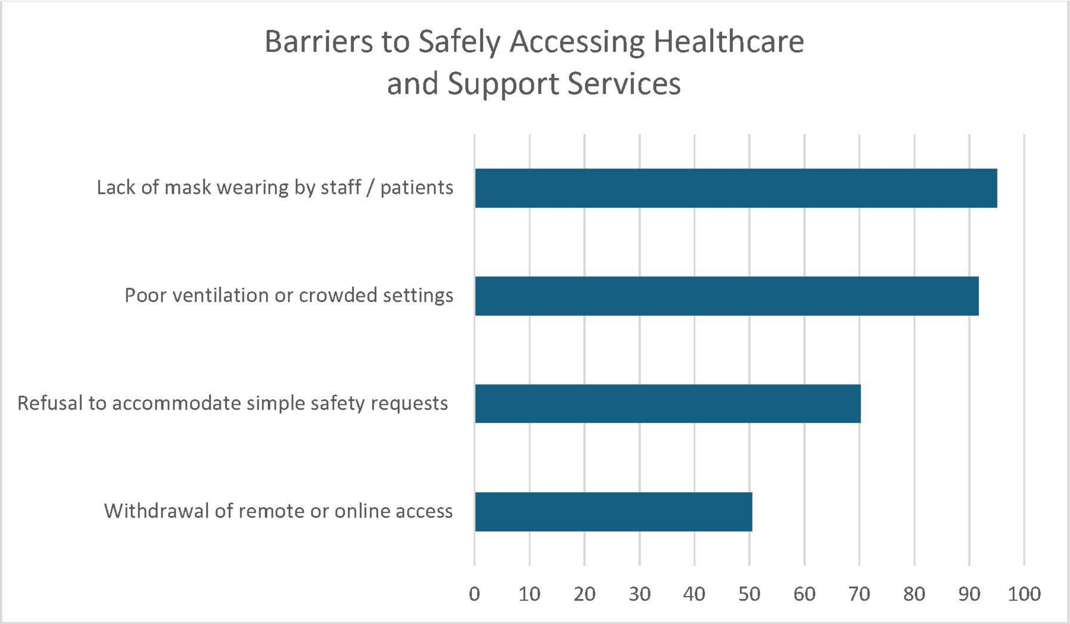
189. CVF's survey revealed widespread barriers to safely accessing healthcare and support during the pandemic. As seen in figure 6 below, respondents identified multiple issues, many of which related to a lack of basic infection control and refusal to accommodate reasonable safety needs:

   a. **95.0%** reported that lack of mask wearing by staff or patients affected their ability to safely access care.

b. **91.7%** were also impacted by poor ventilation or crowded healthcare settings.

c. **70.2%** said they experienced a refusal to accommodate simple safety requests.

d. **50.4%** reported being affected by the withdrawal of remote or online access options, which had previously enabled safer appointments.



(Figure 6)

190. There was a significant psychological impact from the way shielding was ended. Shielding was described as “protective and reassuring” while it lasted, but its withdrawal felt sudden and unaccompanied by risk mitigation or recovery plans. CVF members were left to navigate risk alone, often continuing to isolate while wider society reopened — creating a deep sense of abandonment.

<u>Long-term isolation and its legacy</u>

191. From the CVF survey, only 1.7% of respondents said they felt able to safely return to public places during periods of reopening due to mitigations they took and an additional 19.0% said they only partially returned to public spaces, taking extra precautions and avoiding places they deemed unsafe. Nearly all respondents faced barriers to full participation in public life even as society reopened. CVF members

were often left with an enduring sense of being overlooked or "forgotten" as society moved on.

192. These harms, consequent upon shielding (formal or informal) were not all inevitable. Many resulted from poor communication, the absence of any long-term plan, and ultimately the withdrawal of protections before the risks of airborne transmission had meaningfully decreased - without any follow-on support for those at higher risk.

Comparison of Impacts and experiences between England and the devolved nations

193. While many of the most severe challenges faced by clinically vulnerable and clinically extremely vulnerable people were common across the UK, CVF found that there were inconsistent approaches taken by devolved governments in England, Scotland, Wales, and Northern Ireland. Shielding advice, lockdown timings, economic support packages, and access to healthcare services all varied by region. For Clinically Vulnerable people, this created:

a. Geographic disparities in the support available.
b. Confusion among those living near regional borders or for those who moved between regions.
c. A perception that their safety was subject to arbitrary political decisions rather than public health need.

194. CVF members reported that regional inconsistencies sometimes compounded feelings of abandonment and added to the mental and logistical strain of navigating an already complex set of rules.

England

195. A strong theme among English respondents was a sense of abandonment around 'Freedom Day' and 'Living with Covid' policies, with some continuing to shield or reduce social contact and continuing to mask without any support or recognition.

196. The removal of protections came earlier in England and more abruptly than in the devolved nations. From "Freedom Day" in July 2021, legal requirements around masking, distancing, and limits on gatherings were withdrawn, with further steps in February 2022 under the "Living with Covid" plan, which ended the legal duty to self-

isolate and most forms of support. This shift to a "personal responsibility" model occurred while clinically vulnerable and clinically extremely vulnerable people remained at higher risk of serious illness and greater responsibility, and without equivalent measures to enable safe inclusion.

197. For many, healthcare environments became functionally inaccessible after national infection prevention guidance stepped down universal masking in mid-2022.

198. Similarly, the emphasis on reopening workplaces and promoting social activities, such as through the "Eat Out to Help Out" scheme, created pressures to return to high-risk environments without adjustments or protections in place. As a result, CV and CEV households in England experienced earlier and sharper exclusion from public life, and were left to manage risk largely on their own.

199. Key decisions regarding around managing Covid-19 were taken on a national scale, but these decisions often had mixed results in terms of addressing the needs of high-risk individuals and their families.

   a. The government decided to centralise the TTI system under England's NHS Test and Trace program. CVF found that the centralised approach sometimes resulted in delays in testing and tracing, particularly in areas with high demand or less access to healthcare resources.

   b. Guidance for self-isolation applied to the general population, including people who were Clinically Vulnerable. However, this guidance was not sufficiently tailored to the specific needs of vulnerable groups. The provision of support services, such as food and medical supplies for those isolating, were left to local authorities, resulting in a "postcode lottery" where support varied significantly depending on the individual's location [LW10/067 - INQ000505903].

<u>Scotland</u>

200. Longer lockdown periods in Scotland contributed to a sense of protection for some, particularly early in the pandemic. As CVF member put it:

Quote 40 - Katherine, 40 years old

"Restrictions were lengthier in Scotland than England, which although isolating also made us feel protected."

201. The Scottish Government's communication was generally considered to be more transparent and consistent, especially in the first year of the pandemic. Several Scottish members explicitly cited clear updates from Scotland as beneficial.

Quote 41 – Anne, 58 years old

"I lived alone so potentially very isolating (I did have a bubble for second lockdown) … Getting good updates from Scottish government helped ease anxiety."

202. Despite this, many also described ongoing isolation, disrupted healthcare, and limited practical support - especially when they were not formally recognised as shielding. While Scotland's initial approach was welcomed, gaps in inclusion and sustained support mirrored challenges seen elsewhere in the UK.

203. In Scotland, protections were retained for longer - especially in health and social care. For CV/CEV households, this slower step-down - particularly the extra year of masking in healthcare - generally meant safer, more reliable access to clinics and hospitals for a longer period. However, once guidance was withdrawn in May 2023, people reported similar exclusion pressures as seen elsewhere, only later in time.

204. The Scottish Government implemented its own Test, Trace, Isolate and Support ("TTIS") system, known as 'Test and Protect'. CVF members felt the title in itself recognised the purpose of testing to protect lives. Recognising the heightened risk faced by CEV individuals, the Scottish Government incorporated specific measures:

    a. Priority Testing: Severely immunosuppressed individuals exhibiting symptoms were given priority access to testing to ensure rapid diagnosis and care.

    b. Support Services: Isolation was supported by services and crisis grants from the Scottish Welfare Fund, including food deliveries and mental health resources. Local authorities played a pivotal role in coordinating this support as demonstrated by Aberdeen City Council [LW10/068 - INQ000505904].

Financial support linked to self-isolation remained available longer than elsewhere, with the Self-Isolation Support Grant closing to new applicants on 5 January 2023 [LW10/069 - INQ000652727].

c. Guidance: The Scottish Government provided detailed guidance tailored for CEV individuals, advising them on how to minimise risk and what steps to take if they developed symptoms.

205. While 'Test and Protect' played a vital role, there were challenges including capacity issues during periods of high demand. The 'Protect Scotland' app was a valuable tool, but its effectiveness depended on widespread public adoption. In a press release by the Scottish Government on 10 September 2020, the First Minister Nicola Sturgeon urged smartphone users across Scotland to download it to help suppress the spread of Covid-19 [LW10/070 - INQ000505905]. Efforts were made to promote its use, but varying levels of uptake influenced its overall impact.

206. Because Scotland and England developed their own contact tracing apps independently this led to issues, as the apps could not communicate effectively across the UK. Later integration allowed apps to share exposed 'tokens' from users across the different nations, but this also created security concerns for users and staffing concerns for employers.

Northern Ireland

207. There were fewer responses from CVF members in Northern Ireland, however, a consistent theme was the lack of tailored protections for Clinically Vulnerable people. Several reported that shielding guidance was confusing or insufficient, and that Clinically Vulnerable people were often misunderstood.

208. Northern Irish members described high levels of stress and emotional strain, with many continuing to shield or mask beyond official guidance to protect their households without any official recognition in government messaging.

209. Public messaging was also flagged as insufficient and not aligned with the needs of Clinically Vulnerable people. Concerns were raised that communications were often aimed at the general population and that they did not adequately reflect the

heightened and ongoing risks faced by Clinically Vulnerable populations. This contributed to pressure to return to pre-pandemic activities without sufficient safeguards, reinforcing their feelings of abandonment and invisibility.

Quote 42 – Alex, 23 years old

"None of those things [public messaging, government policy, or health guidance] properly considered the needs of clinically vulnerable people. They were not advocated for or advertised enough. […] There was no large public messaging on CEV. It wasn't clear at all."

210. In Northern Ireland, government and public health messaging sometimes caused unnecessary fear and distress for Clinically Vulnerable people and their families. The following account from a CVF member illustrates how official communication could be framed in a way that appeared to normalise the death of care recipients, with harmful emotional consequences:

Case Study (viii) – Distressing Messaging in Northern Ireland

"We received a letter from DHSS that was to be read to my daughter who is CV. The letter advised us to watch a video about making funeral arrangements in case of death by Covid. That letter was sent to every household in Northern Ireland who received social care, either in the home, from care agencies, or hospital. I watched the video and was scared and horrified. The video prepared by NISCC (Northern Ireland Social Care Council, who regulate all social care staff in NI), showed a woman sitting with a cup of tea, like a cosy chat. I thought, there's an assumption here that death of disabled people or care receivers was being normalised, and it was acceptable to expect it. […]

That letter really scared me, I told my daughter about it and she didn't want to hear anything. I tweeted about this letter and within 24 hours that video was removed from NISCC. […] My daughter had a domiciliary care agency at the time and our social worker advised us to stop the service due to risk of infection. […] That letter really frightened me, it was like having a target placed on my daughter's head."

Anonymous, CVF member

211. The impact of such messaging went beyond the immediate distress described above. It illustrates how official communications, when poorly framed, could

undermine trust in public health bodies and even lead families to disengage from essential services. For CVF members, this reinforced a wider perception that their lives were undervalued, with long-term consequences for their confidence in seeking care and support.

212. In Northern Ireland, key decisions regarding the TTI system were through the Public Health Agency, with an emphasis on local control and cross-border coordination.

a. StopCOVID NI app: This was rapidly developed and deployed using the decentralised Apple-Google protocol, also used by the Republic of Ireland, enabling cross-border functionality across the island of Ireland. However, in a blog written by Dr Amgela Daly and Professor Maurice Mulvenna for the Ada Lovelace Institute and published on 24 September 2020 [LW10/071 - INQ000505907], this created challenges with the original NHSX app in England. Telephone support was also available as an alternative.

b. StopCOVID NI app for u18s: As explained in a press release published on 14 September 2020 by the Department of Health [LW10/072 - INQ000505908], Northern Ireland uniquely developed a contact tracing app specifically for under-18s, this initiative was generally welcomed by CV families. However there were concerns about its effectiveness as children were often required to turn off their phones or were not allowed to bring them to school, limiting the app's utility as a tool during school hours, where transmission risks for our families were at their highest.

Quote 43 – Donna, 40

"My older daughter used the under 18 app and we specifically told her to keep her phone on in school. At one point she got a notification that she had been a close contact but the date given was 10 days prior and in that 10 days she had been around her vulnerable little sister. The only place this could have happened was school but there was no notification from school themselves."

c. Vulnerable Populations: The Northern Ireland Executive initially did not prioritise messaging around vulnerabilities [LW10/073 - INQ000505909]. It was only as the Test, Trace, and Protect program wound down that the focus shifted to those eligible for antiviral treatments, highlighting their needs more prominently, as explained in a press release by the Department of Health on 21 April 2022 [LW10/074 - INQ000505910].

d. Guidance: The Northern Ireland Executive issued general guidance to the public on, for example, "close contacts". They also provided more specific guidance to CEV individuals, offering advice on how to reduce their risk of exposure and outlining the steps to follow if they began to show symptoms.

213. Because Northern Ireland revoked all remaining guidance on 15 February 2022, CV/CEV households lost protections in one step, which reduced confidence to access care. England's step-down was slightly more staggered in comparison.

Wales

214. CVF members living in Wales reflect a mixed experience with Welsh Government communication and support during the pandemic. Several respondents acknowledged positive aspects relating to clearer messaging from Welsh Government compared to UK-wide communications. Several respondents in Wales referenced a slightly slower pace of reopening, which was appreciated by some as it allowed for more cautious decision-making.

Quote 44 – Aisha, 64

"Living in Wales helped as I felt that our First Minister, Mark Drakeford & other key ministers had our best interests at heart which I never felt from the central UK government. The messaging was very clear, the genuine concern and worry was evident from the briefings. Any deviation from UK/England was explained (like extended 1st lockdown), earlier circuit breaker in Oct 2020, earlier lockdown Dec 2020 etc"

215. However, there was also strong criticism and calls for improvement. Respondents expressed lasting emotional harm and a sense of abandonment. One member wrote:

Quote 45 – Morgan, 30

"Once everything opened again it was like we were forgotten about."

216. There was a specific call for a dedicated minister responsible for vulnerable groups in Wales, perhaps suggesting a gap in targeted leadership and accountability.

Delays in identifying higher-risk individuals for priority supermarket delivery in Wales caused significant stress and increased exposure risks.

Quote 46 – Megan, 64

"My son was really anxious about infecting me as he was the one who had to buy food from shops until priority access to food shopping became possible [6 weeks]."

217. By 2021, the Welsh approach was described as becoming harder to navigate, especially as guidance and support fragmented. One respondent noted that the Welsh vaccine rollout was harder to access. As was common across the UK, some expressed feeling left behind or overlooked, particularly when support networks disappeared and communication decreased.

218. Wales stepped down protections more gradually than some others. From 28 March 2022 the legal duty to self-isolate moved to guidance (with the £500 self-isolation payment continuing until June) [LW10/075 - INQ000652728], while two legal protections remained - face coverings in health and social care and Article 16 risk assessments - before both were lifted on 30 May 2022 [LW10/076 - **INQ000652749**]. Once the laws ended, experiences increasingly depended on local decisions, leading to variability similar to elsewhere in the UK.

219. The Test, Trace, Protect ("TTP") strategy was central to the Welsh Government's response to the Covid-19 pandemic. CVF note that the Welsh title of "Test, Trace, Protect" clearly links testing to protection contrasting with more technical titles elsewhere in the UK.

220. The key decisions made by the Welsh Government reflect a commitment to local responsiveness and community-based support:

a. Priority Testing: Wales prioritised severely immunosuppressed people for PCR testing to enable early treatment access. However, CVF members reported challenges with identification, awareness, and timely access.

b. Decentralised Approach: Local health boards and authorities led implementation testing, tracing, and protection measures, tailoring responses to community needs across Wales, particularly in rural areas where centralised services struggled. This supported a more agile locally aligned provision to support communities, including CV people.

c. Enhanced Community Support: The Welsh Government enhanced community support mechanisms and a press release was issued in June 2021 described the support as providing targeted assistance to those self-isolating [LW10/077 - INQ000505906]. This included food deliveries, mental health support, and coordination with local volunteer networks -these measures were particularly important for CV people.

d. Clear and Regular Communication: The Welsh Government emphasised clear and regular updates, including specific guidance for CV individuals and their families, exposure isolation steps. Their transparency and consistent communication strategy supported timely information and built public trust.

e. NHS Covid-19 app: Wales also integrated the NHS Covid-19 app into its strategy. Effectiveness depended on uptake and digital access.

221. Overall, Welsh Government decisions demonstrated a commitment to local responsiveness and support for vulnerable people. Despite access challenges, CVF considers the decentralised approach and community-support focus key strengths in Wales's response.

Overall

222. Structural gaps in support were experienced nationwide, but the pace, tone, and clarity of communication significantly affected how safe or visible CVF members felt in different parts of the UK. CVF members frequently expressed that policy differences shaped how well (or poorly) they were able to protect themselves and their households. CVF believes that this highlights the need for future public health planning to not only be coherent, but also equitable and inclusive across all four nations.

223. Having a nationalised approach which was both geographically and clinical vulnerability blind, increased risk significantly for Clinically Vulnerable populations. This centralisation may have allowed for a more of a uniform response across the

country, but it was slow to adapt to local needs, particularly for high-risk individuals who required more targeted support.

224. Over time, there was a shift towards a more decentralised approach, especially in devolved administrations like Scotland, Wales, and Northern Ireland, where local health boards played a larger role in tailoring services to meet the needs of their populations, including those who were Clinically Vulnerable.

PART E – Impact on Keyworkers

225. CV people were defined early in the pandemic by the government as being at increased risk of poor outcome from Covid-19 infections (see [LW10/078 - INQ000068624], pages 3-4). Yet they were not afforded the protections given to shielded CEV people. This had a particular impact on keyworkers, who were required to continue working in front line roles during ‘lockdowns’, despite evidence that certain conditions faced significantly higher risks from Covid-19. This caused significant stress and concern for CV people who were not given any suitable support or advice on how to reduce their chances of infection. Many were left confused about their level of risk, felt unsupported and were unclear on what measures they should take; unlike CEV people, they were not afforded any specific protections.

226. Many CV people left their place of work rather than return to a workplace that they did not consider protected them sufficiently from the risk of Covid-19 infection. This had a substantial consequence for this group in terms of financial loss, especially in terms of income. It has also likely reduced the number of CV people in the workplace, especially amongst older and high-risk keyworkers. Some members of CVF reported that they took early retirement.

Quote 47 – Carla, 44

“Being a clinically vulnerable teacher who was not officially shielded during the pandemic was an incredibly stressful experience. ... The lack of specific guidance and support made the situation challenging. I believe there was. Need for comprehensive assistance and clearer guidelines …. The government’s emphasis on CEV individuals sometimes led the public to response with dismissive remarks such as ‘You are only CV, what are you worried

about?' The Inquiry must reflect on what level of increased risk of death should be acceptable to anyone."

227. There were multiple intersecting impacts on Clinically Vulnerable keyworkers: from unsafe working conditions, to emotional distress, financial hardship, and in some cases long-term exclusion from the labour market. Their issues were compounded by inconsistent access to furlough, delayed access to payments, the lack of access to 'reasonable adjustments' relating to their health risks, and ongoing confusion over their entitlement to workplace protections. National data confirms these issues were not isolated, but widespread and predictable - particularly for lower-paid, public-facing workers.

Being exposed to increased risk of infection

228. CV and CEV people (outside of shielding periods) working in keyworker roles during the height of the Covid-19 pandemic faced significantly increased risks which, in many cases, resulted in avoidable harms. Despite being among those at greater risk of severe illness or death from Covid-19 infections, Clinically Vulnerable keyworkers - such as teachers, transport staff, retail workers, and delivery drivers - were often overlooked in workplace 'Covid secure' policies and public health planning.

Workplace pressures (e.g. increased workloads, staff shortages, infection prevention and control measures) and reasonable adjustments at work.

229. Many CV and CEV keyworkers found themselves placed in hazardous working environments without specific risk assessments or protective measures, such as the option to work remotely. CVF's member testimonies revealed that numerous keyworkers were compelled to work in-person despite known high risks to their health.

230. Some employers refused to acknowledge formal shielding letters, failed to conduct risk assessments when asked, or dismissed requests for reasonable adjustments. Others penalised staff for refusing in-person work, even during peak transmission periods, or used the availability of work as a reason to deny furlough or sick pay.

231. Because the government did not require workplace “reasonable adjustments” for Clinically Vulnerable staff, many individuals found themselves without protection at work. This lack of recognition left CV employees at the mercy of employer discretion, creating a knock-on effect for those who needed to shield or otherwise mitigate risk.

Quote 48 – Karen, 62
“When I was told to shield, my school (employer) said that on their risk assessment, that as I was only CV, that I had to work.”

Quote 49 – Nana, 42
“My employers knew what we had been through and that I felt unsafe coming to work. They didn’t have an answer and I had no real protection in place. No specific rights. There is still nothing to protect me so I had to resign. I found a work from home job but this is not secure. We haven’t felt financially secure since all this started.”

232. Despite many taking independent action to limit the risks in other aspects of their lives - such as using food deliveries, restricting social contacts, and delaying or cancelling medical appointments - Clinically Vulnerable keyworkers were still exposed to avoidable risks in their working environments. UK government data also confirms that keyworkers who were unable to work from home were up to 2.5 times more likely to contract Covid-19 than those working in remote roles [LW10/079 – INQ000652729].

233. Parliament’s Women & Equalities Committee “Unequal impact? Coronavirus” series (Dec 2019 – May 2021) acknowledged the heightened risk to older household members in multigenerational settings and examined occupational exposure and disability-related harms. **Parliamentary Privilege**

Parliamentary Privilege

Overall financial security, including issues relating to income and benefits.

234. Among the 33 CVF members who identified as keyworkers in our survey, the majority reported serious failings in workplace safety and rights protections, as set out below and in figure 7:

a. 57.6% felt unsafe going to work

b. 57.6% were asked to return to work in unsafe conditions

c. 54.5% experienced direct discrimination related to their Clinically Vulnerable status

d. 18.1% faced indirect discrimination due to the CV status of a household member

e. 36.4% were denied reasonable adjustments (such as PPE or remote work)

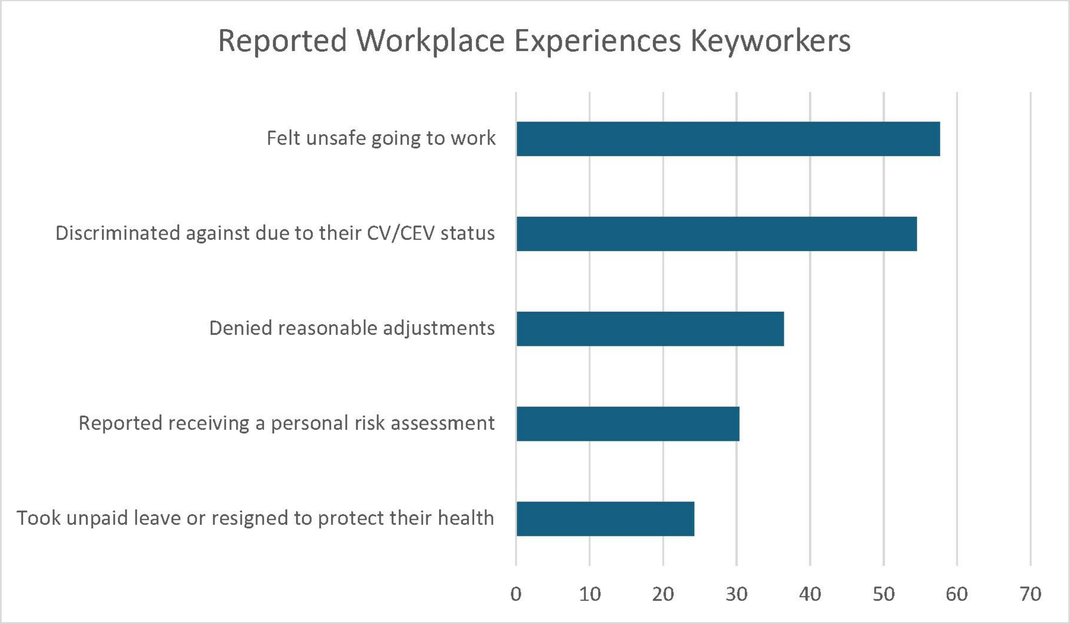
f. Of those who were CV/CEV and given reasonable adjustments, 59.0% felt they were inadequate

g. Only 30.3% reported receiving a personal risk assessment

h. 24.2% had to take unpaid leave or resign to protect health

i. 21.2% said they were ineligible for furlough or financial support

j. 12.1% of those who needed sickness pay were unable to access it



(Figure 7)

235. These findings highlight systemic failures in recognising and accommodating clinical risk within often high-risk key work sectors. Many employers appeared to view the needs of Clinically Vulnerable staff as too complex or inconvenient to accommodate and in the absence of enforceable rights and protections this translated directly into unsafe working conditions, lost income, and in many cases, permanent career setbacks. As a result, these workers faced particularly high risk - both of exposure to Covid-19 and of losing income or employment.

236. Indeed, it is CVF's experience that CV and CEV workers were more likely to experience dismissal, redundancy, or a lack of reasonable adjustments (see e.g., regarding dismissal, [LW10/080 – INQ000652731]). This is likely because keyworker roles were in high demand at that time, and so these staff were often easily replaceable despite being exposed to unsafe conditions. Without the protection of stable employment rights or a guaranteed income, many were placed in unsafe environments even if they chose to formally disclose their health conditions, forced to choose between their health and their income.

237. Case Study (v), on page 42, shared the experience of one CVF member who had to leave their zero-hours job due to repeated exposure to symptomatic individuals, despite formally disclosing their health vulnerabilities to their employer.

Access to sick pay for zero-hours keyworkers

238. Clinically Vulnerable workers on zero-hours contracts were often placed in exceptionally high-risk situations, frequently moving between locations on very short notice. Remote work was not an option, and many chose not to disclose their health risks for fear of losing income. The absence of a consistent employer, combined with agencies focused only on filling contracts, meant there was little oversight of their rights. Unlike colleagues in more stable roles, many could not access furlough because work was technically available - even if it was unsafe - leaving this group the most exposed to both infection risk and financial insecurity. CVF believes that this lack of consideration of their rights amounted to a form of structural discrimination.

239. Other zero-hours contract workers were more likely to attend work sick, with limited access to statutory sick pay [LW10/081 – INQ000652732] and protections, significantly increasing their exposure risk to Covid-19.

240. The UK government did introduce the Test and Trace Support Payment, a one-off payment of £500, intended to help people who were required to self-isolate and who would lose income as a result. However, this payment presented multiple problems for Clinically Vulnerable people, and particularly keyworkers:

    a. **Eligibility criteria were narrow**: The payment was targeted at people who had tested positive or had been officially told to self-isolate by NHS Test and Trace. Many CV/CEV people chose to self-isolate proactively for safety, not because they had tested positive, and were therefore excluded from this support even if there were many infections in their workplace. When a household member was isolating with a positive test, no additional support was offered to Clinically Vulnerable households where people needed separate accommodation.

    b. **One-off lump sums were insufficient**: Even for those who did receive it, £500 covered one whole isolation period of 14 days (before isolation guidance was later shortened to 10 days, and then 5). Even for healthy people, £500 for 14 days in isolation was already not enough.

241. There is a lack of disaggregated data on how many keyworkers who were CV or CEV were unable to access sick pay due to the nature of their employment, obscuring the scale of the problem.

Disparities with non-CV keyworker colleagues

242. Clinically Vulnerable people frequently reported not only a lack of workplace adjustments but also active discrimination and exclusion, which impacted on career progression resulting from their need to shield, work remotely, or mask. Beyond practical exclusions, many CVF members reported a subtle, corrosive, culture of stigma within their workplaces - where mask-wearing, and health conditions were openly mocked, and where having to shield was considered to be a holiday rather than a legitimate health need.

Quote 50 – Christina, 41

"When things went back to being 'normal', colleagues clearly feel a bit worried about making me sick so this can mean they avoid me. This can be quite isolating, if well meant. Two colleagues roll their eyes though any time I say anything about disability support, and … regularly makes digs about all of the time I had off and how nice that must have been. Senior managers [and] HR, have mocked people wearing masks… I missed out on many opportunities, and felt it had an even bigger impact than my maternity leave.... This still has an effect as they ranked us by our research outputs... they chose to examine [the] 2020-22 period, and I simply could not compare to others… most of my peers are now professors and I just had that entire lost period so am not there yet."

243. For many Clinically Vulnerable people, the pandemic did more than just disrupt their working lives, it exposed how fragile their rights were in the workplace. Their need for legal rights and protections were overlooked, and this had serious consequences. Some people lost their jobs, were denied promotion or progression, and in some cases left the workforce entirely. Others were forced into early retirement or long-term financial hardship and insecurity, with associated impacts on mental health and wellbeing.

Quote 51 – Inge, 65

"I was pressured to return to work in a windowless, unventilated room. I refused to do so and was subsequently sacked."

244. Clinically Vulnerable workers do not qualify for reasonable adjustments based on risks. Even when a person met the legal definition of disability, their new pandemic-related needs were often not recognised - because the Equality Act defines disability in terms of the impact of a long-term physical or mental impairment on day-to-day functioning. So shielding or mitigating infection risk wasn't seen as a "disability need," even though it is essential for those facing increased health risks. This has left a gap: Clinically Vulnerable people were almost universally denied adjustments (outside of formal shielding) because the risks they faced did not stem from a functional impairment, but from a higher risk of severe illness.

245. As a result, essential protections like remote work, safer environments, or continued isolation were often treated as if they were preferences rather than health needs with legal entitlements - leaving many without support and exposing a structural failure to accommodate risk-based needs in employment, education and public services.

246. In addition to the accounts and data shared above, a significant number of the 33 keyworkers surveyed by CVF reported that they were treated differently, and often unfairly, compared to their healthier colleagues. While some were given support and more flexible work arrangements, many described facing stigma and exclusion, and experiencing other disadvantages professionally. For instance, 33.3% said they missed out on training or development opportunities more than their non-CV peers, and 63.6% felt their jobs were at greater risk - either through pressure to return to unsafe work, during furlough, or increased risk of redundancy.

247. Some respondents did note more supportive experiences, but they were far less common. The overall picture reveals a troubling pattern: CV keyworkers were frequently left to navigate working environments that not only did not recognise their needs but often disadvantaged them if they acted independently to protect their health.

Statistical Invisibility

248. Across all areas, there remains a concerning absence of disaggregated data on clinically vulnerable and clinically extremely vulnerable keyworkers, making it difficult to fully assess the scale of harm they experienced. CVF's own data is limited. Although individuals with "underlying health conditions" were frequently mentioned both in the media and by politicians, official statistics for Clinically Vulnerable

populations were viewed through the lens of "disability" or "economic inactivity" with only limited data existing for those officially classified as CEV. CVF believes this general lack of visibility of Clinically Vulnerable people particularly non-CEV Clinically Vulnerable people will have contributed directly to their exclusion from necessary protections via reasonable workplace adjustments, and targeted economic support.

PART F – Impact on Specific Groups

Those experiencing housing insecurity or homelessness

249. While no CVF members reported personal experiences of homelessness during the pandemic, the organisation is acutely aware of the elevated risks faced by Clinically Vulnerable people in relation to housing insecurity and unsuitable living conditions.

Elevated Health Risks

250. Homeless people were considered to be 'clinically vulnerable' as they were more likely to experience serious complications or death from Covid-19. This risk was officially recognised by the UK government when those experiencing homelessness were added to Group 6 of the vaccination priority list, on the basis that they had underlying health risks likely caused by poor access to healthcare or safe accommodation. Research shows that people experiencing homelessness die, on average, in their mid-40s – more than 30 years younger than the rest of the population – due to health hazards associated with homeless living (see: LW10/082 – INQ000652733).

251. The alignment of housing vulnerability with clinical risk was only a temporary consideration, as people experiencing homelessness were later removed from the vaccination priority list. However, homelessness must be recognised as a health issue, especially for individuals with suppressed immunity or other clinical vulnerabilities, whose risks were significantly amplified by their living conditions.

252. The pandemic prompted an emergency response that demonstrated what is possible when urgency aligns with political will. Initiatives such as "Everyone In" led to over 37,000 people being provided with emergency accommodation at the start of the pandemic in England alone [LW10/083 – INQ000652734]. For a time,

homelessness was dramatically reduced, showing that the issue could be tackled with a little effort.

253. The "Everyone In" initiative did not evolve into long-term housing protections, and Clinically Vulnerable individuals in insecure housing were left exposed once emergency support ended. The lack of structural follow-through had serious implications for homeless people who needed to shield, or to isolate, and who faced increased risk.

Those living in supported housing, shared accommodation, or unsuitable housing.

254. According to The Health Foundation briefing, 'Better housing is crucial for our health and the Covid-19 recovery' [LW10/084 – INQ000652735], at the onset of the Covid-19 pandemic, one in three households (7.6 million) had "*at least one major housing problem relating to overcrowding, affordability or poor-quality housing.*"

255. Overcrowding has been found to be detrimental to both physical and mental health. The World Health Organisation [LW10/085 – INQ000652750] notes that overcrowding can have a negative impact on mental health, as well as increase the spread of infectious diseases. Much of the research on this association has focused on tuberculosis ('TB'), which is particularly relevant given that, like Covid-19, TB is primarily transmitted through aerosols. Overcrowding has been found to increase the spread of Covid-19, as well as other infectious diseases [LW10/086 – INQ000233778].

256. For CVF's members, keeping themselves and loved ones safe was incredibly difficult while living in accommodation that did not easily - or at all - allow isolation. For those advised to shield, the risks were significant. Poor housing conditions, overcrowding, or shared facilities will have significantly increased the difficulty of shielding safely. CVF members who reported living in unsuitable conditions for shielding highlighted challenges in our survey such as:

a. **59.3%** had shared facilities that limited their ability to isolate from others
b. **53.1%** reported overcrowding
c. **21.8%** cited issues with poor ventilation.

257. While many members had stable housing, not all could meet the practical needs of prolonged isolation or infection control, especially where unsuitable accommodation was involved.

258. Shielding guidance [LW10/086 – INQ000233778] recommended: *"you should: minimise the time you spend with others in shared spaces (kitchen, bathroom and sitting areas) and keep shared spaces well ventilated; aim to keep 2 metres (3 steps) away from others and encourage them to sleep in a different bed where possible; use separate towels and, if possible, use a separate bathroom from the rest of the household, or clean the bathroom after every use; and avoid using the kitchen when others are present, take your meals back to your room to eat where possible, and ensure all kitchenware is cleaned thoroughly."* It also suggests *"arranging space to sit and see a nice view (if possible) and get some natural sunlight. Get out into the garden or sit on your doorstep if you can, keeping a distance of at least 2 metres from others."*

259. This was not realistic for many, especially for low-income families in small homes, flats or high occupancy / multigenerational households, for people in temporary or supported housing, migrants, or those in prisons, for disabled people who required in-home care or assistance with daily tasks, and for those experiencing housing insecurity. People could not simply add additional bathrooms or avoid shared spaces. Approximately one in eight British households (and one in five in London) [LW10/087 – INQ000649017] have no access to a garden or private outdoor space. This lack of personal outdoor space significantly impacted the ability of CEV people to safely shield or get fresh air, especially during stricter lockdown periods. For many, shielding guidance created significant emotional distress as they were told to follow impossible guidance without any external support from public health.

260. The lack of support to meet these conditions (e.g. through rehousing, home adaptations, or delivery of essential services) compounded inequalities, especially for those already disadvantaged. Shielding was not simply about staying at home - it was about living in accommodation that made shielding measures possible.

261. Living in overcrowded accommodation created a "downward spiral" of worsening of health restricting one family's ability to earn enough money to move or to afford the mitigations necessary to help prevent further illness.

Quote 52 – Rowena, 45

"No ability to shield or reduce risk as too many persons for the size house. Had to resort to shielding the most vulnerable in a tent out of the house – not ideal for someone who has a serious respiratory condition which is affected by cold, damp, and pollen etc"

Quote 53 – Emily, 45

"I have a physical disability that made some care tasks impossible. My daughter did not have her own bedroom, we had no communal space, and this negatively impacted the children. […] Where we had been self-sufficient we were then reliant on others and financially disadvantaged as children's dad had no income for three months. Caused mortgage pressures on top of caring for my complex daughter. […] We needed home adaptions - this has only just been completed 5yrs later."

Quote 54 – Martha, 60

"We had 4 adults and a young baby in a small 3-bed house. 2 adults were keyworkers and 2 adults were CV. We had to use a mattress on the floor when my daughter was instructed to isolate so she be in a room away from the rest of the household, but we still had to share bathroom facilities with her."

262. At the time, UKHSA public health guidance [LW10/088 – INQ000089748] advised that individuals who were quarantining should "*Use a separate bathroom from the rest of the household where possible. If a separate bathroom is not available, try and use the facilities last, before cleaning the bathroom using your usual cleaning products. The bathroom should be cleaned regularly*."

263. However, as Covid-19 is primarily transmitted through aerosol particles that can linger in the air for hours, surface cleaning alone would have had minimal impact in reducing the risk of transmission in shared bathrooms [LW10/089 – INQ000348164]. In addition, expecting families caring for an unwell member to thoroughly clean a bathroom every time a potentially infected person has used it is, arguably, unrealistic and impractical.

264. For CVF members, life became even more challenging when workplaces began requiring a return to in-person work. For those living in overcrowded or shared

accommodation, the additional risk this posed was felt acutely. One member, who was unable to isolate, described the stress of her husband being called back to work:

Quote 55 – Helena, 64 (unable to isolate)
"He was called back to work one day a week and had to use public transport which made it difficult to ensure he did not bring anything home - I found this very stressful."

265. The inability to isolate from household members who were keyworkers placed many shielded individuals at ongoing risk. CVF members were acutely aware of the absence of any provision to help separate vulnerable people from potential exposure within their own homes - despite recognising the need to protect NHS and other essential staff. As one member reflected:

Quote 56 – Louise, 46
"Ideally the shielded partners of keyworkers should've been protected or offered temporary accommodation."

Those living alone or in isolated areas.

266. CVF members who were living alone or in isolated areas felt cut off from society after restrictions for non-shielded people were lifted. It should be noted that CVF members' experiences of isolation were particularly acute in that many of our members were on the government's official 'shielding' list and were, at times, under very different guidelines to the non-shielded population. This heightened their feelings of isolation and added significant stress.

Quote 57 – Mandy, 65
"My husband and I were very much isolated in our rural home with no near neighbours."

Quote 58 – Cameron, 55
"Couldn't see family which made me very emotionally drained. I felt isolated and alone."

267. Living alone meant that some individuals had no day-to-day human contact for weeks or months at a time. Those in isolated areas often struggled with poor access to services and limited options for safe community engagement. Even basic support became harder to reach:

Quote 59 –Ali, 53 (lived alone, Scotland)

"I couldn't access food. At one point I didn't eat any fresh food at all for several weeks, only canned/dried food."

268. Others described how even professionals tasked with providing care or social support failed to understand the ongoing realities of risk and exclusion for Clinically Vulnerable people.

Quote 60 – Debbie, 44

"We felt forgotten […] no-one truly cared if we were surviving or not. The social worker called and when we said we were struggling she suggested 'Do something to distract yourself like baking cakes.' It showed a real lack of understanding and empathy and made us feel totally alone, depressed and isolated."

269. Those living alone or in geographically isolated areas experienced a profound and prolonged isolation which took both a psychological and physiological toll. UK-based research found that older adults living alone and having more than 4 chronic conditions were significantly more likely to experience loneliness, particularly during lockdowns [LW10/090 – INQ000548742] and that the *"Psychosocial health of older patients with multimorbidity markedly deteriorated and missed medical appointments substantially increased after the Covid-19 outbreak."*

270. For Clinically Vulnerable people living alone or in remote communities, the removal of mitigations not only made social contact harder, it exposed them to enduring mental and physical health risks from prolonged disconnection. For those who were formally or informally shielding due to ongoing clinical risk, the shift toward "living with Covid" forced some into an extended isolation with little external support. Their continued isolation further increased their vulnerability to indirect consequences of the pandemic, such as deteriorating mental health, delayed care, and an erosion of their social support networks

271. The consequences of shielding were further intensified by reliance on limited or non-existent public transport services. Many rural communities across the UK have experienced significant cuts to bus routes and transport infrastructure over the past decade, making it more difficult to access essential healthcare, supplies, or social contact even before the pandemic. This lack of mobility became a further barrier to

safety and support, especially for those advised not to leave their homes. Shielding in these settings often meant complete isolation. Unlike urban populations who could access food deliveries, more remote populations were often excluded from priority services, making shielding logistically challenging. Those living alone in such areas were more reliant on their communities adding to their psychological burdens.

272. A broader meta-analysis linked social isolation with a 15-20% increased risk of incident heart failure and major cardiovascular events, even when adjusting for age, sex, and socioeconomic factors [LW10/091 – INQ000548743] Loneliness itself was also strongly associated with deteriorating mental health. One UK longitudinal study observed that people reporting frequent loneliness during April - July 2020 were 16 times more likely to report a common mental disorder, such as anxiety or depression [LW10/092 – INQ000548744].

Those in the immigration and asylum system, including where they are in temporary accommodation or detention.

273. The Covid-19 pandemic exposed and exacerbated longstanding failures within the UK's immigration and asylum system, particularly for those with clinical vulnerabilities. Individuals seeking asylum or awaiting immigration decisions were often placed in environments that heightened their risk of exposure to the virus - including crowded hotels, temporary hostels, and immigration detention centres. For those with underlying health conditions, such settings present serious dangers.

274. In March 2020, as concerns about Covid-19 intensified, the Home Office released approximately 300 individuals from immigration detention. This followed legal pressure from civil society organisations who highlighted that many detainees had underlying health conditions that made them Clinically Vulnerable to Covid-19, but had not been identified or safeguarded appropriately. This was reported in The Guardian [LW10/093 – INQ000548745] which said as follows:

> *"The release comes in the wake of a legal action launched last week which argued that the Home Office had failed to protect immigration detainees from the coronavirus outbreak and failed to identify which detainees were at particular risk of serious harm or death if they do contract the virus due to their age or underlying health conditions. It called for the release of all those who are particularly*

vulnerable and for all detainees to be tested, along with the suspension of all new detentions. The action warns even a short delay could have "catastrophic consequences".

275. Despite the existence of the "Adults at Risk" ('**AAR**') policy, it was reported that nearly 40% of remaining detainees, in July 2020, fell into Level 2 or 3 of the AAR categories "and, potentially, that they are at high risk from Covid-19" – yet they remained in detention facilities that lacked adequate protections [LW10/094 – INQ000657073]

276. Conditions within detention centres were widely reported as unsafe during the height of the pandemic. Social distancing was frequently impossible, PPE was reportedly supplied in some cases (although it was unclear which items were provided), and access to testing was limited, healthcare stretched, and this would have increased the spread of infections [LW10/095 – INQ000548746]. Many detainees suffered a deterioration in their mental health and feared for their health and their lives. Some providers suggested that Clinically Vulnerable detainees self-isolated in their cells despite the known harms of such self-isolation (including increased anxiety, risk of self-harming or suicide) [LW10/096 – INQ000196902]. Some individuals exposed to this new regimen fared better than others:

"I received a letter stating that I was a vulnerable prisoner and now to be in isolated lockdown for protection against the virus.… This remained for the first 6 to 8 weeks. When the door to the cell was opened, we had to move to the rear of the cell and put on a face mask (provided regularly for us). Also at this stage staff wore masks and gloves sometimes with plastic aprons.… Initially a member of staff checked weekly if you're okay or needed healthcare or mental health support.… Around week 8, we were unlocked for outside exercise, phone calls, et cetera, seven prisoners at a time, 30 minutes, three times a week. This was later increased to 1 hour at a time. At all times, face masks were worn and two meter distancing observed.… I think we are safe and being well looked after even though the isolation gets a bit boring at times. Generally however I am coping well but certainly looking forward to a gradual relaxation of the regime here." [LW10/097 – INQ000657111]

277. Similar problems were reported for individuals housed in temporary Home Office accommodation, such as asylum hotels and barracks [LW10/098 – INQ000548748].

Evidence submitted to ICIBI by Positive Action in Housing [LW10/099 – INQ000548749] further revealed that no individual vulnerability or Covid-19 risk assessments were carried out before placing asylum seekers in shared flats or hotel rooms. Their report stated:

> *"Everyone we spoke to said they had not been assessed in terms of their vulnerability, risks from someone else or to do with Covid-19 risks when sharing flats."*

278. Additionally, Clinically Vulnerable individuals experienced barriers to accessing appropriate nutrition and healthcare. For example, asylum seekers with diabetes or other medical conditions were skipping meals due to the inappropriate food being provided [LW10/099 – INQ000548749].

279. These failures reflect a broader systemic neglect of Clinically Vulnerable people in asylum accommodation. The absence of screening, inadequate medical and nutritional support, and high-risk housing conditions all illustrate how those with underlying health conditions were placed in environments that directly undermined their safety.

280. Only a small number of CVF members reported going through the immigration system during the early stages of the pandemic. While one member described the process as relatively smooth, another recounted a far more difficult experience, linked to pandemic-related system changes:

Quote 61 – Alex, 38

"They launched a new software for remote biometrics and messed it up, so those of us caught in that period were left without the ability to prove our immigration status for nearly a year."

281. This technical failure created significant hardship. At a time when the anxiety of being Clinically Vulnerable during a pandemic was already considerable, the additional stress of being unable to prove legal status meant they were effectively prevented from moving house or applying for new employment for nearly a year.

282. Another CVF member did not face delays in processing but described distress at being required to remove her face mask indoors for biometric identification - an experience that increased risks and caused stress due to their clinical vulnerability.

283. These accounts illustrate how even routine immigration procedures were rendered more precarious for Clinically Vulnerable individuals, particularly where safety protocols were not adapted or operational failures compounded their issues.

<u>Those in prisons and other places of detention.</u>

284. CVF recognises that Clinically Vulnerable people within prisons and other places of detention were subject to many of the same systemic failings experienced by those in temporary asylum accommodation, supported housing, and other shared or institutional environments. Prisons are inherently high-risk settings for airborne transmission due to structural overcrowding, limited space for isolation, and inadequate access to / use of PPE [LW10/100 – INQ000548750], testing, or healthcare.

285. These risks were evident from the outset of the pandemic, prompting public health and legal experts to call for immediate changes. For instance, in April 2020, an expert report for the Howard League for Penal Reform [LW10/101 – INQ000655684] by Professor Richard Coker, Emeritus Professor of Public Health at the London School of Hygiene and Tropical Medicine, emphasised the need to avoid custodial settings altogether for those at risk:.

> *"In my opinion authorities should consider alternative options to incarceration where feasible that avoids congregate settings, where social distancing and isolation/quarantine are measures that are consistent with the most recent, March 20th 2020 guidelines for others in protecting public health."*

286. These risks were compounded for individuals with underlying health conditions many of whom were never formally identified or safeguarded as Clinically Vulnerable. A peer-reviewed outbreak investigation [LW10/102 – INQ000496187] conducted within a large UK prison between March and June 2020, where a high proportion of residents were Clinically Vulnerable, supported these concerns. Among symptomatic prisoners, 62.1% were aged 50 or older, increasing their risk, and the

wing attack rate reached up to 12.5%, highlighting the impact of Covid-19 spread, particularly when distancing and isolation were not possible.

287. A report by the Prison Reform Trust [LW10/103 – INQ000548753] indicated that isolation measures appeared to be used in lieu of care - for example, Clinically Vulnerable prisoners confined to cells for 23 hours a day without mental health support or adequate clinical oversight. CVF notes that such treatment mirrors the experiences of members in asylum and supported housing settings, where shielding was poorly implemented.

288. CVF notes that early in the pandemic, the heightened risks faced by BAME communities were identified as overlapping with those experienced by Clinically Vulnerable groups. It is therefore unsurprising that concerns from BAME prisoners mirrored those of other high-risk populations:

> *"BAME inmates in particular are concerned about the risks and some want masks and screens to limit the risk. No actions seem to be planned to address this.(21 June, category C prison)"* [LW10/103 – INQ000548753]

289. This reflects broader patterns of structural inequality seen elsewhere, that despite known elevated risks of severe illness and mortality from Covid-19 among BAME individuals, prisons failed to implement sufficient protective measures. The absence of action in response to health concerns is perhaps an indication of a wider disregard for the safety of marginalised groups in these institutional settings.

290. The issues identified within prisons were strongly echoed across other institutional settings - including immigration detention, supported and shared accommodation, and temporary asylum housing - where Clinically Vulnerable people were routinely placed in high-risk environments such as hotels and hostels, often without any health screening or individualised risk assessments.

291. A clear and recurring pattern has emerged across all of these contexts: Clinically Vulnerable people were frequently not identified, appropriately supported, or protected. Instead, they were left to bear disproportionate risk, not as a result of their personal choices, but due to systemic and structural failures.

Survivors of domestic abuse and/or those in unsafe or abusive home environments.

292. For people living with domestic abuse, the Covid-19 pandemic posed additional serious risks. Access to support services for those experiencing domestic abuse was significantly reduced as refuges and face-to-face support services struggled to meet social distancing guidelines and staff were furloughed. In England "84.4% (38 out of 45) of respondents reported that they have been forced to reduce or cancel one or more of their services due to Covid-19." (Women's Aid, *The impact of Covid-19 on domestic abuse support services: findings from an initial Women's Aid survey*, 2022) [LW10/104 – INQ000475126].

293. Several CVF members reported experiences of domestic abuse during this period. A small number described existing abusive dynamics becoming more intense under the pressure of lockdowns, enforced isolation, or the additional control enabled by their clinical vulnerability. In some cases, Covid-specific coercive control was evident - with abusers using the new threat of infection, the denial of medication, or the restriction of access to care as tools of control. Indeed, The Open University identified that coercive control increased during this period, with perpetrators using aspects of the pandemic as another means of control and abuse:

> "*Perpetrators may, for instance, invent COVID-19 symptoms and fabricate test results. They may refuse to share sanitisers and soaps, refuse to socially distance, or refuse to wear face masks to deliberately make their victims feel fearful. This is particularly abusive where a victim needs to shield themselves or others*." [LW10/105 – INQ000588118]

294. This pattern was echoed in some CVF member' experiences. One member stated:

Quote 62 – CVF Member, Female, 45

"The coercive control would have included deliberate exposure to Covid and withholding of critical asthma medication."

295. Another CVF member described how their clinical vulnerability was systematically exploited within a controlling relationship, with shielding used to isolate and destabilise them.

Case Study (ix) - Shielding and Coercive Control During a Pandemic

“As someone with complex chronic illness and a transplant, I was classed as Clinically Extremely Vulnerable and required to shield throughout the pandemic. My medical vulnerability was used against me by my abuser who restricted access to care, cut off support networks, and used my health risks as tool to increase his control. I was denied financial autonomy and the ability to attend essential medical appointments or seek legal and practical help. This form of coercion was difficult to detect because it exploited real clinical risks and took place in the enforced isolation of shielding, which removed me from view cutting me off from my closest friends and it made outside intervention almost impossible when I was struggling the most.

Safeguarding simply wasn't accessible to me. The systems did not respond, and I felt trapped in my isolation with no route out. Shielding made people like me more controllable and far more invisible. I found myself entirely dependent in ways that I hadn't been before, not just physically but also legally and financially. My health risks have been weaponised, and I was trapped in fear for my life. Pandemic policies forgot me. I was already unable to access prophylactic treatments and safe healthcare or public environments, and without any of those things, I am still living with the consequences of being trapped by my risks and circumstances.”

Anonymous, CVF Member

296. These accounts highlight how, for some CEV and CV people, the intersection of clinical vulnerability and domestic abuse created a situation of extreme risk and near-total isolation. Shielding guidance for those who were CEV told individuals to remain at home for extended periods without in-person contact, which would have included healthcare professionals, social workers, or wider support networks – precisely the places that might otherwise detect or interrupt abuse. The more intense period of ‘staying at home’ experienced by this group was intended to protect them from health risks, but for some, it significantly increased their exposure to other forms of harm.

297. A new dynamic developed whereby clinical risk itself became a tool of coercive control. In these cases, perpetrators exploited the genuine public health threats to limit freedom, decision-making, and access to health and other care. This form of abuse was often invisible to systems designed to identify more conventional forms of harm, and it was compounded by the same Covid-specific barriers that affected

CVF members more broadly - lack of access to safe public spaces, health settings, or legal services.

298. CVF believe that this compounded form of vulnerability was rarely recognised by safeguarding or health professionals. While public messaging emphasised “staying safe” at home, little attention was paid to those for whom home was unsafe. Refuge spaces and other forms of emergency or supported accommodation were often inaccessible, full, or presented their own risks, including shared spaces that were unsafe for those needing to shield. As a result, some survivors were left with no safe option at all.

Impact and experience of those using the civil, family and criminal justice systems

299. CVF has gathered limited but important evidence showing that the justice system did not and do not consistently recognise or accommodate the needs of Clinically Vulnerable people. Flexibility was granted more readily at first, but later gaps in protections often forced people into unsafe conditions and unnecessary stress.

300. Early in the pandemic, some people in Clinically Vulnerable households who were summoned for jury service were frequently excused. However, as restrictions relaxed, members reported greater difficulty in securing either excusal from jury duty or any other adjustments in court despite continuing health risks. Experiences included pressure to remove masks in court, and lack of previously widely available remote attendance options. One member of CVF explained:

Quote 63 - CVF member, England

“[My husband] was selected for a jury. He was the only one masked. Someone in court objected to him being masked. So he was put on the spot in front of the whole court. Either remove his mask or the whole jury would be deselected.

That should have been easy - except the previous day they had all spent 8 hours waiting to be selected and had been very bored. So you can imagine the peer pressure was off the chart. No one asked WHY he was masking. They didn’t check anything at all. So he removed his mask.”

301. Another CVF member described being refused the option of remote attendance despite being severely immunosuppressed and having caring responsibilities:

Quote 64 - CVF member, England

"I asked to attend court remotely because I am severely immunosuppressed and have caring responsibilities for young children. I didn't want to leave them with other people who might expose them to infection risk. My request was refused. I had to attend in person and was told I could not wear a mask to speak, which made an already stressful hearing feel even more stressful. I refused and kept my mask on. On one occasion, I was worried about being symptomatic myself, and I was waiting for a test result (needed for urgent antiviral treatment). The court told me that I must attend infected, so not only was that a real concern for health, but it didn't reassure me of my safety if someone else was attending infected."

302. A longer case study illustrates the pressures faced by professionals within the justice system:

Case Study (x) – Barrister in Law

"I work as a barrister. My partner has had an organ transplant and is permanently immune-suppressed. Towards the end of 2019, I went on parental leave and I returned to practice in 2021. This was longer parental leave than I had originally planned to take, as my partner and I wanted to minimise the risks from childcare. When I returned to practice, we chose a smaller childcare setting rather than a larger nursery because we hoped that would reduce the risk.

When I first returned, I tried to only do online hearings and paperwork. Initially this was possible as many hearings were online. The first hearing I did in person was in late 2021. At that time the tribunal building was still quiet, and I masked almost the entire time – I only removed my mask during submissions as I felt it was difficult to establish a rapport with the judge with the mask.

Since then, the number of face-to-face hearings I have done has increased, as it would not be possible for me to have a sustainable practice without them. I still try to mask as much as possible but I do find it difficult as so few others do and because establishing relationships in my line of work with clients, opponents and judges is really key in my mind. Generally, when the hearing is happening I do not mask. This

> *is a very personal decision for me but also a difficult one because of my partner. At home we still live quite a restricted life – we have very few people in our house, we all still lateral flow test regularly, I pay to have a regular Covid booster (my partner gets theirs free), and often my partner will mask round me and our children because of the risks we take from me going to work and the children going to school.*
>
> *Case management hearings and bail hearings remain online which I think is helpful and practical. From time to time there are still remote hearings which I think generally work well although for some vulnerable clients attending in person is important. There can also be some difficulties if the judge and my opponent are in court but I am joining remotely – I think it is preferable for all parties to be remote rather than some being in the courtroom together."*
>
> *Anonymous, CVF Member*

303. Collectively, these accounts show that Clinically Vulnerable people faced inconsistent treatment and an erosion of adjustments over time. Initially, remote access and jury duty excusals were offered, but these became harder to secure as "normal" operations resumed. For those in Clinically Vulnerable households, this meant being forced into situations that compromised health or made it difficult to participate.

304. Broader justice system issues included:
    a. Denial of remote participation as a reasonable adjustment in court, despite specific needs due to Covid risks.
    b. Lack of recognition of mask use as a legitimate health protection, with members reporting feeling pressured to remove masks in hearings after widespread measures were withdrawn.
    c. Unequal treatment where advocacy support was remote.

305. The justice system's move back to face-to-face hearings often disregarded the fact that risks remain disproportionately high for Clinically Vulnerable people. The absence of a remote option left many feeling that their need for safety was treated as secondary to the system's preference for standard, in-person proceedings.

306. In CVF's view, the pandemic exposed structural failings: the absence of recognition of clinical vulnerability within justice system processes, the lack of protective

measures once laws were removed, and the reliance on discretionary rather than enforceable rights. Without a framework that explicitly protects the rights of Clinically Vulnerable people in legal proceedings, there is a risk of exclusion, coercion into unsafe environments, and disadvantage - not only for Clinically Vulnerable individuals themselves but also those in Clinically Vulnerable households - when pursuing or defending cases.

PART G – Innovations, Societal Strengths, Lessons to be Learned

307. CVF observed that despite significant systemic failings, there were some examples of actions and community responses that did make a measurable difference to the safety, health, and wellbeing of some Clinically Vulnerable people. Many of the strengths emerged from efforts made on the ground and rapid adaptation of services. They demonstrate that with the right future planning, protections, and partnerships, it should be possible to further reduce risks further to prevent some of the most damaging impacts on those at highest risk in public health emergencies.

308. **Early access to vaccines.** Prioritisation of Clinically Vulnerable people in early vaccine rollout reduced risk of severe illness and death. We also recognise the important role of proactive GP-led outreach and in-home vaccination for housebound individuals to improved uptake.

309. **Antiviral treatments**. Despite the concerns CVF raised in Module 4, the rapid development and deployment of antiviral treatments to eligible, severely immunosuppressed / immunocompromised, patients saved lives.

310. **High quality data**. Large-scale surveillance (e.g. ONS infection surveys, NHS hospital data) provided rapid insights into transmission trends and highlighted risk factors such as age, and underlying health conditions, enabling targeted vaccination and public health interventions.

311. **Lockdowns and shielding measures**. Periods of national or local lockdown and formal shielding guidance helped many Clinically Vulnerable people feel safer by reducing community transmission and to recognise the different needs of some who may have required urgent additional support. They created a sense of collective action, with the public as a whole making changes to prioritise reducing transmission to protect everyone in their community.

312. **Protective measures indoors**. Face-covering mandates, guidance to improve ventilation, and physical distancing to reduce the population density in indoor spaces offered added protection to reduce risks.

313. **Remote and flexible healthcare**. Expansion of telephone and video consultations for routine care reduced exposure risk. Infection-controlled 'hot' and 'cold' sites or spaces for treatment and triage. Remote monitoring of certain health issues and the use of 'virtual wards' reduced the need for hospital visits and stays.

314. **Work adjustments and protections**. Employers enabling remote work, flexible hours, and adjusted duties reduced exposure risk helped many clinically extremely vulnerable workers. Some sectors providing paid leave (often for pregnant workers), furlough, or redeployment of some more vulnerable staff to lower-risk roles.

315. **Home delivery and adaptions to retail**. National and local schemes provided home delivery of groceries, prescriptions, and other vital supplies for CEV people and those in their households. Designated shopping hours, contact-free payment, roadside collection, also reduced exposure risks. Priority access hours in supermarkets may have meant that people who were more focused on taking precautions shared a space, with the potential to reduce risks.

316. **Locally coordinated assistance.** Councils coordinating food parcel distribution to CEV individuals, and welfare calls (including from local care providers and volunteer organisations), local responsiveness - particularly during local tiered lockdowns.

317. **Community support networks**. Informal peer support networks helped to reduce isolation and share up-to-date guidance in a more accessible way, as well as sharing practical advice from peers.

318. **Third sector support, advocacy and resources**. Charities and patient advocacy groups producing plain-language guidance, webinars, and template letters empowered some Clinically Vulnerable people to request reasonable adjustments and support.

319. **Faith and cultural organisations.** Places of worship streamed services, including funerals, and conducted sometimes check-ins with their more vulnerable members. Some also delivered culturally appropriate meals to those shielding.

320. **Remote access to museums, theatres and other venues.** During lockdown and, in some cases, beyond a number of institutions opened their virtual doors to the public. This enabled families to 'visit' museums or watch live performances they

would have otherwise missed out on. This helped to make people feel ‘seen’ and included.

321. **Regional examples of good practice.** Across the UK, devolved governments and local authorities trialled different approaches at different times—for example, Wales and Scotland embedded community efforts into public health messaging.

322. **Improve identification of Clinically Vulnerable groups.** Accurate and comprehensive data is essential for identifying all Clinically Vulnerable people. This is vital to ensure they receive critical resources such as priority PCR tests or lateral flows and access to antiviral treatments.

323. **Improve communication to Clinically Vulnerable people in terms of testing and treatments**. Consider providing a dedicated helpline and website during acute epidemic or pandemic scenarios to ensure CV people can receive correct and timely advice. Ensure communication is across multiple channels including, phone, TV, radio, and print, alongside digital platforms to ensure accessibility. Special attention must be given to avoid digital exclusion, ensuring that those without internet access or technical skills are not left without essential, clear information. Alternative media and non-digital methods should always be employed to ensure everyone can access critical updates.

324. **Ensure consistency in public health messaging.** Public health messaging must be consistent and clear to maintain public trust.

325. **Regularly update testing criteria.** Symptoms should be monitored and testing criteria regularly updated to reflect the evolution of new variants. This must also include any different symptoms identified in children, to ensure timely diagnosis, isolation, and treatment.

326. **Optimise testing timelines and accuracy.** Minimising delays and errors in PCR test processing is important to ensure rapid access to antiviral treatments and timely isolation of those infected. While LFTs provide immediate results, they lack the sensitivity to detect low viral loads, potentially delaying detection in some cases. In contrast, PCR tests, when processed quickly and effectively, allow for early detection of variants, which can inform healthcare decisions regarding appropriate treatments. Both testing methods offer advantages and disadvantages depending on the

population. There is a need for a balanced approach given the different strengths of each.

327. **Address geographical and accessibility barriers.** Testing sites should be easily available to the whole UK population and equipped with appropriate protective measures to ensure that CV individuals can safely access testing.

328. **Improve contact tracing in education.** Effective and consistent contact tracing in schools and colleges is essential to prevent untracked transmission and protect households with Clinically Vulnerable members, especially when in-person attendance is required. Responsibility for tracking and managing transmission chains should be centrally coordinated to reduce the burden on school leaders, ensuring that the heightened risks in these environments are managed effectively. CVF are concerned that, despite Covid-19 remaining a notifiable disease, there is significantly more awareness of head lice outbreaks in schools than of Covid-19 infections. This highlights a critical gap in communication to families, which undermines efforts to keep them informed about potential health risks in educational settings.

329. **Provide adequate support for isolation.** Sufficient practical and financial support is necessary for those required to isolate, particularly for those living alone, to ensure they can do so safely without risking health or well-being.

330. **Develop practical guidance for isolation.** Isolation guidance should be practical and consider the realities of household sizes and caregiving responsibilities to minimise transmission risks and reduce risks and mental health challenges, especially for those who are CEV or expected to isolate for prolonged periods.

331. **Enforce isolation regulations consistently.** Isolation regulations should be enforced consistently and communicated clearly to prevent confusion and ensure compliance.

332. **Restore wastewater testing for early detection.** Wastewater testing should be reinstated as it is a vital tool for the early detection of outbreaks, providing essential data to guide public health responses and protect vulnerable populations.

Positive impacts that could inform future pandemic responses

333. In addition to the factors that directly mitigated adverse impacts outlined above, CVF identified a range of adaptations, innovations, and examples of good practice that emerged during the pandemic. These developments often arose from rapid collaboration and problem-solving. While some were improvised responses to immediate needs, they demonstrated new ways of working that could be built into future public health emergency planning.

334. **Prioritised vaccine and antiviral access for high-risk groups**. Although there were sometimes significant access issues, the rapid prioritisation of vaccines and treatments - combined with pathways via the newly established Covid Medicine Delivery Units (CMDUs) - had an overall positive impact.

335. **Airborne infection-controls in healthcare.** Temporary improvements to airborne infection control in health care settings and the use of triage systems for planned treatment. Local adaptations including those above and beyond national guidance helped to reduce risks such as waiting in cars with phone calls to invite patients in to attend their appointments, and the innovative use of outdoor spaces to reduce transmission.

336. **Improvements to air quality including air filtration**. Increased awareness and use of air filters and CO_2 monitors in indoor shared spaces, including homes empowered families to reduce their risks. Dissemination of this advice via CVF and peer networks filled critical gaps in official communication. Improvements to air quality such as the deployment of air filters or improvements to ventilation strategies were also observed within some healthcare settings, education settings, and workplaces.

337. **Rapid rollout of pulse oximetry and remote monitoring**. NHS 'COVID Oximetry @home' [LW10/106 – INQ000548756] programme allowed high-risk patients to self-monitor oxygen levels with clinical oversight. It was both reassuring and may have reduced unnecessary hospital admissions whilst enabling the rapid identification of more seriously affected patients.

338. **Shielding Letters**. Provision of shielding letters enabled the identification of high-risk individuals without the need to share private medical information.

339. **Shielding infrastructure**. This enabled outreach, welfare contact, and provision of support and services.

340. **Carer recognition**. Recognition of unpaid carers (although it was often disability focused not vulnerability focused) for vaccine prioritisation enabled better protection based on household risks.

341. **Inclusive public health messaging**. Devolved governments framed public health messaging in terms of community care and solidarity. In Scotland, campaigns explicitly invoked "*kindness*" and "*compassion*" [LW10/107 – INQ000548757] focusing on shared behaviours and the more caring "*Stay Safe, Protect Others, Save Lives*" [LW10/108 – INQ000370317] In Wales, public messaging such as "*Together we'll keep Wales safe*" [LW10/109 – INQ000066121] stressed everyone playing a part to protect others, especially those at risk. In Northern Ireland, campaigns used solidarity slogans such as "*Stay Safe, Save Lives*" [LW10/110 – INQ000370986] emphasising collective responsibility. In CVF's view, shared responsibility to protect everyone improved compliance with protection measures and reduced stigma.

342. **Reopening where there were creative low-risk options**. Outdoor, distanced, or masked activities or events enabled re-entry into society for many Clinically Vulnerable people. Where adaptations addressed and reduced airborne transmission risks, they created a more inclusive pathway back to participation in public and civic life.

343. **Protective measures indoors**. Face-covering mandates, guidance to improve ventilation, and physical distancing to reduce the population density in indoor spaces offered added protection to reduce risks.

344. **Remote and flexible healthcare**. Expansion of telephone and video consultations for routine care reduced exposure risk. Infection-controlled 'hot' and 'cold' sites or spaces for treatment and triage. Remote monitoring of certain health issues and the use of 'virtual wards' reduced the need for hospital visits and stays.

345. **Work adjustments and protections**. Employers enabling remote work, flexible hours, and adjusted duties reduced exposure risk and helped many clinically extremely vulnerable workers. Some sectors provided paid leave (often for pregnant

workers), furlough, or redeployment of some more vulnerable staff to lower-risk roles.

346. **Home delivery and adaptions to retail**. National and local schemes provided home delivery of groceries, prescriptions, and other vital supplies for CEV people and those in their households. Designated shopping hours, contact-free payment, and roadside collection, also reduced exposure risks. Priority access hours in supermarkets may have meant that people who were more focused on taking precautions shared a space, with the potential to reduce risks.

347. **Wastewater testing for Covid-19.** This built on earlier methods used for viruses such as polio, but was novel in its scale and application monitoring the spread of the virus across communities in the UK. By analysing sewage samples, public health officials could detect the presence of the virus in specific areas, often identifying outbreaks before clinical cases were reported. This method was particularly useful for monitoring asymptomatic cases and tracking the spread of variants, providing a crucial early warning system for potential hotspots.

348. The above mentioned innovations and adaptations, many of which originated outside central government planning, show that rapid, inclusive, and locally responsive measures can help to protect high-risk groups. Building these practices into formal contingency plans would strengthen preparedness for future health crises.

Recommendations that CVF would propose in the event of a future pandemic or other public health emergency.

349. CVF have identified three cross-cutting priorities:

350. **The first is Legal recognition**: Equality law currently ties the majority of enforceable ‘reasonable adjustments’ to disability - which is defined by a “*physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities*”. [LW10/111 – INQ000548761]. Many Clinically Vulnerable people (e.g. older adults without mental or physical impairments; those on medications facing increased short-term risks; people whose conditions are well-managed and whose day-to-day function is not impaired) and household members at risk from transmission are *not* disabled. As a

result, they had no clear right to risk-mitigating adjustments (remote work/learning, safer environments, air filtration, or even the use of FFP2/3 masks) and decisions were left to the discretion of individual employers, educator, or service providers.

351. Health and safety law created only general, "reasonably practicable" duties, and public-sector equality duties are systemic, not individually enforceable. Clinical risk is invisible in the Equality Act, which is why Clinically Vulnerable people were frequently denied basic protections even when facing serious health risks. In contrast, pregnancy (identified as 'clinically vulnerable', vaccine priority group 6) was protected under the Equality Act, and HSE guidance required an individual risk assessment with adjustments (including working from home) or simply paid and withdrawn where their risks cannot be controlled. This shows that time-limited, risk-specific protections can exist outside of disability to provide essential protections. We propose creating a parallel status for clinical vulnerability to infection risk.

352. **EHRC Code of Practice:** Furthermore, and in any event, the Equality and Human Rights Commission must update its Codes of Practice to include express reference to clinical vulnerability and ensure that existing protections such as relating to disability, age and pregnancy are fully applied in the context of protecting people who are Clinically Vulnerable to Covid-19 or other infections such as 'flu.

353. **The second is data visibility:** Recognise Clinically Vulnerable people in data. Create a privacy-protected flag for the NHS, UKHSA and ONS so anonymised outcomes and access for these groups can be measured and published. Also restore population infection surveillance (randomised prevalence, wastewater, GP & hospital) to provide the context those data need.

354. **The third is airborne safety:** The UK needs national safety standards for indoor air urgently across the NHS and public buildings - using both ventilation and air filtration. Currently, building ventilation standards only focus on comfort and odour control, not the risks associated with airborne infections. Airborne transmission risk is not even addressed in high-risk healthcare settings. Clean air improves short and long-term health for everyone (fewer respiratory infections, better cognition and attendance, reduced triggers for asthma and COPD) and improves accessibility for Clinically Vulnerable people. It would also build resilience for future airborne epidemics and pandemics.

355. Building on these three cross-cutting priorities, CVF has also identified a series of specific recommendations across the key domains of health, education, work, and wider society:

356. **Vaccines, treatments, and prophylaxis:** CVF recommends a comprehensive framework ensuring:

i. Reliable and equitable access to vaccination for all clinically vulnerable groups and their households.
ii. Advance procurement and rapid deployment of prophylactic treatments.
iii. A simple, responsive antiviral pathway that guarantees access as early as possible within treatment window.

357. **Workplace protections and financial security:** Clinically Vulnerable keyworkers in frontline sectors such as teaching, transport, retail, cleaning, and delivery were often compelled to attend unsafe workplaces without PPE, ventilation, or adjustments, and without equitable access to sick pay. Some reported being constructively dismissed due to unsafe conditions, the absence of personal risk assessments, and the failure to offer reasonable adjustments. Others felt forced to resign because Statutory Sick Pay was inadequate, furlough was inaccessible, and there was no legal duty to provide Covid-19 related adjustments unless workers were recognised as pregnant.

358. **Testing, surveillance, and early warning:** Testing criteria lagged behind new variants, and free testing was withdrawn from most households. The ‘Living with COVID-19’ strategy (published 21 February 2022 and updated 6 May 2022) promised to maintain *“scaled-down critical surveillance capabilities including the COVID-19 Infection Survey, genomic sequencing and additional data”* [LW10/112 – INQ000497852]. Yet in practice, these systems were dismantled.

359. The ‘Coronavirus Infection Survey’ (CIS) was ‘paused’ in March 2023 [LW10/113 – INQ000548763]. The replacement ‘COVID-19 and Respiratory Infections Survey’ (CRIS) ended on 28 June 2023 [LW10/114 – INQ000548764]. This left Clinically Vulnerable households without the population-level data needed to understand residual risk. CVF recommends restoring universal surveillance (randomised

prevalence, wastewater, GP and hospital datasets), keeping symptom criteria updated with emerging evidence, and ensuring free testing for those who need them.

360. **Mental health and wellbeing:** We recommend that future public health planning integrates mental health protections for high-risk groups, by improving safe participation in community life, access to specialist mental health services, and recognition of the role of peer and voluntary organisations in sustaining wellbeing.

361. **Bereavement and support:** Clinically Vulnerable people faced disproportionate mortality. CVF recommends that bereavement planning in future pandemics explicitly address the needs of vulnerable families, ensuring access to safe funeral practices utilising fresh air in outdoor spaces, and timely, funded bereavement services.

362. **Public communication and trust:** CVF recommends that future public health communication should acknowledge airborne spread and clearly explain practical benefits of measures such as high-grade respirator mask (FFP2/FFP3) use, ventilation, and air filtration. These should be co-designed with input from Clinically Vulnerable people and organisations to ensure trust, accuracy and inclusivity.

363. **Participation and accountability:** Clinically Vulnerable people were rarely consulted on decisions that directly determined their safety. Policy was developed in silos without integrating the perspectives of those most affected. This exclusion contributed to repeated failures across healthcare, education, workplaces and community support.

364. CVF recommends embedding structured engagement with high-risk groups in public health planning, so that pandemic response is informed by lived experience as well as clinical and epidemiological expertise.

365. **Consistent recognition as a group requiring legal protection:** CVF recommends ensuring consistent recognition of Clinically Vulnerable people as a group with distinct and specific needs. CVF considers that consistency in recognition of this group would help ensure that the risks faced by Clinically Vulnerable people are identified accurately and, consequently, that appropriate responses to and mitigations are put in place. Conversely, CVF would advise against creating specific groupings (e.g., as was the case with CEV lists) that vary over time or that are

withdrawn when perceived risks to society as a whole are reduced or in response to external factors such as NHS system pressures. Recognition of Clinically Vulnerable people should be based on the group's distinct needs and clinical risks, and such recognition should be fixed, and not be amended or withdrawn on the basis of extraneous factors.

366. By contrast, *"people whose immune system means they are at higher risk",* or as CVF identify them those who are "Severely Immunosuppressed" were only identified later and remain the only Clinically Vulnerable group with guidance to this day " [LW10/015 – INQ000652400]. Their continued recognition may stem from the comments visible within the *'Living with COVID-19'* policy document" [LW10/112 – INQ000497852] that acknowledged their unique persistent risk. However, the existence of this guidance was not widely publicised, did not guarantee any specific rights, and did not provide enforceable protections in workplaces, schools, or healthcare settings.

367. The much larger CV population - included people with chronic conditions such as diabetes, cardiovascular disease, and respiratory illness (many of which are relatively common in the population) - accounted for the majority of Covid mortality because of their numbers and their greater exposure risks. Yet they were given no specific protections beyond general advice, and were compelled to work under the same standards as the general population despite their known, and significantly increased risk.

368. CVF recommends the establishment of a unified category of "clinical vulnerability", covering all Clinically Vulnerable people (CV, former CEV, severely immunosuppressed). Like disability, which is recognised in law as a spectrum of impairments, clinical vulnerability should be recognised as a spectrum of higher risks, with all who fall within it entitled to enforceable rights to adjustments.

369. As set out above in paragraph 349 - 351 and in 364 - 367 on legal recognition, CVF proposes that clinical vulnerability should be recognised in law under equality and health and safety frameworks, ensuring explicit protection from discrimination when people act to reduce their risks. Building on this, we also recommend the following baseline rights should apply equally to all members of the category:

a. Safe participation in society, through enforceable reasonable adjustments in workplaces, education and public services (which may include remote or hybrid access, safer environments).
b. Clean indoor air standards, with national requirements for ventilation and air filtration across healthcare, education, and public buildings.
c. Access to protective equipment, including the right to use and be supported in using high-grade respirators (FFP2/FFP3) without challenge or stigma.
d. Accessible healthcare, with safe care pathways in hospitals, dental practices, and GP surgeries that control airborne risk.
e. Equitable access to vaccination and testing, including free testing for all Clinically Vulnerable people and NHS vaccine eligibility.

370. Within this category, some may require different additional measures - for example, prophylaxis, antivirals, and ongoing remote work or education due to individual risks and circumstances.

371. **Equality of access to treatments:** Disparities arose from inconsistent eligibility lists for vaccination, treatments, and support. People with overlapping conditions were often omitted despite facing equivalent or greater risk, while access frequently depended on GP coding practices or local discretion rather than consistent national standards. In particular, the needs of severely immunosuppressed people were disregarded in decisions around Evusheld, leaving those unable to mount vaccine responses without an alternative form of protection.

372. CVF recommends that eligibility criteria be transparent, evidence-based, and subject to regular review in consultation with patient groups, ensuring equitable access across all high-risk groups.

373. **Regional variation:** Significant inequalities emerged between and within UK nations, as discussed above. CVF recommends national minimum standards for infection prevention, testing and treatment access, with devolved flexibility used only to enhance - never reduce - protections. Monitoring and publishing regional disparities should be routine.

374. **Intersectional Risks:** Risks were compounded for people facing multiple inequalities - including disabled people, ethnic minority households in multigenerational housing, and those in insecure housing or frontline work. Clinically

Vulnerable workers outside the “CEV” definition were denied adjustments, and overlapping inequalities sometime amplified exposure or outcome risks. CVF recommends adopting an intersectional approach in pandemic planning, recognising how clinical vulnerability also interacts with other factors. This should be embedded within both equalities and public health duties.

375. **Healthcare:** The needs of Clinically Vulnerable people must be considered, not just those of healthcare workers, when it comes to nosocomial transmission. CVF recommends embedding airborne infection control standards across all healthcare and social care settings, including ventilation, filtration, and respirators as normalised protective equipment across the NHS estate. CVF further recommends the provision of safe care pathways for particularly vulnerable patients from the moment they enter a facility. Airborne infection prevention training for all frontline healthcare staff and carers should form part of basic training and CPD.

376. Patients must be supported, not stigmatised, when taking steps to protect themselves. They should not be challenged for choosing to wear masks; high-grade respirators should be normalised as a recognised protection. A clear public education campaign is needed to counter the damaging legacy of “face coverings” messaging and to provide accurate information on how high-grade respirator masks protect the wearer from airborne hazards, including viruses, bacteria and pollution. Such messaging is vital to restore public confidence and enable people to take control of their health, particularly in high-risk healthcare environments.

377. **Work:** Employers should be required to consider, and, where appropriate, grant requests for remote work or redeployment made by Clinically Vulnerable workers. Appropriate EHRC guidance should be provided to employers in this respect, as discussed above.

378. **Education Settings:** Education settings operate as high-contact environments linking households and wider communities. Inadequate infection-prevention measures during the pandemic increased exposure for school staff (key workers) and for Clinically Vulnerable families including parents and carers due to household transmission. Recognising air quality and masking as reasonable adjustments, together with risk-assessed options such as remote and hybrid participation and professional duties during surges in infections would reduce transmission risks, by

reducing population densities, while maintaining teaching continuity and improving workforce safety.

379. Recognition of learning impacts on young people must also extend into further and higher education so that universities track and support these students as a disadvantaged group.

380. **Public Services:** All public Services must implement clean air standards (ventilation, filtration, and CO_2 monitoring) to ensure they can be safely accessed by Clinically Vulnerable individuals. Where safety in public services cannot be ensured, providers of those services must ensure that other measures are implemented to ensure that Clinically Vulnerable individuals are not disadvantaged. For instance, if education settings are unable to implement appropriate clean air standards, they should ensure that Clinically Vulnerable students are protected, for instance by recognising masking as a legitimate adjustment and / or ensuring access to remote or hybrid education particularly during periods of high risk of infection.

381. National frameworks for public service delivery should include a formal mechanism to recognise household clinical risk so that those who take action to protect their health - or that of a Clinically Vulnerable family member - are supported. This should include clear guidance to prevent harms (such as in-person attendance-related sanctions, any withdrawals of access, or impacts on employment opportunities) and the use of constructive solutions that make services inclusive for those with health risks particularly during emergencies.

382. **Social Care:** CVF recommends introducing mandatory infection-control standards across social care, with provision of effective PPE (including fit-testing of respirators) for all staff. Clear guidance must affirm that the rights of service users to request protective measures take precedence, and that safety is a fundamental condition of accessible care.

383. **Mental Health and Bereavement:** Mental health services need to be tailored to the needs of high-risk groups, and recognition of peer and voluntary organisations as essential partners. Bereavement planning should ensure safe but compassionate access to funerals and provide funded support for affected families.

Closing summary

384. Clinically Vulnerable people have been treated as an afterthought - at times invisible in law, absent from data, disregarded in workplaces and schools, and forced to carry impossible choices between their health, livelihoods, and education. The result has been unequal risk, unnecessarily high death rates, and a legacy of exclusion that continues today.

385. CVF does not present our recommendations as optional extras. They are the minimum steps needed to restore equality, dignity, and safety to millions of people who remain at higher risk in every epidemic, pandemic or public health emergency. Legal recognition, safe environments, access to treatment, financial and educational protections, and meaningful consultation are not privileges - they are rights. Embedding them would not only protect Clinically Vulnerable households but would strengthen resilience for the whole of society.

386. Unless action is taken, Clinically Vulnerable families will remain excluded, forced into isolation, or exposed to disproportionate harm whenever the next wave of infection comes. The lessons are clear, solutions practical, and the moral case undeniable. We urge the Inquiry to ensure that our experiences translate into permanent protections, so that never again are the most vulnerable asked to carry the heaviest burden alone.

Statement of Truth

I, Lara Wong, for and on behalf of CVF, believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Personal Data

Signed Mrs Lara Wong (Oct 17, 2025 12:16:44 GMT+1) ______________________________

Lara Wong, Chief Executive Officer of Clinically Vulnerable Families

Dated 17/10/2025 ______________________________

Annex A

Case Study (i) – Living in a CEV household.

“Due to complications at birth, [my son] has had complex cerebral palsy from birth. … Even before the pandemic, my son’s health issues render him extremely vulnerable and he is at a higher risk of a poorer outcome it he was to contract an illness and become unwell. In terms of [my son’s] mental health, he was struggling with being inside all the time. When we were required to shield and in the period before that when I had kept [my son] at home because I felt I had to, it was difficult for him because he liked getting out and seeing other people and being around others. This helped lift his spirits and so it was a very difficult time for him mentally. Little support was given by the Government to help combat this. In more recent times he has enjoyed getting back to college then moving on to his day centre and around others, but it has taken years to get to the point where we feel comfortable and able to do this, though some activities we still have not. We are not going anywhere indoors unless absolutely necessary for his health because the risk to him still remains high.

In relation to my own physical health, the pandemic made it really hard because of the additional support I had to provide to [my son]. We stopped going to see my horse in case I brought Covid-19 home or in case [my son] touched anything which may have been touched by someone who had Covid-19. It was physically demanding and draining because there were periods when I was not receiving the same support from the personal support workers because I feared the risk of them bringing Covid-19 into the house, so I had to do everything myself pretty much 24 hours a day 7 days a week on my own, and that was tough.

My mental health really struggled during that period. I was angry that I was being left to struggle without support and paranoid by the misinformation that was being communicated and apparent lack of understanding of the virus and how it was transmitted, and how to keep someone like [my son] safe. There appeared to be a reluctance by some to take Covid-19 seriously, which further compounded the need for me to stay at home with [my son] to keep us both safe. When we were able to leave the house, I didn’t even want to drive with the windows down because of the images I was seeing from the devastation which was being caused particularly to those who were vulnerable. I felt that Covid-19 was able to rage without any protection for the vulnerable. It was almost as if we were so low down on the list of priorities that if the virus got us, nobody would care and we would be left to die because that was a cheaper and easier alternative to trying to save someone like [my son] and to keep the most vulnerable and at risk people safe. I remember with disgust it being reported in the news that *former Prime Minister Boris Johnson saying that he would rather see 'bodies pile high' than put the country into a third lockdown."*

Lesley Jean Moore, CVF Member

Case Study (ii) – Experience of a CEV person

"In 2017 I became unwell with Blood Cancer and have had extensive interactions with the NHS since due to this and other subsequent diagnoses. My medical conditions are multiple and complex and I am under more than ten NHS consultants most of whom are still not allowed to offer face to face appointments. I stopped working in 2017 because of my illness. I had tried a bit of working from home between June and November 2017 but after my second surgery, I realised I just had to stop working and unfortunately, I have never since been able to go back to work.

The hope I felt at the end of 2019 for a better 2020 would turn out to be false and was about to enter what has been by far the worst time of my life, a living nightmare that in many ways still continues today. I required virtual counselling. I was feeling alone, isolated, uncared for, disposable and that society had given up on me. I could at times understand why some people would want to end their own lives.

Obviously, everything changed in 2020 as Covid started to spread. I remember being completely terrified. You can imagine the impact it had on me when I saw data which suggested that people with similar levels of low antibodies and low T cells like me had around an 80% chance of dying in hospital if they had Covid. I decided before lockdown and shielding that I was not going to go out. Luckily due to a broken rib I was already spending my days and nights in bed in my bedroom.

In August 2020 I had a nasty fall at my temporary home due to my autonomic dysfunction which triggers dizziness. I had blood bursting out of my leg as though an artery had burst. I was terrified, I didn't think an ambulance would come and so somehow, I managed to get into my parents' car and get to hospital. My experience at the hospital was horrific. I told them about my condition and how I was immunocompromised but not everybody was wearing a mask, not all the medical staff and not all the patients. I was wheeled through a general area and I felt incredibly unsafe.

I continue to worry about catching Covid, and I worry that next time getting antivirals may not be possible in such a timely manner and that therefore I might need hospital or worse. I remain frustrated that there are not better attempts to improve access to society for people like me. I avoid any place that is poorly ventilated but surely public buildings if they are required to have a ramp ought to also be required to have adequate ventilation to at least reduce the risk of infections. Why should masking be despised even by health staff? My life remains significantly limited by Covid, but I do take some risks. Why should society not be doing its best to allow me to reintegrate as much as possible?

Perhaps the following quote from one of my articles best sums up how so many of us now feel: "We are the ones dying in hospital. And some of us feel that society is quite happy about that. There are huge social justice issues going on."

Dr Adrian Paul Warnock, CVF Member

Case Study (vi) – Living in a CEV Household

"I was determined to see [my son] survive through the pandemic […]. It felt, at times, like there was only me who understood [my son] and the risks to him and only me who was doing all I could to keep him safe. Then to further compound that worry, I had anxiety thinking that if he did become unwell no one would save him.

Overall I would describe my experience during the pandemic as being a negative one. The pandemic really brought home how vulnerable we are […] It really brought out in glorious technicolour that [my son] costs too much money to the state and people like him are seen as a hindrance. He is nothing more than a wheelchair and we were made to feel like we had no support to get through an incredibly difficult and challenging period in our lives.

I want to share my lived experience with this Public Inquiry so that it is understood how difficult it was for a clinically extremely vulnerable household like mine to survive with little support and little understanding by the Government on the impact of their policies and guidance on people like [my son]."

Lesley Jean Moore

Case Study (vii) – Living as a CEV person

"The emerging groups of the Clinically Vulnerable families, and a subset of that which I founded and which we called "Blood Cancer Uncensored" helped us all deal with the pandemic since we did not feel supported by the official bodies. But trying to help others navigate the bewildering and toxic official communication we were receiving was very distressing and added to psychological pressure.

On 31 May 2020 the government relaxed its shielding guidelines for the first time. We were told we could go out for a walk. With hindsight, I think that the initial advice was overly restrictive and caused massive social and psychological damage for all of us, locking us up in our homes for ten weeks, and certainly it did for me. Some of my friendships and family relationships never recovered.

Blood Cancer UK stated at the time: "The Government's handling of it has added to the worry in our community. The way it has announced this on a Saturday night with no warning or consultation with charities and clinicians has created confusion and this adds to the impression already created that the shielding group isn't high enough on its list of priorities." I quoted this in an article written on that day which again reveals the huge amount of anxiety I was feeling at the time. I wrote: "A lot of us are by now after months of social isolation rather scared about ever going out again, in fact we may even have a full case of agoraphobia."

In the above mentioned exhibit, I also talk about how confusing the official guidance about shielding had been because it had stated that all people with blood cancer: "at any stage of treatment" were included, not making it crystal clear that they intended to include people who are on "watch and wait" i.e. not actually taking treatments but being monitored. I was very angry about this and about the BBC's communication also being unclear so made a complaint which like all the other ones I made during lockdown did not get an adequate response.

The emphasis on washing hands made us very paranoid and we washed all of our shopping and vegetables. I only felt safe hiding at home. I was emotional, irritable, and unable to think clearly and calmly about anything throughout these months. These feelings destroyed some of my relationships. As society began to open up, like many others I felt increasingly left behind.

I was absolutely flabbergasted when we were given the advice to stop shielding and I simply ignored that advice because I thought it was stupid and irresponsible, I remain incredibly *frustrated because nothing has been done about air quality for public buildings such as schools and hospitals. I was aware that Parliament and government departments have ensured that they have state of the art air quality systems. We were becoming outcasts as others returned to some semblance of normality. For severely immunocompromised people like me to feel safe we have to have clean air in buildings. We know this is possible due to machines like HEPA filters and ventilation and yet the government have completely failed to do this. It is as bad as if all the ramps were removed from buildings so that wheelchair and mobility scooter users could no longer access them.*

There has been no official communication to help immunocompromised people to assess air quality but some do use carbon dioxide levels as a proxy for air quality. Personally, I still try not to go into public buildings unless absolutely necessary because I don't feel the air quality is safe. This all adds up to a sense of ongoing social disadvantage and makes ordinary living very hard. Asking people to help reduce my risk e.g. by opening a window is often met with mocking or other unhelpful comments. This leaves one feeling very vulnerable and frustrated. Gaslighting feels like the right word to describe how this process feels. Even doctors and nurses sometimes criticise us for wanting to take preventive measures.

There has been a long-lasting impact that these experiences have had on me. I have gone from someone who worked within the NHS, trusted the NHS and had received a high quality of care prior to Covid in relation to my cancer and other illnesses to being someone who now does not trust the NHS, does not trust society and does not trust the government. I genuinely believe that somebody somewhere in government and / or the NHS has made a calculation that people like me are more expensive to keep alive and it is better for them if we die.

There aren't any proper Covid tests or masks now in many hospitals and other healthcare settings and that also makes me feel that people just want me to die of Covid. It is a huge psychological burden to feel that government, the NHS and society no longer cares about people like me who are severely immunocompromised. It has had a massive impact on my relationships, and I am very cautious about what I do now and the risks that I take."

Dr Adrian Paul Warnock, CVF Member