

Tuesday, 24 February 2026

1  
2 (10.01 am)  
3 **MS BLACKWELL:** Good morning, my Lady. Can you see and hear  
4 me?  
5 **LADY HALLETT:** I can, Ms Blackwell. Thank you.  
6 **MS BLACKWELL:** Thank you.  
7 This morning's first witness is Dr Pauline Nolan.  
8 If she can be sworn, please.  
9 **DR PAULINE NOLAN (affirmed)**  
10 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 10**  
11 **MS BLACKWELL:** Thank you. Can you begin by giving us your  
12 full name, please.  
13 **A.** My name is Dr Pauline Jane Nolan.  
14 **Q.** Thank you. Dr Nolan, you should have in front of you  
15 a copy of the witness statement which is signed by  
16 yourself on behalf of Inclusion Scotland, Nuala Toman on  
17 behalf of Disability Action Northern Ireland, and Kamran  
18 Mallick on behalf of Disability Rights UK.  
19 **A.** Yes.  
20 **Q.** For our reference, it is INQ000655852.  
21 Can you confirm, please, Dr Nolan that this witness  
22 statement has been provided on behalf of all three  
23 organisations that make up the Disabled People's  
24 Organisations?  
25 **A.** Yes.

1

1 society, and the overall goal is to improve legislation,  
2 policies and practice; is that right?  
3 **A.** Yes.  
4 **Q.** Thank you.  
5 You tell us in paragraph 11 in your statement that  
6 disabled people have a wide range of impairments and/or  
7 long-term conditions, that you include autistic people,  
8 people with learning disabilities, those with sensory,  
9 cognitive, mobility and energy-limiting impairments, and  
10 also people with mental distress.  
11 **A.** Yes.  
12 **Q.** Some of you face multiple discrimination, you tell us,  
13 on the basis of disability, race, age, being LGBTQ+,  
14 and/or other personal characteristics; is that right?  
15 **A.** That's right.  
16 **Q.** We heard from Professors Marmot and Bamba in the  
17 Inquiry last week that all of the social determinants of  
18 health apply more to disabled people, and does that  
19 accord with your understanding?  
20 **A.** Disabled people face various health inequalities,  
21 absolutely.  
22 **Q.** Thank you. Turning, then, to mortality rates, please.  
23 The Inquiry heard last week from professors --  
24 **A.** Should I have reports coming up on the screen? Because  
25 I don't.

3

1 **Q.** And that the facts stated within it are true to the best  
2 of your knowledge and belief?  
3 **A.** Yes.  
4 **Q.** Thank you very much.  
5 I'd like to begin by giving a brief overview of each  
6 of the organisations. You, together, have substantial  
7 reach across the United Kingdom, do you not?  
8 **A.** We do.  
9 **Q.** Yes. For example, Disability Rights UK has  
10 a substantial following on social media with over 72,000  
11 X followers, and it had over one million visitors to its  
12 website during the pandemic. You tell us that Inclusion  
13 Scotland represents disabled people across Scotland with  
14 a wide network of partner organisations, and that  
15 Disabled Action Northern Ireland is the largest Northern  
16 Ireland-wide disabled persons-led organisation and  
17 membership organisation; is that right?  
18 **A.** That's correct.  
19 **Q.** And together, you provide a variety of different support  
20 services to people across the UK, including advocacy,  
21 employment support services, digital connectivity,  
22 transport, community integration, information and  
23 advice, mental health and wellbeing services, and you  
24 also raise awareness, you campaign with government  
25 departments on key issues impacting disabled people in

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1 **Q.** No, I was hoping, Dr Nolan, that you had agreed with me  
2 that you've got a copy of your report before you.  
3 **A.** I do, yes.  
4 **Q.** I'm about to put up a table, in fact, from Professors  
5 Shakespeare and Watson's report which shows the -- thank  
6 you very much --  
7 **A.** Thank you.  
8 **Q.** -- which shows us the age standardised mortality rates  
9 for deaths involving Covid-19. This table shows the  
10 rates in relation to men.  
11 **A.** Mm-hm.  
12 **Q.** And Professors Watson and Shakespeare pointed out to us  
13 last week that the difference between more disabled men,  
14 at the top, and non-disabled men, at the bottom, in  
15 terms of mortality rates within wave 2 of the pandemic  
16 was threefold, so in other words, more disabled men were  
17 three times more likely to die in wave 2 of the pandemic  
18 than non-disabled men.  
19 And for the sake of completeness, please can we  
20 display table 2, which show similar figures, but this  
21 time for mortality in women. And we can see that those  
22 rates are very similar.  
23 **A.** Yeah, I think we broadly, you know, add that we quote  
24 slightly different statistics, but during the pandemic  
25 we've quoted that disabled people accounted for

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1 approximately six out of ten deaths, and that comes from  
2 the Office for National Statistics. It was seven in ten  
3 in Wales, and it increased for different groups of  
4 disabled people, including different equality  
5 backgrounds and including different impairments as well.

6 **Q.** Thank you.

7 You also go on to tell us that for some disabled  
8 people -- thank you, we can take that down now -- for  
9 some disabled people, the mortality rates were even  
10 higher than those that you've just provided us with.  
11 For example, there was a Public Health England report  
12 that estimated that people with learning disabilities  
13 were six times more likely to die compared to the  
14 general population; is that right?

15 **A.** That's right. And that the deaths rate for 18-34-old  
16 people with learning disabilities was 30 times higher.

17 **Q.** Thirty times, three zero?

18 **A.** Which is a shocking rate. And that was in the same age  
19 group -- compared with the same age group without any  
20 disability.

21 **Q.** Thank you.

22 Would you agree that a significant reason for the  
23 mortality statistics you've outlined is the fact that  
24 many disabled people also had underlying health  
25 conditions which increased their risk of severe outcomes

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1 disease itself, second, reduced access to routine  
2 healthcare and rehabilitation, and, thirdly, the  
3 deleterious social impacts of efforts to mitigate the  
4 pandemic. And so -- and one has to take into account  
5 that they have told the Inquiry those three different  
6 types of effect.

7 **A.** Yes.

8 **Q.** Do you agree with that?

9 **A.** Absolutely. Inclusion Scotland, right at the start,  
10 when we were reporting on our survey, we described that  
11 as rights at risk, but it's the same thing; it's across  
12 the board, both the disease itself, the actions taken,  
13 and the loss of access to healthcare, which was really  
14 del --

15 **Q.** Deleterious?

16 **A.** Yes.

17 **Q.** Thank you.

18 Moving on to mental health and wellbeing, please.  
19 You tell us at paragraph 15 in your report that in  
20 April 2020 Disability Rights UK highlighted a study by  
21 the Office for National Statistics which found that  
22 nearly two-thirds of disabled adults stated that  
23 Covid-19-related concerns were affecting their  
24 wellbeing. And in a study published a year later, in  
25 April of 2021, again by the Office for National

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1 from Covid-19? That is, that they were clinically  
2 vulnerable to the virus?

3 **A.** Yes. So I do agree with that, many disabled people did  
4 have underlying health conditions making them clinically  
5 vulnerable, but also many disabled people didn't  
6 necessarily have underlying health inequalities or  
7 health -- sorry, conditions making them clinically  
8 vulnerable. And that would include this group of people  
9 with learning disabilities whose, sort of, health  
10 inequalities in the first place were worse than for the  
11 general population, for a range of reasons, and who were  
12 more likely to be living in group housing, have social  
13 care support, and not have information in accessible  
14 formats.

15 And so there are other reasons why people were more  
16 likely to die of the pandemic, apart from clinical  
17 vulnerability. But of course, as Professors Shakespeare  
18 and Watson have laid out, that does play its part.

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

20 They also have described, haven't they,  
21 Professors Shakespeare and Watson, what's termed  
22 a triple jeopardy --

23 **A.** Yes.

24 **Q.** -- due to the pandemic? So that disabled people were at  
25 greater risk, first, of negative outcomes for the

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1 Statistics, it showed that the disproportionate impact  
2 of the pandemic on disabled people's mental health and  
3 wellbeing had persisted?

4 **A.** Yeah, the data in our report shows that a range of --  
5 that, you know, the statistics show how disabled people  
6 felt like a burden, we felt stressed and anxious, our  
7 mental health deteriorated. We were lonely and  
8 isolated, and we had no one, necessarily, to talk to  
9 about it, any of it.

10 It was one of the starkest findings of our own  
11 survey, Inclusion Scotland survey, undertaken in  
12 April 2020. We know that suicide rates were already  
13 higher for disabled people than the general population,  
14 and they went up as disabled people faced increased  
15 levels of stress, anxiety and loneliness.

16 And we, actually, in fact, had 15 respondents -- we  
17 hadn't explicitly asked about mental health in our  
18 survey, but 15 told us that they were feeling suicidal  
19 at the time of their response.

20 **Q.** Thank you. The position, it would seem, was very  
21 similar for clinically vulnerable people, and I'd like  
22 to just display, please, part of the witness statement  
23 of Ms Lara Wong, who is coming to give evidence later  
24 this morning.

25 Thank you very much. This, for the record, is at

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1 page 60 of her witness statement, where she talks of the  
2 psychological and emotional impact of Covid.

3 "Isolation was widely understood by members as  
4 necessary for survival [this is in relation to  
5 clinically vulnerable people] but also deeply traumatic  
6 and psychologically costly. From CVF's recent survey,  
7 95.2% of respondents described negative mental or  
8 emotional impacts linked to shielding or cautious  
9 living -- including stress, depression, anxiety,  
10 loneliness, suicidal thoughts, burnout and other trauma.  
11 These effects were often felt not only by the person  
12 shielding but by other household members, including  
13 children, partners and carers. Shielding, especially  
14 when unsupported, resulted in significant psychological  
15 fallout."

16 And there were two examples given, firstly of Emily,  
17 54, who said:

18 "Myself, my husband and my two adult sons all  
19 shielded to protect my CVF husband, as a result of this  
20 we lost friends. I lost my job, affecting my confidence  
21 and self-worth, my eldest son's mental health has been  
22 severely affected and he is now on medication and  
23 awaiting counselling."

24 And Vivian, age 62:

25 "In short it has ruined our lives. One person had

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1 individuals and families.

2 **Q.** Thank you.

3 We can take that down, please.

4 To your knowledge, during the pandemic, were there  
5 mechanisms in place to identify early signs of  
6 escalating mental distress or suicide risk among  
7 disabled people?

8 **A.** No, not to my knowledge.

9 **Q.** What, in your opinion, could or should have existed?

10 **A.** So had authorities had data and information about  
11 disabled people and their circumstances, they might have  
12 been able to offer advice via GPs and health settings  
13 and mental health support services. They might have  
14 been able to offer online or -- you know, face-to-face  
15 support was all but gone, but telephone or online  
16 support could have been offered.

17 **Q.** Yes.

18 **A.** Of course, that wasn't accessible for everyone, but just  
19 checking in and, you know, public campaigns, as well,  
20 would have been helpful. This idea of never seeing  
21 people once they brought in the, you know, measures  
22 where people could see people, it was still dangerous  
23 for a lot of people to do that, so that had a worsened  
24 effect. And of course we know that it's still dangerous  
25 for people now who aren't getting their needs met in

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1 to give up working as a GP. Both suffered socially and  
2 emotionally and continue to do so. Winters are  
3 unbearable, we are locked away. We can't go to any  
4 dining or entertainment venues, nor to friends' and  
5 families' houses. We spend Christmas alone. It's not  
6 living, it's existing."

7 Finally on this topic, the mental health toll was  
8 closely linked with deteriorations in physical wellbeing  
9 due to a lack of safe access to healthcare, including  
10 cancelled appointments and fear of infection in unmasked  
11 clinical settings, reduced mobility and exercise,  
12 especially for those who did not feel safe any more, and  
13 the exacerbation of existing chronic conditions due to  
14 prolonged isolation or stress.

15 So, serious toll on mental health, and also  
16 deteriorations in physical wellbeing. Are those two  
17 effects very redolent of what your members were telling  
18 you?

19 **A.** Yeah, absolutely. People were left alone, given limited  
20 guidance, people were never sure. A lot of disabled  
21 people who were potentially also clinically vulnerable  
22 or at risk were not necessarily put on the shielding  
23 list but were shielding or self-isolating without  
24 support, without information, and it really had a really  
25 disastrous effect on mental health for many people,

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1 public places and health settings as well.

2 **Q.** Thank you.

3 Turning to look at some of the factors that  
4 increased detrimental mental health impacts for disabled  
5 people, you have identified, within your report, six  
6 areas. Firstly, the financial stressors --

7 **A.** Mm-hm.

8 **Q.** -- and poverty. You tell us at paragraph 18 that the  
9 intersection between disability and poverty is well  
10 documented --

11 **A.** Yes.

12 **Q.** -- and that, across the past two decades, poverty rates  
13 have been, on average, 11% higher for families with  
14 a disabled member compared to non-disabled families?

15 **A.** Yeah, we estimate that 50% of households -- so,  
16 actually, it wasn't an estimate, this is fact. Before  
17 the pandemic, 50% of households with a disabled person  
18 in them were under the poverty line, living in poverty.

19 **Q.** You tell us at paragraph 19 that:

20 "It is well known that the experience of debt is  
21 strongly associated with poorer mental health  
22 outcomes ..."

23 What did that mean for people on a personal level?

24 **A.** On a personal level, it made people really distressed  
25 and worried for the future, unable to afford food,

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1 unable to, you know -- so there was an example of one  
 2 person -- I'll find the quote -- who was absolutely  
 3 terrified, couldn't afford to put on the heating or --  
 4 **Q.** I think that's at paragraph 19.  
 5 **A.** Yeah, thanks.  
 6 **Q.** "Heating is off, night time" --  
 7 **A.** "Heating is off" --  
 8 **Q.** Sorry, go on.  
 9 **A.** Yeah, I'll find it. Bear with me.  
 10 **Q.** Shall I read it to you, Dr Nolan?  
 11 **A.** Sure, yeah -- (overspeaking) --  
 12 **Q.** "Heating is off, night time I use candles, I can  
 13 honestly say I have never been so unhappy."  
 14 **A.** "So unhappy", yeah.  
 15 **Q.** And:  
 16 "None of this is helping my mental health and  
 17 severe PTSD."  
 18 **A.** PTSD, that's right, yeah.  
 19 **Q.** And in terms of the second identifiable factor  
 20 increasing mental health deterioration, you tell us that  
 21 one wholly avoidable cause amongst disabled people  
 22 during the pandemic was access to key public health  
 23 guidance and advice?  
 24 **A.** Yeah.  
 25 **Q.** So is it your experience, and that of your members, that

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1 **A.** -- that disabled people were put at level 5 and  
 2 level 7 -- between level 5 and level 7, were told they  
 3 wouldn't get treatment and then they pulled back from  
 4 that but --  
 5 **Q.** There was a change -- (overspeaking) --  
 6 **A.** -- it was too late, yeah, that change in guidance, it  
 7 was too late for many disabled people who heard that,  
 8 felt like a burden, felt like they were scared of going  
 9 to the doctor's, going to hospital and not being  
 10 ventilated. It was a real fear.  
 11 **Q.** So even though the position improved with the Clinical  
 12 Frailty Score your evidence --  
 13 **A.** The message had got out there.  
 14 **Q.** All right.  
 15 The third point you raise is digital exclusion.  
 16 **A.** Mm.  
 17 **Q.** And you say at paragraph 25 that linked to the anxiety  
 18 caused by the lack of information was whether or not it  
 19 was in an accessible format. For many disabled people  
 20 going online meant that they were removed from having an  
 21 ability to access that material.  
 22 **A.** Mm-hm. Yeah. So we already knew, in 2019 the data  
 23 showed that disabled people were more likely to be  
 24 offline than non-disabled people, with 21% saying they  
 25 had no access to assistive technology that they would

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1 not only was the advice late in coming, but it was also  
 2 unclear when it did come?  
 3 **A.** Yeah, it was. Various types of advice, including  
 4 shielding, as I've already mentioned, but also clinical  
 5 protection, you know. And even the daily announcements  
 6 from the Prime Minister, there was no BSL interpreter,  
 7 so deaf BSL users were excluded. Scotland did introduce  
 8 one for the First Minister after pressure from  
 9 ourselves, Inclusion Scotland, but then letters were  
 10 sent to disabled people in inappropriate formats and  
 11 guidance was actually inconsistent and there was no  
 12 co-design, despite the fact that we Inclusion Scotland  
 13 and the Scottish Government were facilitating co-design  
 14 on social care support, that just dropped off during  
 15 April, March and April 2020, when the government went  
 16 into crisis mode and failed to co-design and it all  
 17 increased people's anxiety.  
 18 **Q.** Well, that's what I want to concentrated on. What was  
 19 the impact of all of that? You say an increase in  
 20 anxiety.  
 21 **A.** Increase in anxiety, not knowing what's going to happen,  
 22 fear of the pandemic, fear -- fear, if you are -- you  
 23 know, there was that Clinical Frailty Scale that came  
 24 out --  
 25 **Q.** Yes.

14

1 have required, and in 2020, 42% had low or very low  
 2 digital engagement due to, for example, low digital  
 3 literacy, lack of Internet coverage, including in remote  
 4 and rural areas, insufficient funds to cover access  
 5 requirements, and at the same time, many services went  
 6 digital by default, and disabled people weren't being  
 7 considered, the barriers weren't being considered, even  
 8 though these issues were well known, and that's what was  
 9 really frustrating about it.  
 10 Initiatives were set up to provide devices but they  
 11 failed to account for digital barriers. And in late  
 12 2020 -- oh, yeah -- no, I'll leave it there.  
 13 **Q.** Right. I was just going to say that you go on at  
 14 paragraph 27 to tell us that there were some efforts  
 15 made, which I think you've just accepted.  
 16 **A.** Yeah.  
 17 **Q.** But it wasn't enough. The digital divide was not  
 18 bridged, is how it was described?  
 19 **A.** Yes, and there was funding available for third sector  
 20 equality groups to do projects to connect people but we  
 21 were unable to access because we weren't providing  
 22 specific services -- Inclusion Scotland weren't. But  
 23 later in 2020 we did actually receive funding, all the  
 24 DPOs across the UK received funding from the National  
 25 Emergencies Trust -- the DPOs that are part of this

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1 Inquiry, I mean.

2 **Q.** Yes.

3 **A.** -- the National Emergencies Trust, and it meant that we  
4 were able to put funding out to DPOs across the UK, and  
5 in Scotland we provided nine DPOs with funding and some  
6 of those used it to connect disabled people isolating  
7 who faced the greatest barriers.

8 **Q.** Thank you.

9 **A.** So we made sure it was about independent living and  
10 removing barriers.

11 **Q.** Thank you.

12 Other issues that you raise are reduction in social  
13 care support, barriers in access to mental health care  
14 and support, and, finally, you mention an --  
15 intersectional trends in mental health.

16 As we heard yesterday from Professor Bécares, LGBTQ+  
17 communities are at a higher risk of suicidal thoughts,  
18 suicide attempts and self-harm, compared to people who  
19 don't identify as such.

20 And we know that disabled people, in terms of  
21 suicide rates, as you set out at paragraph 42, are --  
22 include those have faced discrimination for their  
23 sexuality and gender.

24 **A.** That's right, yeah. There were disabled -- there was an  
25 LGBT Foundation survey that surveyed LGBTQ+ disabled

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1 over twice as likely to report that access to healthcare  
2 had been affected, and more likely to report that  
3 medical treatment had been disrupted during the pandemic  
4 than non-disabled people.

5 **Q.** Thank you.

6 Reduction in social care support, including for  
7 those in residential settings. At paragraph 54 you say:

8 "For recipients of social care support, and  
9 particularly those in residential settings, [you] heard  
10 accounts of Disabled people experiencing reduced access  
11 to healthcare services, such as ... cancelled visits by  
12 GPs ... Community Nurses, mental health services and  
13 podiatrists. [You were] also aware of reports of  
14 instances where care home residents were not transferred  
15 to acute settings and people nearing the end of their  
16 lives didn't receive adequate palliative care ..."

17 **A.** That's right.

18 **Q.** And again, was that reflected across the UK?

19 **A.** It was, yeah.

20 **Q.** Thank you.

21 For many disabled people across the UK, the greatest  
22 impact of the Covid pandemic was on how they accessed  
23 vital support through social care support.

24 **A.** Yes.

25 **Q.** So, firstly, I'd like to ask you about the impact of the

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1 people, LGBTQ+ people in general, and found that  
2 disabled individuals were more likely to want access to  
3 mental health support and were less likely to feel safe  
4 where they were staying, compared to other non-disabled  
5 respondents.

6 **Q.** Thank you.

7 I'd like to turn now to ask you about access to key  
8 services and support and, in particular, the reduction  
9 in access to healthcare services.

10 You tell us that -- at paragraph 52:

11 "In Scotland, a Glasgow Disability Alliance survey  
12 reported that the pandemic had seen crucial healthcare  
13 treatment cancelled with NHS Scotland reportedly  
14 cancelling 73% of planned treatment in the month of  
15 April 2020."

16 And this meant that:

17 "Disabled people lost access to essential healthcare  
18 and treatments, including physiotherapy, pain clinics,  
19 [neuro] appointments, and other vital services."

20 And was that position reflected across the UK?

21 **A.** It absolutely was. Glasgow Disability Alliance are one  
22 of the biggest members of Inclusion Scotland, and so  
23 they did their own research survey of their thousands of  
24 members. But reduction in access to healthcare  
25 disproportionately impacted disabled people. They were

18

1 pandemic on the reduction in social care support  
2 services. And we'll look at five examples that you give  
3 in your report.

4 **A.** Yeah. A large -- you know, multiple reports showed that  
5 a large number of supported people lost some or all of  
6 their social care support. Our own April 2020 survey  
7 showed that 30% of respondents said their usual support  
8 was either stopped completely or reduced, sometimes  
9 overnight or without any warning.

10 **Q.** Yes.

11 **A.** And this deeply impacted our rights to independent  
12 living, losing -- so, for example, RNIB Cymru survey  
13 showed 60% -- 66% of blind or partially sighted  
14 respondents felt less independent than they did before  
15 lockdown. And it was also postcode lottery, due to  
16 responsibility lying with local authorities or, as in  
17 Scotland, integrated health and social care authorities.  
18 So it depended where you lived.

19 But, for many, it was just overnight stopped, and  
20 people were really anxious about not getting social care  
21 support recovered after the pandemic because they were  
22 seen to manage.

23 **Q.** Thank you. Is it right that in some cases, care workers  
24 who had previously worked with adult disabled people  
25 were reassigned to care for older people, leaving

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1 disabled adults without any care and support?  
 2 **A.** We weren't told what happened to social care support  
 3 workers, but many were, yeah, I think so.  
 4 **Q.** Thank you. Domiciliary care and recipients of that. We  
 5 have heard from Professors Shakespeare and Watson that  
 6 there was a lack of understanding regarding domiciliary  
 7 care and that this was a problem across the UK, for  
 8 example not appreciating that many disabled people  
 9 relied on domiciliary care, and a member of Disability  
 10 Wales, I think, you told us at paragraph 75, who usually  
 11 received three care and support visits of 45 minutes  
 12 each per week, which enabled her to bathe and to do  
 13 other things which she couldn't manage herself was cut  
 14 off without any consultation or warning.  
 15 **A.** Yeah, and as we said, causing her considerable distress  
 16 and loss of personal dignity. And this was not isolated  
 17 at all. It was across the board. It included people  
 18 with personal assistants, and we've heard from my former  
 19 colleague Dr Jim Elder-Woodward who was saying that  
 20 because his PA has had to self-isolate but there was no  
 21 alternative source of social care support. So he was  
 22 just left high and dry, literally, like sitting upstairs  
 23 without any support, without any washing or -- and he  
 24 had a mental health crisis due to that.

25 But yeah, by May 2021, it also caused increased

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1 **A.** And no warning.  
 2 **Q.** Can I ask you about impact for people with learning  
 3 disabilities, please.  
 4 You deal with that at paragraph 91 of your statement  
 5 and you refer to the report entitled "Living through the  
 6 pandemic: the impact of Covid-19 on people with learning  
 7 disabilities in Wales", which was based on a survey of  
 8 two groups: people with learning disabilities who were  
 9 group one, and family carers and paid staff, who  
 10 answered questions for those who were unable to answer  
 11 for themselves, and that was group two.

12 What did that survey tell you?

13 **A.** It told us that -- is this the one that said -- yes, 26%  
 14 said they didn't receive any support while 32% said they  
 15 were getting less, and that carers of people with  
 16 profound learning disabilities, 9% said that the person  
 17 that they cared for was getting no formal support, 48%  
 18 said they'd got the support reduced.

19 And other services were closed so, for example,  
 20 daycare centres and respite centres, which disrupted  
 21 long-term, longstanding routines and social connections  
 22 for those disabled people.

23 **Q.** Thank you.

24 **A.** So isolation was a key concern there, as well,  
 25 deteriorating mental wellbeing, which had its impact on

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1 deaths. So possibly more, I think, in proportional  
 2 terms, than those who died in care homes. About 28,000  
 3 that we know of, recipients of domiciliary care, had  
 4 died across England and Scotland by May 2021.

5 And again, it was the postcode lottery pandemic,  
 6 where areas like Slough and Haringey saw 677.8% and  
 7 431.3% increases respectively, and it's upsetting  
 8 because these risks were known in -- and unpredictable.

9 **Q.** Dr Nolan increases in what?

10 **A.** In deaths.

11 **Q.** In deaths?

12 **A.** In mortality, people in social care support. Some had  
 13 to rely on family and friends, move in with family in  
 14 houses that weren't accessible -- I'm just painting  
 15 a picture here.

16 **Q.** Yes, of course.

17 **A.** -- so that they continued to get care. Some were unable  
 18 to get up, having to sleep in wheelchairs without any  
 19 personal care support at all. Some had support cut  
 20 down, but that example of someone losing time to  
 21 properly wash.

22 **Q.** Yes.

23 **A.** But there was no contingency at all, no planning with  
 24 disabled people who received support. It was just --

25 **Q.** And no warning.

22

1 carers as well as the cared-for person.

2 **Q.** And members of families who lived with disabled people?

3 **A.** Yeah, yeah.

4 **Q.** And although that was a Welsh survey --

5 **A.** That was across the board, yeah.

6 **Q.** -- again, that was reflected across the UK.

7 **A.** And guidance was inappropriate. It was ARC Northern  
 8 Ireland that was saying that there was no guidance, and  
 9 if there was, it was inappropriate, conflicting, and  
 10 inaccessible.

11 **Q.** Thank you.

12 The next topic is impact of rules and guidance, and  
 13 we have touched upon this already, Dr Nolan. You've  
 14 told us that there was a lack of translation and  
 15 messages that were being issued by the government both  
 16 verbally and in written form, were not often translated  
 17 into many languages, and the British Sign Language  
 18 organisation had to step in and help in that regard.

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

20 **Q.** You've also told us about digital exclusion and you've  
 21 explained to us the impact of that upon those who were  
 22 unable to access services digitally.

23 **A.** Mm-hm.

24 **Q.** I want to ask you about the phrase "vulnerable" and  
 25 "clinically vulnerable" and ask you whether you agree

24

1 that "clinically vulnerable" as a phrase functioned as  
2 a descriptive public health term to identify people at  
3 increased risk of severe outcomes from Covid-19 due to  
4 their own health conditions, age, or the fact that they  
5 might be undergoing certain medical treatments?

6 **A.** Yes, it did and it didn't. So it did for groups that  
7 had certain conditions, as Watson and Shakespeare have  
8 laid out, but it didn't, for example, for those groups  
9 of people that I've talked about who had underlying  
10 health inequalities, and people that saw themselves as  
11 clinically vulnerable but didn't get the shielding  
12 letter, didn't, you know, were self-isolating without  
13 any of the advice or support that came with that.

14 So it's a bit more nuanced, I think, than it was  
15 used -- I think it was used inconsistently and it wasn't  
16 always applied to the right groups --

17 **Q.** Yes.

18 **A.** -- necessarily.

19 **Q.** Thank you.

20 Moving to deal with the impact on specific groups of  
21 disabled people, you tell us at paragraph 130 that:

22 "The proportion of Disabled people who had to endure  
23 shielding and lockdown restrictions in unsuitable  
24 housing was an unacceptable hardship caused by a failure  
25 to address pre-pandemic issues."

25

1 DRUK have given an example of Banane Nafeh, who had  
2 damage to her adapted bathroom before the pandemic, and  
3 then the lift to her toilet broke early on in the  
4 pandemic and, due to the delays, it took two years for  
5 the flooring to replace and she was feeling really  
6 unsafe.

7 And then another example, a young woman who was  
8 a member of Inclusion Scotland reported -- and GDA,  
9 I think, Glasgow Disability Alliance -- reported having  
10 to move to her parents' house due to living alone, but  
11 her PAs could no longer access the house because the  
12 house was inaccessible. She was living in their living  
13 room, she had no access to the bathroom. So she had no  
14 personal care support. And, yeah, we've got 44% at risk  
15 of homelessness.

16 **Q.** Homelessness. So you're describing issues that were  
17 present before the pandemic that were exacerbated by  
18 changes during the pandemic to care --

19 **A.** Yeah.

20 **Q.** -- and to support?

21 **A.** Yeah.

22 **Q.** And you were just going on, I think, to talk about  
23 homelessness and the fact that, going into the pandemic,  
24 44.1% of people identified -- who identified as homeless  
25 were disabled.

27

1 The impact, you tell us, of that, was that during  
2 periods of shielding and lockdown, disabled people were  
3 forced to spend extended periods of time in unsuitable  
4 conditions, leading many to report feeling trapped in  
5 parts of their own homes.

6 And you refer to a YouGov poll that was commissioned  
7 by the Habinteg Housing Association in 2020 which found  
8 that:

9 "... of Disabled people who described their  
10 activities as limited a lot, 21% said that the  
11 inaccessibility of their home undermined their wellbeing  
12 during lockdown, 35% said they were not able to carry  
13 out all daily tasks in their home with full independence  
14 and almost a quarter of all Disabled respondents said  
15 they did not have a home which [met] their access  
16 needs ..."

17 **A.** Yeah.

18 **Q.** So disabled people, you tell us, were also at heightened  
19 risk of homelessness?

20 **A.** Yeah. And the lack of accessible housing was an issue,  
21 again, that we'd already been campaigning on, but there  
22 was delays at the time to things like occupational  
23 therapy assessments for aids and adaptations, and that  
24 we've noted a 47-year wait for wheelchair accessible  
25 homes.

26

1 Crisis described, in autumn 2020, how there had been  
2 a continued new flow of people experiencing homelessness  
3 since the start of pandemic. And although they  
4 commended the Everyone In programme for providing  
5 support and reduced infection rates, they noted that  
6 those structural barriers that existed prior to the  
7 pandemic, including a limited housing supply and  
8 a welfare system that didn't address the underlying  
9 causes of homelessness, only increased during the  
10 pandemic.

11 **A.** Yeah.

12 **Q.** So more people were becoming homeless?

13 **A.** Yeah.

14 **Q.** Yeah.

15 Turning, please, to deal with those disabled people  
16 who experience domestic abuse. Now, the Inquiry has  
17 heard evidence about this recently, in fact as recently  
18 as yesterday, and you cover this topic at paragraph 139  
19 in your statement where you say that disabled women are  
20 three times more likely to be victims of domestic abuse  
21 compared to their non-disabled peers, and that the  
22 Disabled People's Organisations were, therefore,  
23 particularly concerned to hear reports that the rates of  
24 domestic abuse increased during the pandemic.

25 You go on at paragraph 140 to say that:

28

1 "The lack of care workers coming into people's homes  
2 forced Disabled women to be more dependent on partners  
3 and family members while also being more isolated, with  
4 reduced outside scrutiny, [which resulted] in instances  
5 of psychological and physical abuse."

6 And you go on to describe as particularly alarming  
7 the increased domestic abuse rates during the pandemic,  
8 and that, often, abusive partners were not leaving the  
9 home, due to lockdown policies --

10 A. Mm.

11 Q. -- and therefore the opportunities for survivors to  
12 report abuse was limited?

13 A. Yeah, and, for example, for specific groups of disabled  
14 people, people with learning disabilities who might have  
15 relied on a carer who was abusive, and who had no access  
16 to advocacy either to be able -- or people who had no  
17 access to comms support to report abuse. Yeah, it was  
18 a real concern and different groups of disabled people,  
19 particularly women, also LGBTQ disabled people, BAME  
20 disabled people, all (unclear) affected, you know, and  
21 it doesn't matter who you are, where you're from, you  
22 can be affected by domestic abuse, but because of  
23 disability and the barriers disabled people face, it's  
24 exacerbated, the risk is exacerbated and the impacts can  
25 be as well.

29

1 participate in matters that they needed to. Is that  
2 right?

3 A. Yeah. Infection rates also went right up in prisons,  
4 also -- and places of detention, where disabled people  
5 were more likely to be. I think we've got now new data  
6 suggesting around half of prison inmates are disabled  
7 people, that's in Scotland at least, with a really  
8 recent report, and people were stuck in isolation for  
9 long periods and didn't have their adjustments met or  
10 mental health support given.

11 DRUK, our colleagues at DRUK, actually produced  
12 updated guidance on regulatory changes needed within the  
13 justice system throughout the pandemic.

14 Q. Yes.

15 A. So we were working hard to address it.

16 Q. So there are two issues there, I think, aren't there:  
17 there's those who were present in places of detention  
18 and prisons --

19 A. Mm.

20 Q. -- and the difficulties that disabled people in those  
21 positions experienced during the pandemic, and there are  
22 issues relating to access to the justice system?

23 A. Yeah.

24 Q. But both of which, I think, suffer, in your opinion,  
25 from a lack of suitable data. Is the collection of data

31

1 Q. Thank you.

2 Finally on this topic, those in mental health wards,  
3 prisons, and places of detention. At paragraph 143 you  
4 tell us that in June 2020, the Equality and Human Rights  
5 Commission stated that the criminal justice system was  
6 failing disabled citizens and needed reform to ensure  
7 fairness for all, and that that followed the publication  
8 of the EHRC's report "Inclusive Justice: a system  
9 designed for all" in April 2020.

10 They had noted that there was an over-representation  
11 of people with learning disabilities and mental health  
12 issues within the system that the government had failed  
13 to document. And it went on to describe how accused  
14 individuals who were not routinely provided with the  
15 adjustments they needed to participate in the justice  
16 process further suffered when the process became  
17 digitalised, because of the reasons that you've already  
18 set out.

19 To help address these issues, you tell us that the  
20 EHRC called on governments to adopt their  
21 recommendations, which included addressing gaps in the  
22 collection and monitoring of disability data and support  
23 for the duty to make reasonable adjustments. And in  
24 light of those criticisms, the criminal justice system  
25 didn't allow disabled people, in your opinion, to fully

30

1 for disabled people something that in your opinion  
2 should be improved?

3 A. It's one of our recommendations, the collection of  
4 disaggregated data. And of course, we've made an  
5 emphasis on disabled people having intersectional  
6 barriers, because of being from different equality  
7 backgrounds, potentially, and so that data needs to be  
8 collected as well, and no matter how small the data  
9 might be, it would address, you know, meeting different  
10 disabled people's needs, which currently aren't met.

11 There was also issues in mental health wards, as  
12 well. I'm sure you're going on to that, though, but in  
13 detention there was infection prevention and control  
14 measures meant that people were just isolated and so  
15 their mental health would have been much worse.

16 Q. Thank you. Is there anything you would like to tell us  
17 about those in detention during the pandemic, disabled  
18 people?

19 A. There was a UCL study that found that 38% of older  
20 adults in psychiatric wards in London were infected at  
21 the height of the pandemic.

22 Q. Thank you. Going back, if I may, to an improvement  
23 that's needed in data collection, what has been the  
24 impact of insufficient data being available on disabled  
25 people and their plight during the pandemic?

32

1 **A.** It's decisions being made that don't take account of  
2 needs, don't take account of access requirements,  
3 including access to information and guidance. Didn't  
4 take into account, for example, the people employing PAs  
5 and disabled people in social care, domiciliary care,  
6 who weren't getting the protections that people in  
7 hospitals and care homes were getting, the masks and  
8 coverings and so on. You know, across a range of  
9 different protections, these weren't applied accessibly  
10 to disabled people because the data wasn't there.

11 **Q.** Yes.

12 **A.** Yeah.

13 **Q.** That's why it's so important that it's collected and  
14 considered?

15 **A.** Absolutely, yeah.

16 **Q.** At paragraph 153 you talk about the need for  
17 consultation and you say this:

18 "In order to understand the needs of disabled people  
19 from their perspective, a surface-level approximation is  
20 not good enough. Improved systems of consultation and  
21 participation are not just about providing feedback on  
22 services and flagging issues, but also in sharing  
23 success stories of what has worked well and delivered  
24 public value. As health care increasingly moves to  
25 digital services and becomes more reliant on automated

33

1 that they had in order to aim it at the provision that  
2 was most in need. So is funding, going forwards, an  
3 important issue as well?

4 **A.** It's always an important issue for DPO. We do have good  
5 recognition in Scotland of the role of DPOs, not  
6 necessarily in other parts of the country, but we did.  
7 At the start of the pandemic, we were, in fact, funded  
8 to do co-design and co-production, which is the best  
9 anyway of consulting and informing disabled people,  
10 involving disabled people, and we were funded to  
11 co-produce reform of social care support, adult social  
12 care support in Scotland. And the funding wasn't  
13 removed, but the people in the Scottish Government that  
14 were working with us were all moved into Covid crisis  
15 response and didn't bring us with them. And they knew  
16 about concept of co-production and co-design, and yet  
17 that wasn't taken forward at the time.

18 **Q.** What was the impact of that?

19 **A.** Well, I've mentioned earlier, confusion and anxiety, but  
20 also just lack of knowledge of people's needs and  
21 preferences, their access requirements, and how they're  
22 impacted.

23 **Q.** So that is something which needs to be considered going  
24 forward?

25 **A.** Absolutely, yeah. Key recommendation, yeah.

35

1 decision making, it is all the more important that those  
2 advances are not hindered by inaccessibility and  
3 failures of inclusion. Finally, throughout the process,  
4 there was lack of structured support and engagement for  
5 the use of the third sector. Organisations, including  
6 DPO, were expected to contribute to pandemic efforts  
7 while maintaining existing commitments to funders,  
8 beneficiaries and the state. Such organisations are  
9 often grassroot bodies and, while faced with limited  
10 resources, are well positioned within communities to  
11 disseminate messages, engage cohorts, and then collate  
12 and provide feedback."

13 **A.** Yes.

14 **Q.** So there are two questions that I have about that,  
15 please, if I may.

16 **A.** Okay, mm-hm.

17 **Q.** So the first is, the need that you identify for there to  
18 be consultation about disabled people's needs, but in  
19 particular, with third sector organisations such as your  
20 own.

21 **A.** Mm-hm.

22 **Q.** And the second issue, I think, and please tell me if  
23 I have this right, is that those organisations such as  
24 your own, as you have already made reference to, stood  
25 up during the pandemic and pivoted their -- the funding

34

1 **MS BLACKWELL:** Thank you very much.

2 Dr Nolan, those are all the questions that I have  
3 for you.

4 My Lady, I don't think that there are any additional  
5 Rule 10 Core Participant questions. I notice the time,  
6 and I don't know whether my Lady wants to rise now or to  
7 move on to the next witness, who I'm told is ready to  
8 start.

9 **LADY HALLETT:** I'm in your hands, Ms Blackwell, and the  
10 witness's hands. I don't know if you'd rather break now  
11 and then -- it's up to you.

12 **MS BLACKWELL:** I'm being given a message, I think, from  
13 outside.

14 Yes, I think we'll continue, please, until the  
15 natural breaking time.

16 Thank you, Dr Nolan.

17 **THE WITNESS:** Thank you very much.

18 **LADY HALLETT:** Dr Nolan, thank you very much indeed. Some  
19 of the stories you've told us were very distressing and  
20 I do understand and appreciate the work that you and  
21 your colleagues do for people who suffered so much. So  
22 thank you very much for all that you and your colleagues  
23 did and for your assistance with the Inquiry.

24 **THE WITNESS:** Thank you for allowing us to give this  
25 evidence. It's so important that you hear it. Thank

36

1 you.

2 **MS BLACKWELL:** Thank you.

3 My Lady, in fact there's a change of plan. May we

4 have our break now, please, and we'll come back after

5 15 minutes, if my Lady agrees.

6 **LADY HALLETT:** Keeping me on my toes, Ms Blackwell.

7 **MS BLACKWELL:** Yes.

8 **LADY HALLETT:** Very well, I shall return -- shall we

9 say 11.10?

10 **MS BLACKWELL:** Yes, thank you very much. Thank you.

11 **(10.52 am)**

12 **(A short break)**

13 **(11.13 am)**

14 **LADY HALLETT:** Ah, got you.

15 **MS BLACKWELL:** My Lady, welcome back. Can you hear and see

16 me?

17 **LADY HALLETT:** I can, thank you.

18 **MS BLACKWELL:** Good.

19 The next witness is Lara Wong. May she be sworn,

20 please.

21 **MS LARA WONG (affirmed)**

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

23 **MS BLACKWELL:** Is your full name Lara Wong?

24 **A.** Yes.

25 **Q.** Ms Wong, you should have in front of you a copy of your

37

1 by the Inquiry. I remind us that Module 3 has looked in

2 detail at shielding and the clinically vulnerable and

3 clinically extremely vulnerable population, and the

4 impact on their health and access to health care. It

5 has examined the impact of the shielding programme on

6 people's mental health and wellbeing, and considered the

7 problems encountered in identifying people who were

8 clinically extremely vulnerable, and it has looked at

9 some of the practical challenges faced by people who

10 were shielding, including accessing healthcare and the

11 effectiveness of the shielding programme as a whole.

12 This module has heard from Professors Herrick,

13 Majeed, Shakespeare and Watson on issues of definition.

14 So the Inquiry has heard that there was an overlap

15 between the two descriptors, that the boundary was not

16 clear, that there was fluidity from both categories, and

17 that definitions changed over time.

18 Clinically vulnerable and clinically extremely

19 vulnerable were labels that came into being during the

20 course of the pandemic. And is it right, Ms Wong, that

21 you hold the view that those who were identified as

22 falling into one category or another were not consulted

23 before those categories were defined and that they

24 should have been consulted?

25 **A.** I wouldn't say that. It's not about consulting those

39

1 witness statement. It bears our reference INQ000657970.

2 Please can you confirm that that is the witness

3 statement that you have provided to Module 10 on behalf

4 of Clinically Vulnerable Families?

5 **A.** It is.

6 **Q.** And can you confirm that any facts stated within the

7 statement are true to the best of your knowledge and

8 belief?

9 **A.** They are.

10 **Q.** Welcome back to the Inquiry. I understand that you have

11 previously given evidence in Modules 4 and 8?

12 **A.** Thank you, yes, and I appreciate being invited back.

13 It's very good of you.

14 **Q.** Thank you.

15 So the Inquiry is already aware of your

16 organisation, but I will introduce it briefly, if I may.

17 Clinically Vulnerable Families is a grassroots

18 organisation founded in August of 2020. You are the

19 Chief Executive Officer of the organisation, which

20 represents those who are clinically vulnerable, those

21 who had been identified as clinically extremely

22 vulnerable, and including people who are severely

23 immunosuppressed, and those in their households, across

24 the United Kingdom.

25 I'm conscious not to repeat work already undertaken

38

1 groups. When we're talking about people who are

2 clinically vulnerable or clinically extremely

3 vulnerable, which was a term which, as you say, was used

4 at the time --

5 **Q.** Yes.

6 **A.** -- it was based on their true intrinsic risk that they

7 faced due to the health conditions that they had. And

8 so consulting them wouldn't have changed that risk.

9 **Q.** No, but do you say in your statement that they weren't

10 consulted, and that had there been a better

11 understanding of the effects of what they were told to

12 do because they were formulated into one category or

13 another, then there would have been a better

14 understanding within the government of the restrictive

15 lifestyles that would therefore have progressed?

16 **A.** So I mean, as I say, I think part of it is about the

17 lexicon that we're using here, so it's telling people

18 that they are really vulnerable and so yes, it's --

19 I know many groups have objected to the choice of

20 terminology and, to be honest, we don't object to that.

21 We do feel that people may not have understood their

22 risks fully, they didn't understand what that

23 terminology meant and how it applied to them. And also,

24 how that affected changes to their lives and so --

25 **Q.** So that relates to the messaging, does it --

40

1 A. Yeah.

2 Q. -- rather than the delineation of clinically vulnerable  
3 or clinically extremely vulnerable categories?

4 A. Yes.

5 Q. Right, okay.

6 There was, of course at the time that these  
7 definitions began to be used, a lack of data, because  
8 they were created during the course of the pandemic.

9 Is it your view that there is data now available  
10 that could be used to identify those who are most  
11 clinically vulnerable going into what might be a future  
12 pathogenic pandemic?

13 A. Absolutely. So, I mean, I think we didn't know, it was  
14 a novel virus. We didn't know precisely to what extent  
15 different groups of clinically vulnerable people would  
16 be affected.

17 Q. Yes.

18 A. We did probably, I would say, know, based on the flu  
19 categories, who would be likely to face disadvantage due  
20 to their health risks. I say disadvantage, disadvantage  
21 intrinsic, disadvantaged because of their health  
22 condition, their biological susceptibility, their immune  
23 systems put them in that situation where they were going  
24 to face higher risks. So those things kind of didn't  
25 change. And so would -- we would expect would have

41

1 management became a constant feature of daily life."

2 Now, was that for clinically vulnerable or  
3 clinically extremely vulnerable people, as they were  
4 then designated, or both categories?

5 A. It was both, because both of them faced increased risks.  
6 So clinically extremely vulnerable was devised by the  
7 government to offer the shielding programme, which  
8 related to giving food parcels and other, sort of,  
9 social-based care, that they were kept, sort of, within  
10 that sort of loop, whereas clinically vulnerable people  
11 were not identified directly but they still knew that  
12 they had those health risks, they knew that they  
13 qualified for a flu vaccine, for example, they knew they  
14 were at risk and so they still had to manage the same  
15 risks.

16 Q. Thank you. And you go on to say that:

17 "... the knowledge that exposure to airborne  
18 infections may cause severe illness or death [was] not  
19 hypothetical [for those categories of people]. The  
20 removal of mitigations in healthcare and public  
21 spaces ... [you say] forced [people] to choose between  
22 protecting their physical health and participating in  
23 [what you describe as may have been] essential  
24 activities ..."

25 A. Yes. So, I mean, I think this is -- for us, it's kind

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1 resulted in poor health outcomes and I'm pretty sure if  
2 you'd have spoken to any medic, they would have been  
3 able to identify the high-risk groups that they knew  
4 those conditions would have put them in. And rapidly,  
5 we could see, once people were turning up in healthcare,  
6 there were large numbers of diabetics, for example,  
7 there was -- a third of the deaths were diabetics.

8 We could see that many of them were older. We could  
9 see lots of risk factors. And we gathered data over  
10 time to get very specific details on them, and obviously  
11 where a group was a smaller group, it was much harder to  
12 get that information on them. So we wouldn't  
13 necessarily know quite to the extent to which they were  
14 at risk, but we would know that they were a higher-risk  
15 group.

16 Q. Yes, understood, thank you.

17 I want to turn to ask you about the impact on mental  
18 health and wellbeing, please, which you begin at  
19 paragraph 20 in the report. There are three main areas  
20 which you identify. Firstly, the impact on clinically  
21 vulnerable people including survey findings. And you  
22 tell us at paragraph 20 that:

23 "Extended shielding ([either] formal or informal),  
24 repeated disruption to healthcare access, and prolonged  
25 exclusion from everyday activities meant that risk

42

1 of about how your physical health risk, so those  
2 intrinsic risks, interrelate with your external  
3 environment. So, if you're of a high clinical risk if  
4 you are to catch the virus, then your risk of worse  
5 outcomes are significantly higher. If you're a healthy  
6 person and you catch the virus, your risk of severe  
7 outcomes were not particularly high. And so, for those  
8 people, it was a real problem that they had to manage  
9 those risks, and so those environments or risks that  
10 they faced did change from environment to environment.

11 So, if they lived quite a reclusive life alone, then  
12 their risks might be -- if you're shielded in that  
13 environment, you might be relatively safe, versus  
14 somebody, who, for example, was a key worker on those  
15 front lines, exposed to people, not with appropriate  
16 PPE. So there are huge differences.

17 And so I think one of the things that the Inquiry  
18 hasn't really drawn out yet is the difference between  
19 people with those intrinsic risks and those  
20 environmental extrinsic risk factors, and how they  
21 interrelate. Because just having a high extrinsic risk  
22 factor does not mean that you're necessarily going to --  
23 result -- you know, end up -- it's where those domains  
24 cross that the highest risk exists.

25 Q. Yes. And so, as you say, somebody who was clinically

44

1 extremely vulnerable but lived a very isolated life  
 2 would have had a different pandemic experience to  
 3 somebody who was clinically extremely vulnerable and  
 4 also had been working as a key worker?  
 5 **A.** Absolutely. So, like, for example, if you were  
 6 extremely vulnerable, you -- maybe you were a transplant  
 7 patient, but you were an astronaut and you were on  
 8 the ISS at the time, your risk of infection was zero,  
 9 you were not going to die of Covid. But then if you  
 10 returned to living and you happen to then take up a key  
 11 worker role, then yes, then your exposure risk then  
 12 rises, and so your risks obviously shift with that.

13 **Q.** Thank you.

14 At paragraph 22 you explain that your organisation  
 15 gathered insight from its members through a survey  
 16 called Impact on Society, and we've already made  
 17 reference to that and I think we'll look at that soon.

18 The survey ran in the summer of 2025, so recently,  
 19 and received 125 responses from people in clinically  
 20 vulnerable households across the UK which captured  
 21 experiences over the course of the pandemic, and it  
 22 combined structured questions on specific impacts with  
 23 also open text accounts that provide what you describe  
 24 as qualitative detail, and we will look at some of those  
 25 throughout the course of your evidence.

45

1 circumstances such as being unable to visit dying  
 2 relatives, restricted funerals, or lack of  
 3 post-bereavement support due to shielding."

4 And (v):

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

10 And that final point was something we touched upon  
 11 in Dr Nolan's evidence earlier this morning, that it  
 12 wasn't just the individual themselves but the effect  
 13 that the provisions had upon their family members?

14 **A.** It was, and I think, and I know we'll come on to the  
 15 government messaging, but I think it was really  
 16 unhelpful. People often felt really pressured and  
 17 stigmatised by the fact that they faced these higher  
 18 risks, and in fact I was talking to one of our members  
 19 yesterday who recounted a story that's very common  
 20 actually among our group, where they found that they  
 21 were talking to their friends about their situation,  
 22 trying to explain it to them, and the response that they  
 23 had back was that they should hurry up and die so that  
 24 they could get their lives back. And so they were being  
 25 kind of blamed, and they found that they lost friends

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1 The survey findings, in fact we have already looked  
 2 at, but I'm going to put them up again because they are  
 3 part of your report. And we can see that:

4 "[The] responses showed that impacts were  
 5 multi-layered, often combining social, emotional and  
 6 practical challenges. Participants described both the  
 7 direct strain of living with increased health risks and  
 8 the secondary effects of prolonged exclusion from safe  
 9 public spaces, healthcare and social contact."

10 And the key themes emerging from the data included  
 11 the following:

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

18 "(ii) A large proportion described their concerns  
 19 linked to increased infection risks, particularly in  
 20 healthcare environments, workplaces, and high population  
 21 density places without ventilation or masking.

22 "(iii) Many experienced depression and a sense of  
 23 hopelessness when mitigations were lifted without  
 24 protections for high risk individuals.

25 "(iv) Grief and trauma were compounded by

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1 and family where these divisions were kind of -- and  
 2 these fault lines fell, and yeah, so focusing on that  
 3 group in that way made it incredibly hard, and they had  
 4 to try to manage their own risks, often alone.

5 **Q.** Thank you. Just pausing to reflect upon the example  
 6 that you give at paragraph 30 in your statement, which  
 7 describes the account of Jayden, who was referred to  
 8 a clinical psychologist after his Macmillan counselling  
 9 sessions ended and whose experience suggested a lack of  
 10 understanding of his clinical vulnerability, including  
 11 being encouraged to undertake activities that were not  
 12 safe.

13 What impact did receiving advice that did not  
 14 reflect somebody's clinical vulnerability have on their  
 15 mental wellbeing and confidence in professionals?

16 **A.** It was incredibly hard. So there was this conflict,  
 17 again, that sort of grew up around it. And so where  
 18 a physical health risk was being addressed as a mental  
 19 health issue, it was a real problem because people  
 20 didn't understand. People genuinely thought that there  
 21 was a mental health problem. It's not that it didn't  
 22 lead to potentially mental health problems where they  
 23 then, they were facing these real risks, nobody was  
 24 understanding them, they weren't being supported even by  
 25 the mental health professionals that we would hope

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1 should understand these risks, so it was incredibly hard  
 2 for these individuals to manage that situation, and  
 3 unless that individual had been moved on to the correct  
 4 professional who could understand how those risks  
 5 interrelated, and actually then shifted the focus on to  
 6 the psychological impacts rather than trying to address  
 7 a physical health risk, and trying to reintegrate them  
 8 into society where actually it was unsafe for them to  
 9 do so.

10 **Q.** So, are you also describing a concern about lack of  
 11 training of professionals?

12 **A.** Lack of training of professionals has been a huge issue,  
 13 certainly. And I think -- and this links to something  
 14 that hasn't been raised in the Inquiry, I don't think,  
 15 but pandemic trauma, it's how we would view it.

16 Certainly health professionals, they were exposed to  
 17 these incredibly difficult situations and decisions, and  
 18 even seeing a mask can be quite triggering for those  
 19 people. But pandemic trauma has affected how everyone  
 20 has, kind of, behaved going forward, and it has had  
 21 a knock-on to this group. And, yeah, we talk about  
 22 moral injury when we talk about healthcare professionals  
 23 but there was also the injury on the other side as well,  
 24 where, you know, people have been affected negatively,  
 25 and also how that then affects them and how they view

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1 life looked now. Not only had I been shut out of my  
 2 workplaces since March, but the door to every aspect of  
 3 public life now appeared firmly locked.

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

20 Was that -- thank you, we can take that down,  
 21 please.

22 Was that confused case study something which is  
 23 common in the stories that you've heard from your  
 24 members?

25 **A.** It was incredibly common. And I think the fact that

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1 the value of their own lives.

2 **Q.** Yes. And that's something that the Inquiry has heard  
 3 about before.

4 **A.** Yes.

5 **Q.** Thank you.

6 Factors impacting on mental health and wellbeing  
 7 then, as well as the ones you identified. Within your  
 8 report, you identify the closure and subsequent opening  
 9 of cultural leisure and recreational facilities, which  
 10 you say had a profound and lasting impact on clinically  
 11 vulnerable people.

12 Let's display, please, a case study that comes from  
 13 your statement. It's page 15. Thank you very much.

14 And it's the case study of an actress who is  
 15 clinically extremely vulnerable due to cancer. She said  
 16 this:

17 "By the autumn of 2020, when theatres were  
 18 tentatively reopening and I was starting to do remote  
 19 auditions, I was diagnosed with cancer and started  
 20 18 months of chemo and immunotherapy. I was severely  
 21 immunosuppressed, and I had to shield. So, ironically,  
 22 if I thought my life felt dispensable before, those  
 23 appalling government adverts suggesting ballet dancers  
 24 simply abandon their hard-won careers to 'Retrain in  
 25 Cyber' ... then it was nothing compared to how I felt my

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1 clinically vulnerable people weren't truly being  
 2 recognised as group, their risks became invisible. Even  
 3 though we knew very clearly at the start of the  
 4 pandemic -- all of the news reports were saying, "This  
 5 person lost their life sadly, but they had underlying  
 6 health conditions." It repeatedly came up. And for  
 7 this group, they felt the pressure of every single loss  
 8 and that sadness.

9 But, you know, the lack of -- the fact that they  
 10 weren't offered support increased their risk. The fact  
 11 that people didn't want to address and would rather not  
 12 tell people that they were sick increased their risk.  
 13 When I'm talking about increasing their risk, their  
 14 exposure risk, not their intrinsic risk.

15 **Q.** Yes.

16 **A.** And the fact that we didn't give them the information  
 17 and knowledge that they needed about higher-grade masks,  
 18 that we knew about, we knew that a higher-grade mask can  
 19 filter the air up to 99% or more for an FFP3, or 95% for  
 20 an FFP2. They weren't told that they could manage their  
 21 risks in a better way. We weren't working on improving  
 22 ventilation in a sustained way. And so -- and other  
 23 protections and awareness within society that these  
 24 people existed, they -- they became invisible. And it  
 25 was uncomfortable. People didn't want to know about it,

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1 because they wanted to move on with their own lives,  
2 partly, again, due to their own, sort of, pandemic  
3 trauma.

4 **Q.** Thank you.

5 Let's look at two other examples of impact, please,  
6 at page 17 of your report.

7 Thank you.

8 First, Aisha.

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

17 You go on to say that:

18 "The failure to provide even minimal  
19 accommodations -- such as support for those who mask, or  
20 outdoor events -- was [in your view] exclusionary. For  
21 Clinically Vulnerable people, it is about the right to  
22 participate in public and cultural life on equal terms.  
23 Reopening (particularly following 'Freedom Day' and  
24 'Living with Covid') without protections effectively  
25 denied many their rightful safe access to society -- and

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1 effectively excluded vulnerable households and  
2 reinforcing their feelings of abandonment or  
3 incentivising risk-taking behaviour.

4 "Venues rarely provided information about  
5 ventilation of crowding, leaving people unable to assess  
6 risk."

7 So just pausing there, the impact of not having  
8 information available to people to make choices meant  
9 that people were taking a risk in attending such venues?

10 **A.** Yes, so they understood their intrinsic risk but they  
11 also understood how that exposure extrinsic risk would  
12 make things more inaccessible to them. And so where  
13 those measures were withdrawn over time and, kind of,  
14 gradually, every single step down made them feel even  
15 further excluded from society, and places became  
16 inaccessible to them, particularly high-risk  
17 environments. And that's where we saw people choosing  
18 to delay or cancel medical care, because the exposure  
19 risk in health care is much higher, and so those even  
20 essential reasons to leave your home became  
21 inaccessible.

22 **Q.** Yes. And then finally, just on this page, an additional  
23 impact was that:

24 "Many expressed frustration that online or hybrid  
25 access to cultural events, which had been valuable, was

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1 continues to do so."

2 Now, I'd like to look, please, at the Impact on  
3 Society survey which took place and was -- the report is  
4 dated, I think, October, yes, we can see at the bottom,  
5 pre-release October 2025.

6 This is the document to which reference has already  
7 been made, and I'd like to go, please, to page 16 and to  
8 have a look at society, culture and hospitality. Thank  
9 you.

10 So it starts with a quote from Robin:

11 "I was unable to attend my daughter's wedding  
12 abroad. I felt very lonely. No hugging or physical  
13 contact with my close family was difficult, especially  
14 when my first grandchild was born."

15 And then this:

16 "For many clinically vulnerable people, reopening  
17 was not experienced as freedom. The removal of  
18 protections such as masking, ventilation, occupancy  
19 limits made everyday activities more unsafe.

20 "Hospitality, retail, and tourism were repeatedly  
21 identified as especially inaccessible, since eating and  
22 drinking required unmasking. The government's 'Eat Out  
23 to Help Out' scheme amplified the divide by promoting  
24 indoor dining without safeguards at a time when no  
25 vaccines or treatments were widely available. This

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1 quickly withdrawn once protective measures were lifted.  
2 The sudden loss of hybrid access was experienced as  
3 another layer of exclusion, removing opportunities for  
4 connection that had briefly opened up."

5 Were similar frustrations and experiences  
6 encountered with the closure and subsequent reopening of  
7 places of worship?

8 **A.** Yes. It very much was, and actually some very sad cases  
9 of people who felt so excluded by their religious  
10 community that they felt that actually they would give  
11 up on their faith completely, because for many people,  
12 I think for many faiths, they talk about vulnerable more  
13 broadly, and I think in a pandemic -- in a pandemic, you  
14 know, it is the clinically vulnerable that are going to  
15 be the most at risk from the outcomes of the virus  
16 itself, I'm not talking about the wider outcomes, and  
17 so, you know, I think where -- they thought that their  
18 faith had particular values, and they felt that then  
19 that clashed with their lived experience and so yeah,  
20 those environments became inaccessible for them, and  
21 even things like funerals where they lost loved ones to  
22 the virus itself, they felt they couldn't attend even  
23 when people could attend.

24 **Q.** Thank you. Let's look at some examples of that which we  
25 can see at page 19 of your Impact on Society survey.

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

4 And we can see:

5 "Among respondents who had engaged in religious  
6 life, participation [as you've described, Ms Wong] was  
7 widely affected. 54.6% said significantly affected,  
8 35.9% somewhat, and 9.3% said they were unaffected.

9 "Early online services helped, but later withdrawal  
10 of mitigations and online access left many feeling  
11 abandoned or excluded from communities and key rituals.  
12 Hybrid and outdoor services early in the pandemic were  
13 widely valued.

14 "Later, the removal of live streaming and  
15 mitigations created difficult choices around funerals,  
16 weddings and communal worship. Several respondents  
17 described tensions within congregations about masking  
18 and ventilation that affected their sense of belonging."

19 And:

20 "Clear expectations set by faith leaders, together  
21 with practical precautions, made a noticeable difference  
22 to inclusion. Steps sometimes included opening windows  
23 and doors, services without singing, providing a masked  
24 area or remote options."

25 Then we see the experience of Morgan:

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1 a barrier to this group to be able to engage.

2 **Q.** Thank you.

3 The restrictions on carers, family visits or access  
4 to advocates, as you describe it, during lockdown.

5 At paragraph 53 you tell us that this had severe  
6 wide-ranging impacts on mental health, and sometimes on  
7 the dignity of individuals who were unable to care for  
8 themselves without that level of care. And of course  
9 that chimes very much with what Dr Nolan told us this  
10 morning about the removal of social care packages.

11 **A.** Yeah, it did. And I think, you know, it had a massive  
12 impact on people's sort of mental wellbeing when they  
13 faced these particular restrictions. It affected their  
14 autonomy, their safety, and they had to, you know,  
15 households, and when I talk about clinically vulnerable  
16 families, we talk about the whole household -- they were  
17 all impacted by this and so they weren't being provided  
18 with adequate support, and for us also, that included  
19 things like PPE. If the PPE provided was -- was  
20 non-existent or was inappropriate or where people felt  
21 that they interpreted government guidance that pointed  
22 to personal responsibility as a personal choice, and  
23 they felt that they shouldn't need to wear a mask. They  
24 didn't understand that the risks that those people faced  
25 in their own homes, and that perhaps, you know, it's

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

11 So quite a severe reaction and impact for that  
12 particular person?

13 **A.** Exactly. I mean, it's incredibly harmful. These people  
14 felt that their religion should provide them some kind  
15 of refuge and safe space, and actually in some of these  
16 instances it led to greater isolation when these things  
17 were removed.

18 It's not to say, just to kind of give a positive  
19 angle, it's not to say that we didn't learn through this  
20 and, actually, I've heard many stories since of weddings  
21 and funerals and things abroad, you know, where, you  
22 know, people can attend internationally, and people are  
23 aware of this now. This is a new way to kind of connect  
24 people. But it doesn't always happen, and I think  
25 that's the thing. Like I say, it became kind of

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1 something that they should be able to request and also,  
2 obviously, issues like respite and the fact that those  
3 families who were taking caring responsibilities 24/7  
4 with no let-up, there was no kind of opportunity for  
5 them to safely transfer their care for a short period of  
6 time.

7 And I don't know how you would deal with that, but  
8 it certainly was something that was a real issue for  
9 people.

10 **Q.** Yes. Thank you.

11 Moving to look at the impact of the pandemic on  
12 clinically vulnerable and clinically vulnerable people  
13 compared to the rest of the population. There are three  
14 topics to cover here.

15 First of all, the extended periods of shielding that  
16 were imposed. What was the impact of that on those who  
17 abided by the shielding rules?

18 **A.** So, I mean, shielding had positive sides to it, whereby  
19 people were receiving support and extra assistance. But  
20 also, it had the negative side of people feeling sort of  
21 excluded in many senses from their workplace, from their  
22 colleagues, from their friends, from their families.  
23 And so they had to kind of manage their own risks  
24 independently. And so I think it kind of fell on the  
25 individual, and how they understood what their risks

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1 really were, how they reduced their risks. It wasn't  
2 always clear for them. And so there was kind of unequal  
3 mental health harm on that group, and kind of ongoing  
4 as -- I'm sure you're aware -- we paused shielding at  
5 certain times.

6 **Q.** Yes.

7 **A.** Shielding was paused not because those individuals,  
8 their in -- ex -- sorry, their extrinsic risk had  
9 changed, but because the pressures on the NHS had  
10 reduced.

11 **Q.** Yes.

12 **A.** And so --

13 **Q.** But, so far as the impact of shielding on those  
14 individuals were concerned, and you --

15 **A.** So the shielding was at certain times -- oh, sorry, just  
16 to explain.

17 **Q.** Yes.

18 **A.** Yes. So they weren't shielded when they were still at  
19 really high risk sometimes.

20 **Q.** Yes, right.

21 **A.** And -- yes, sorry.

22 **Q.** That led to its own impact, I think is what you're  
23 saying?

24 **A.** Yes, because they felt like that they'd been ignored and  
25 they didn't understand how -- they didn't understand how

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1 be gathered. And we can do that retrospectively.

2 **Q.** Thank you.

3 Paragraphs 81 to 98 of your report address what many  
4 clinically vulnerable family members reported in terms  
5 of their experiences of dialysis, cancer,  
6 immunosuppressed patients, those who were older,  
7 obesity, diabetes, and those with learning disabilities.

8 **A.** Yes.

9 **Q.** I mention those because I'm not going to dwell upon  
10 those in your live evidence this morning -- but,  
11 my Lady, you have that evidence in the report, and that  
12 will all be taken into account in this module.

13 So I want to move on, please, to look at the impact  
14 on access to services and support, and you deal with  
15 seven examples here. The first is accessing healthcare  
16 and healthcare behaviours. And you say at paragraph 189  
17 that:

18 "[Your] survey revealed widespread barriers to  
19 safely accessing healthcare and support during the  
20 pandemic."

21 Is that right?

22 **A.** Yes.

23 **Q.** Yes. You go on to say, at paragraph 100, that:

24 "... as awareness of airborne transmission increased  
25 among Clinically Vulnerable people and those in their

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1 the withdrawal of shielding changed their real risks.

2 **Q.** Yes.

3 **A.** And so people who may have felt that their risk was  
4 completely changed may have gone out and gone to Eat Out  
5 to Help Out, and then had an increase to their exposure  
6 risk at a time when cases were rising. Or people who  
7 then completely withdrew and felt that they had no  
8 support and they didn't understand why -- why they'd  
9 been dropped in that way.

10 **Q.** You talk also in your statement about various  
11 socioeconomic groups of clinically vulnerable people,  
12 and you say at paragraph 77 that you only have minimal  
13 data on this topic, but it suggests in itself that  
14 further research is needed to investigate such  
15 intersectional experiences?

16 **A.** Yes. I mean, that's our broader message to the Inquiry,  
17 is that because we're not recognised as a group, because  
18 this data wasn't collected, you know, we are really  
19 limited in what we can say. But we do know for a fact  
20 that these experiences were very real, and wide  
21 ranging --

22 **Q.** Yes.

23 **A.** -- and so, without that data, it's really problematic to  
24 then -- for the government or the decision makers to  
25 respond to. So we do need some really firm evidence to

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1 households, their assessment of risk in shared clinical  
2 settings changed. With the subsequent withdrawal of  
3 measures such as universal masking, attention to  
4 ventilation, and isolation of potentially infectious  
5 patients, many respondents reported [to you] that even  
6 though clinical services were technically 'open', they  
7 were often inaccessible ..."

8 Because of the environments in which they were being  
9 provided.

10 **A.** Yes, very much so. And this is where, you know, you're  
11 increasing the harms to a group who were already facing  
12 health issues, health disadvantage.

13 You're increasing it because they then can no longer  
14 access the additional care and support that they need.  
15 And, in particular, areas, I mean, where you have to  
16 demask. For example, dentistry, where someone is up  
17 very close to you, it was and remains a concern for  
18 people that they can't manage those risks independently,  
19 which is why we would be asking for, sort of, broader  
20 measures and clean air standards and things like that,  
21 to hopefully make those places more accessible, because  
22 they're essential care.

23 **Q.** Yes, thank you.

24 You also talk about the use -- or lack of use -- of  
25 face masks in healthcare settings, of local improvements

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1 air quality, of the exclusion from services due to risk  
2 or shielding of people, and accessing benefits and/or  
3 financial support.

4 Were all of these factors that you identify within  
5 your statement affecting the quality of life that  
6 clinically vulnerable and clinically extremely  
7 vulnerable people were managing during the pandemic?

8 **A.** Yes, hugely. And, I mean, I think -- you've mentioned,  
9 sort of, Universal Credit.

10 **Q.** Yes.

11 **A.** And so I think for that group, for example -- I mean,  
12 there is a recognition -- it's interesting, there is  
13 a recognition in the application for Universal Credit of  
14 health conditions as different to disability, as  
15 a disadvantage, and considerations --

16 **Q.** Yes.

17 **A.** -- but it's not protected in any way.

18 But that group, you know, it's recognised that they  
19 will have these issues and these challenges. It's  
20 problematic for them because they're disadvantaged as  
21 they're going through this process and they're  
22 disadvantaged by their risks, and they were invited for  
23 face-to-face appointments that they had to attend in  
24 order to receive the money that they needed to live.

25 And so -- it's not just clinically vulnerable; in

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1 symptomatic people and was struggling with increasing  
2 stress daily despite doing everything I could to  
3 mitigate my risks by opening windows and doors, cleaning  
4 hands and surfaces, and eating alone in my car.

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

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

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

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1 their households as well.

2 **Q.** Yes.

3 **A.** But, yes. And so it posed particular challenges,  
4 because they didn't have a choice.

5 **Q.** Well, we're going to look at the experience of Phil.  
6 Again, this comes from your study and the impact report.

7 **A.** Okay.

8 **Q.** And this relates to accessing Universal Credit. And he  
9 says:

10 "I was a keyworker on a zero-hours contract when  
11 I rapidly became very aware that I was also at high-risk  
12 from Covid, every day that I worked before I locked  
13 myself down felt like living with a ticking timebomb.  
14 Planning each move to avoid risks. The risk of working  
15 became too high. My employer was aware of my health  
16 risks -- as I was explicit early on and asked to not to  
17 be put anywhere where I was covering sick staff.  
18 However, they repeatedly and knowingly put me into  
19 hazardous situations. I found out through others  
20 that I had been used to replace a staff member pulled  
21 out only minutes before because they had symptoms. In  
22 the end, I made the difficult decision to leave my job  
23 a week before the first lockdown, because it simply  
24 wasn't possible to continue in-person work without  
25 risking my health as I had been surrounded by

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

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

18 And although Phil's story sadly contains lots of the  
19 issues that you have just highlighted, were there many,  
20 many other people whose lives were touched by only some  
21 of what Phil there describes?

22 **A.** Yeah, I mean -- yes, very much so. And it's really,  
23 really key that the Inquiry, sort of, understands how  
24 those multiple domains of vulnerabilities that are  
25 beyond clinical vulnerability can overlay to cause these

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1 issues. And where Phil mentioned "following the  
2 guidance" --  
3 **Q.** Yes.  
4 **A.** -- I have to say that this is something that's been  
5 a repeated issue for us. It's something that very often  
6 people hide behind because they don't, they're not able  
7 to, they're not willing to, for whatever reason, give  
8 those adjustments to individuals to make things safer.  
9 And Phil was only asking for a phone call or a Zoom. It  
10 wasn't very difficult, it was perfectly available, it  
11 was something that they'd done before and that they'd  
12 chosen to deny at a point where it was clearly unsafe.

13 So the pressure on those individuals to have to  
14 manage those risks, and again, where -- I mean, Phil  
15 obviously made a particular choice, but someone else  
16 might have chosen the choice to increase their risk and  
17 that could have led to, obviously, very severe  
18 consequences for those individuals. So they were being  
19 forced to make decisions that they should never have  
20 been forced to make. They shouldn't have been  
21 challenged in that way.

22 **Q.** Yes. I want to move on to the impact of rules and  
23 guidance.

24 We started with a discussion of the definition of  
25 clinically vulnerable and clinically extremely

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1 shield. We can just leave them to it. But it was  
2 still -- it was, you know, summer of 2020, the virus was  
3 still around. We didn't have any vaccines. It was  
4 incredibly high risk, potentially -- if those people  
5 were exposed, the consequences for them were still very  
6 real, and so to put something that maybe even medical  
7 people didn't necessarily precisely know how at risk  
8 those individuals were, to expect them to understand and  
9 manage those risks at that point in time, without giving  
10 them any tools to do so, without explaining to them,  
11 "Actually, there are these better masks. Yes, if you  
12 meet outdoors then you're reducing your risks". If they  
13 had had the tools and the skills -- and everybody knew  
14 this -- then we'd have been reducing transmission  
15 overall.

16 **Q.** You tell us at paragraph 163 that many faced dilemmas,  
17 and you list them, such as whether to return to unsafe  
18 workplaces, how and when to mix with others, how to  
19 manage risks in enclosed indoor environments, which  
20 masks were the most protective, how to manage children  
21 returning to school, and how to access healthcare  
22 services safely in person.

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

24 **Q.** And what was the impact of those dilemmas that were  
25 being forced on to people for decisions being made in

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1 vulnerable and how that changed over time, but in terms  
2 of the understanding and interpreting of subsequent  
3 government-issued Covid-19 rules and guidance, was there  
4 also, in the experience of your members, a confusion  
5 around the message or the messages that the government  
6 was giving, and the level of those who were -- were  
7 clinically vulnerable, that that would affect?

8 **A.** So, I mean, I think there was -- yeah, there was a huge  
9 amount of confusion about the level of the individual's  
10 health risk, because it wasn't always very clear. Just  
11 as people have explained, that we were learning at that  
12 point. There was a new virus, we didn't know precisely  
13 how different groups were going to be affected, so there  
14 was that aspect, but there was also, you know, the  
15 extrinsic risks, as well, so where their exposure might  
16 change and how they can manage those issues.

17 And so I remember -- I remember, in the news at the  
18 time, I think both Matt Hancock and Grant Shapps said,  
19 when shielding was ended for the first time, they said  
20 the vulnerable know how to look after themselves.

21 **Q.** Was this the introduction of what we've heard described  
22 as personal responsibility?

23 **A.** It was, like it was edging towards that. So yes,  
24 exactly. It was this idea of well, the vulnerable can  
25 cope with it now, they understand that they have to

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1 those aspects of their lives?

2 **A.** So I think the impacts were -- well, it kind of depended  
3 upon what part of the split they came. So if people  
4 chose to completely withdraw, then there were issues  
5 around isolation, and that's sort of one range of  
6 issues. If they chose to engage and face risks, then,  
7 you know, return to normal, kind of became a priority at  
8 a certain point. And so their safety wasn't being  
9 prioritised and they had to manage making those  
10 decisions and understanding the risks and consequences  
11 whilst facing stigma from society who was -- you know,  
12 were aware that -- where the government said, "Stay at  
13 Home, Protect the NHS, Save Lives", "save lives" was us.  
14 The finger was very clearly pointed in our direction.  
15 We were the reason that people had to stay at home.

16 And so that started to kind of seed this idea that  
17 this group of people were almost responsible for the  
18 pandemic. They weren't responsible for the pandemic;  
19 they were facing the worst consequences of it. But the  
20 messaging at the time was hugely problematic, and  
21 personal responsibility was something that we never  
22 could have taken when it's an airborne virus.

23 **Q.** Yes.

24 **A.** You can wash your hands, you can eat from clean plates,  
25 you can, you know, make a sterile environment or

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1 a surgical environment or whatever, you can do things to  
2 reduce risk in all sorts of environments, but  
3 controlling the air is something that as an individual  
4 you can't do.

5 **Q.** No. Thank you.

6 The experiences of people that responded to your  
7 survey and that you have got to know throughout your  
8 work with clinically vulnerable families, and that  
9 you've described to the Inquiry today, are those  
10 experiences that have been shown to have been present  
11 across the United Kingdom, or have there, in your  
12 experience, been variations in impact between England  
13 and the devolved nations?

14 **A.** Okay, so I would say there have been some variations.  
15 However, I think overall, generally, it's a pretty kind  
16 of homogeneous experience that everybody understands and  
17 shares. And so within the group, there doesn't seem to  
18 be that many differences in terms of their experiences  
19 overall.

20 **Q.** Was there a particular level of confusion amongst those  
21 living near perhaps regional borders or national borders  
22 in terms of the messaging that they were getting and  
23 a clear understanding of what could and couldn't be  
24 done?

25 **A.** I would say that yes, there was. I think much of the UK

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1 witnesses; and finally, those in prison and other places  
2 of detention.

3 Now, at paragraph 287 you tell us that a report by  
4 the Prison Reform Trust indicated that isolation  
5 measures appeared to be used in lieu of care, for  
6 example clinically vulnerable prisoners were confined to  
7 cells for 23 hours a day without mental health support  
8 or adequate clinical oversight, and indeed we're going  
9 to hear from some witnesses later this week who will  
10 tell the Inquiry about what was going on in prisons and  
11 places of detention. But that is also your  
12 understanding of the position that took place throughout  
13 the pandemic.

14 **A.** Yes, and I think prisons, immigration, I mean, they've  
15 all got similar issues around people who were in certain  
16 circumstances, confined spaces, high population density,  
17 and increased risk. And potentially a population who  
18 may have higher clinical vulnerabilities. People in  
19 prisons generally were of a -- male and of an older age  
20 and more likely to be ethnic minority groups. All of  
21 those things overlay with their clinical vulnerability,  
22 so they're more likely to be clinically vulnerable, more  
23 likely to be higher risk.

24 **Q.** Yes.

25 **A.** Because of those risk factors, more likely to have

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1 messaging was across the UK. If you watched the news at  
2 the time, you could have watched -- you were in England  
3 but you could have watched the Welsh or the Scottish  
4 giving their kind of health updates, whatever they were  
5 doing at the time.

6 **Q.** Yes.

7 **A.** I think for people in Northern Ireland in particular,  
8 because you've got two different countries overlapping,  
9 there were differences there that people were crossing  
10 the border, perhaps, like more -- well, maybe not more,  
11 sorry, but they were -- I think many of the ideas  
12 between the two were kind of crossing. So, you know,  
13 there were influences. They talked about cocooning, not  
14 shielding. So there were different languages --

15 **Q.** Phraseology, yes.

16 **A.** Yes, different ways of talking about similar things.

17 **Q.** Right. Thank you. I want to now turn to look at what  
18 you describe as the impact on specific clinically  
19 vulnerable and clinically extremely vulnerable groups,  
20 and we've touched upon this already; those being key  
21 workers; those experiencing housing insecurity and  
22 homelessness, about which this module has heard evidence  
23 already; those living alone or in isolated areas which  
24 you've touched upon, Ms Wong; those in the immigration  
25 and asylum system, which we heard about with other

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1 certain conditions that put them in those risk groups.  
2 So it was a higher-risk population or people who --  
3 people who are homeless, their immune system drops,  
4 because you're living a really exposed life, people who  
5 are homeless may live until sort of 43, 45 years old, on  
6 average. So their immune system is reduced, they are at  
7 greater risk, they are more exposed so -- and immigrants  
8 may probably face similar kind of risks.

9 So yeah, where you've got a higher-risk group with  
10 higher health risks, then it's a difficult thing to  
11 manage.

12 **Q.** Thank you.

13 And finally, on this topic, victim-survivors of  
14 domestic abuse, you tell us at paragraph 292 that for  
15 people living with domestic abuse the Covid-19 pandemic  
16 posed additional serious risks, which we've looked at,  
17 and access to support services for those experiencing  
18 domestic abuse was significantly reduced, as refuges and  
19 face-to-face support services struggled to meet social  
20 distancing guidelines and staff were furloughed. So  
21 that reduced the level of support?

22 **A.** Yeah.

23 **Q.** Thank you.

24 The intersection of clinical vulnerability and  
25 domestic abuse, you say created a situation of extreme

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1 risk, and for some, near-total isolation. Do you agree  
2 that the government failed during the pandemic to  
3 properly recognise the intersection between clinical and  
4 non-clinical vulnerability, and do you believe that that  
5 left individuals with multiple vulnerabilities without  
6 appropriate support?

7 **A.** Yes, so where people were clinically vulnerable but they  
8 faced those additional risks and challenges, then, yes,  
9 they were at higher exposure risk, which then could  
10 result in sort of worse outcomes in that sense, but  
11 also, as I'm sure you're aware, domestic abuse --  
12 abusers would use the virus particularly against those  
13 people who were very high risk, or use their  
14 medications, access to medicines. And the fact that  
15 they were shielding perhaps meant that they were already  
16 more isolated from other organisations who may have been  
17 able to help them, from friends from family, and so they  
18 became incredibly high risk, because they were unable  
19 to -- even if they could find a space where they could  
20 speak openly about the risks and challenges that they  
21 were facing, they then would struggle to necessarily  
22 remove themselves from that environment, because if they  
23 were then moved into a place where there were lots of  
24 people living, then they increased their exposure risk  
25 as a result.

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1 guidance for isolation. Ten, shielding letters and  
2 shielding infrastructure to be improved. At nine [sic],  
3 to -- protective measures indoors to be improved. And  
4 finally, as you have already mentioned, Ms Wong, legal  
5 recognition of clinical vulnerability?

6 **A.** Yes.

7 **Q.** Is there anything else that you would like to add to  
8 that list?

9 **A.** So, just to kind of explain, really, our key issues, and  
10 just a reminder obviously that it continues to this day.  
11 In fact, today is the anniversary, the four-year  
12 anniversary of "Living with Covid", where Boris Johnson  
13 told us that we would be learning to live with Covid.

14 **Q.** Can I just implore you, please, to keep on impact,  
15 rather than -- (overspeaking) --

16 **A.** Yes, yes, so --

17 **Q.** -- because that is the --

18 **A.** It leads to the impact, sorry.

19 So, "Living with Covid", itself, should have dealt  
20 with the ongoing issues. And the ongoing issues for us  
21 are safety, you know, making environments safe for  
22 individuals who can't be expected to manage ventilation  
23 and things like that, and understanding about how their  
24 risks interact, how they can manage their own risks in  
25 difficult circumstances.

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1 So they were choosing between different harms.

2 **Q.** Yes, understandable, and that you describe it as such.

3 Do you agree with others who have told the Inquiry  
4 that unclear messaging around the right to leave and  
5 seek refuge placed clinically vulnerable individuals  
6 suffering from domestic abuse in a position where they  
7 were uncertain as to their rights and responsibilities?

8 **A.** Yes, because they were also given this guidance to tell  
9 them that they should be staying at home and restricting  
10 their lives, so, I mean, it was completely in conflict  
11 with that. There was no consideration for how those  
12 things would interact.

13 **Q.** Thank you.

14 Finally, I want to turn to lessons learned, please,  
15 and to go through the list of multiple lessons learned  
16 innovations, and recommendations that you set out  
17 towards the end of your witness statement.

18 First, early access to vaccines and treatment.  
19 Second, remote and flexible healthcare. Third, high  
20 quality data which we've touched upon. Fourth, work  
21 adjustments and protections. Fifth, community support  
22 networks. Sixth, to feel seen and included, access to  
23 remote leisure, theatre and other venues. Seven,  
24 regional examples of good practice. Eight, to improve  
25 communication and messaging. Nine, to develop practice

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1 Obviously, as you mentioned, the status and  
2 recognition that comes with that, of clinical  
3 vulnerability --

4 **Q.** Yes.

5 **A.** -- as different to other issues, and particularly in  
6 pandemics. And the joint chiefs' intelligence report  
7 came out recently and it points to pandemics as one of  
8 our top three risks.

9 So I think we can't ignore pandemics. We already  
10 knew we were overdue a flu pandemic, but for people who  
11 are clinically vulnerable, those intrinsic risks exist  
12 outside of pandemics as well. It's not a purely  
13 pandemic-related issue. They have health conditions  
14 that, if they're exposed to infections, then they will  
15 have worse outcomes but they're not directly, kind of,  
16 considered in that way.

17 And finally, the right to wear a mask. I think  
18 there's been some really harmful messaging around that,  
19 and people don't understand the benefits of wearing  
20 a mask. It would help people to be more resilient in  
21 the future if everybody understood that, actually, if  
22 you've got a cold, maybe you could wear a mask to -- you  
23 could choose to protect other people and not expose your  
24 colleagues.

25 Presenteeism has always been a problem in our

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1 culture, but it particularly disadvantages people who  
2 face those increased health risks. And so the right to  
3 wear a mask without being stigmatised, without having to  
4 go to your employer and justify -- many of us have had  
5 to do this -- justify all of your health conditions as  
6 a reason to choose to wear a mask. We're already  
7 seeing -- tube stations are talking about cameras, and  
8 the issues associated with people wearing a mask and  
9 going through those cameras and being identified,  
10 people's right to wear a mask during protest, things  
11 like that, that's where clinically vulnerable people  
12 need to be considered differently and understood,  
13 because if they don't even have the right to even choose  
14 to wear a mask, where we are left with personal  
15 responsibility as the only thing that individuals have  
16 to manage their own clinical risks, if they can't even  
17 wear a mask, where does that leave them?

18 **MS BLACKWELL:** Thank you very much, Ms Wong.

19 My Lady, that concludes my questioning. There is  
20 permission for the Trades Union Congress to ask  
21 a question.

22 **LADY HALLETT:** There is. Ms Peacock, I think you're asking  
23 the question.

24 **Questions from MS PEACOCK**

25 **MS PEACOCK:** Thank you, my Lady.

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1 were CEV, they were automatically receiving a score of  
2 7, which would mean that they were allowed to work from  
3 home. If they scored, I believe, from 3 to 6, they  
4 would have had significant health conditions, but they  
5 would have had to work potentially in a high-risk  
6 environment still -- it should not be the highest-risk  
7 environments, but it didn't necessarily address the  
8 direct risks that they were facing. And they were not  
9 being necessarily allowed to wear high-grade masks.

10 Sometimes people were told that it was problematic  
11 if they were to wear a mask, particularly even in health  
12 care, they were told that they weren't allowed to wear  
13 a mask because other people would question why they were  
14 wearing a mask in this area and other people who weren't  
15 as high risk were not, you know, were not being given  
16 those same masks.

17 So there were difficulties that were kind of  
18 created, there were issues around it.

19 I think that any consultation around it should  
20 involve clinically vulnerable groups so that they can  
21 then feed into this and recognise the issues that were  
22 created.

23 But in general, broadly, we do recognise that this  
24 was a good idea but I think there's still more work to  
25 develop it.

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1 Good afternoon, I ask questions on behalf of the  
2 Trades Union Congress. My question is on personal risk  
3 assessments. The All-Wales Covid-19 workforce risk  
4 assessment tool was introduced nationally in Wales. The  
5 tool considered clinical vulnerabilities or intrinsic  
6 risk, as you've described it in your evidence, and then  
7 workplace risks, or extrinsic risks, to generate a risk  
8 score. And that score formed the basis of  
9 a recommendation, such as a need for enhanced PPE,  
10 adjusted hours, or working from home. And the  
11 assessment involved a meeting between the employee and  
12 their employer to encourage their shared decision  
13 making.

14 The TUC considers that in any future pandemic,  
15 efforts should be made to devise a national or, ideally,  
16 a four nations tool similar to that which was introduced  
17 in Wales and building on that work.

18 Clearly, a great deal will depend on how the tool is  
19 devised and implemented, but in principle, do you  
20 consider that such a tool could have utility in  
21 supporting clinically vulnerable workers?

22 **A.** Yes, so we had people who were directly affected  
23 obviously by that tool. I think the tool still needs  
24 work. There was kind of a cliff edge at certain points  
25 so I believe, I could be wrong, but I think if people

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1 **Q.** So, if I may, a standardised risk assessment tool would  
2 be helpful --

3 **A.** Yes.

4 **Q.** -- but it needs work, so far as you consider it, and  
5 consultation would be helpful with people who fall into  
6 the category of clinically vulnerable.

7 Do you have any other thoughts on how it can be  
8 improved, the criteria, so there aren't these cliff  
9 edges?

10 **A.** So, I mean, I think we need to look at and understand  
11 the individual risks and the circumstances. And  
12 certainly I think -- I mean, the cliff edges could have  
13 been avoided if we looked -- you know, it wasn't so,  
14 kind of -- such a -- you know, where you reach a 7 and  
15 then there was a massive drop-off, if we would be more  
16 open to giving people remote work, for example. Remote  
17 work is something that many people can do, not  
18 everybody, but there would have been opportunities to  
19 support people better in that way, to take them out of  
20 that risk environment.

21 And I think there probably does always have to be  
22 a degree of a cliff edge, but if we're making the  
23 environment safer, if we're improving the ventilation in  
24 those buildings, so that everybody is at lower risk,  
25 everyone benefits, I think -- one of the things that we

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1 try to, kind of, get across is the fact that when it's  
2 safe enough for the most vulnerable, it's safe enough  
3 for everyone.

4 And so we would like environments to be generally  
5 improved, and it will make everyone healthier. Catching  
6 viruses can harm your health in the long term, and the  
7 long-term impacts and benefits of having cleaner air --  
8 something that we're starting to see in London, as  
9 we've, kind of, introduced the Clean Air Zone -- there's  
10 evidence of that already. And so, if there's something  
11 that we really should be learning from the pandemic, it  
12 is actually that there is something that we can do about  
13 indoor environments. It's quite simple. We can buy  
14 these air filters that are behind me, we can put them  
15 in. They might only cost £100, but it can make a --  
16 reduce the risk, not only of airborne pathogens but also  
17 other airborne -- what's the words? -- sort of chemicals  
18 and things like that. So any other sort of exposure  
19 risk can be reduced, mould and things like that.

20 And -- yeah, and then we can hopefully make it safer  
21 for everyone, is what we would really like to see. And  
22 then it becomes less of a cliff edge, because the  
23 environments are safer, people understand how to wear  
24 a better mask.

25 **MS PEACOCK:** Thank you. I'm sure my client will support  
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1 friendly, and they're really lovely team that you have.

2 **LADY HALLETT:** I do.

3 **MS BLACKWELL:** Thank you, Ms Wong.

4 My Lady, that concludes this morning's business.

5 Could I invite you my Lady to return at 1.25?

6 **LADY HALLETT:** You may.

7 **MS BLACKWELL:** Thank you very much.

8 **LADY HALLETT:** 1.25.

9 (12.20 pm)

(The Short Adjournment)

11 (1.25 pm)

12 **LADY HALLETT:** Mr Jackson.

13 **MR JACKSON:** Good afternoon, my Lady. Could I check if you  
14 can see and hear me okay first?

15 **LADY HALLETT:** I can, thank you.

16 **MR JACKSON:** My Lady, the next witness is Daniel Singleton.  
17 May he be sworn, please.

**MR DANIEL SINGLETON (sworn)**

**Questions from COUNSEL TO THE INQUIRY**

20 **MR JACKSON:** Now, you are Daniel Singleton; is that right?

21 **A.** Yes.

22 **Q.** Mr Singleton, you've provided a witness statement to  
23 Module 10 of the Inquiry. The reference number  
24 INQ000657972. And Mr Singleton, this statement is  
25 produced in your capacity as the National Executive

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1 improving work safety generally.

2 Thank you, my Lady.

3 **LADY HALLETT:** Thank you, Ms Peacock.

4 That completes the questions we have for you,  
5 Ms Wong.

6 I always remember, I think it was probably  
7 a different module, but -- I think it was M3, our very  
8 first hearing where Mr Wagner pointed out about the  
9 quality of the air in that room, and I think I was  
10 holding my breath before he told me we passed.

11 But I've certainly learnt a great deal from you and  
12 your colleagues during the course of the Inquiry, so  
13 thank you very much indeed for all your help, and I do  
14 understand the points you're trying to make. Obviously,  
15 if you feel there are other points that you wish to  
16 emphasise, then Mr Wagner can always put them to me in  
17 any closing submissions.

18 Thank you very much for your help.

19 **THE WITNESS:** Thank you so much. And may I thank you all,  
20 and all of your staff as well, for their hard work to  
21 make this environment a really inclusive environment.  
22 I think the Covid Inquiry is probably one of the safest  
23 rooms in the country that you can be in, so I think --  
24 thank you for all of your work for that, and for the --  
25 for your team to make it safe and inclusive and

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1 Director of FaithAction?

2 **A.** That's correct.

3 **Q.** And that's a post you've been in since 2007?

4 **A.** Yes.

5 **Q.** FaithAction itself is a national network of faith-based  
6 organisations seeking to serve their communities through  
7 social action and by offering services such as health  
8 and social care, childcare, housing, and welfare to  
9 work?

10 **A.** That's right.

11 **Q.** And during the pandemic, you sat on the National Faith  
12 Taskforce, which was tasked by government departments to  
13 ensure that faith communities were supported and able to  
14 respond to Covid-19 impacts and to assist with policy?

15 **A.** Yes.

16 **Q.** And then, to assist with that task, you held weekly  
17 focus groups with representatives from nine different  
18 faith communities. Could you outline which those were,  
19 please.

20 **A.** They were with Christian, Muslim, Jewish groups, Baha'i,  
21 Sikh, Hindu and Jain, Zoroastrian and Buddhist.

22 **Q.** And could you tell the Inquiry, please, what sort of  
23 things, week to week, you were discussing in those focus  
24 groups?

25 **A.** In those groups we would explore any recent information

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1 related to regulation, any information we were getting  
2 through in terms of any questions that were coming to us  
3 from the communities department. We also were taking  
4 soundings on what was happening in faith groups, how  
5 they were responding, how they were doing their  
6 services, their spiritual services, but also their  
7 social activities as well, and -- and essentially  
8 started to gain an understanding of what was happening  
9 with those communities, and then to feed back that  
10 information into government.

11 **Q.** And can you tell us what you consider the importance of  
12 the National Faith Taskforce to have been?

13 **A.** The taskforce was unique in the fact that there was not  
14 a sitting group of faith representation, and initially  
15 the focus was on regulations and on closing places of  
16 worship and then the reopening of places of worship, but  
17 very rapidly there started to be an understanding that  
18 faith itself can be an asset rather than a problem,  
19 rather than a risk, to communities that actually faith  
20 groups were involved with, providing medicines, with  
21 providing food, and so therefore it became  
22 a coordination point where we could wrestle through  
23 different development of regulations and to try to lever  
24 the possibilities of faith for the benefit of the UK.

25 **Q.** And much of your statement, Mr Singleton, that you've  
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1 a growing information about how faith was adapting and  
2 supporting people. But predominantly, the discussions  
3 in this part of my evidence are about life-cycle events  
4 and funerals.

5 **Q.** There would also have been impacts on people's  
6 experiences of prayer?

7 **A.** Yes. So those whole discussions about how some kind of  
8 service can maintain, some kind of faith service can  
9 maintain and what was appropriate, what could move to  
10 online and what couldn't and what could be done, what  
11 people could do with within family settings, all those  
12 things became -- it became very complicated because  
13 there were different restrictions and different  
14 traditions within different faiths.

15 **Q.** And we'll move on to the experiences of the move online  
16 and the different experiences of certain restrictions  
17 shortly, Mr Singleton.

18 Presumably, though, it wasn't just members of the  
19 groups but also faith leaders themselves who were being  
20 affected by that first lockdown?

21 **A.** Yeah, obviously, like everyone else in society, faith  
22 leaders were not particularly ready for this, and the  
23 levels of not knowing what was going to happen and  
24 people did turn to faith leaders with the expectation  
25 that they would be able to walk them through, and  
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1 provided, sets out both the impact that you say you  
2 learnt from these focus groups, but also, as you say,  
3 the positives that the taskforce was able to do in  
4 collaboration with different agencies?

5 **A.** Yes, that's ...

6 **Q.** Now I'm going to start by asking, Mr Singleton, then,  
7 about the impacts in the early stages of the pandemic.  
8 That's impacts on members of faith groups and then on  
9 places of worship. And this is with that backdrop in  
10 that initial stage of places of worship closing in that  
11 full lockdown and then moving to reopening for private  
12 prayer across the UK from May and June 2020.

13 From paragraph 11.1 of your statement, you discuss  
14 the impact on the mental health and wellbeing of people  
15 of faith. Can you tell us, please, what were the main  
16 issues arising from that first lockdown which impacted  
17 the mental health of people of faith?

18 **A.** One of the biggest issues that people faced was related  
19 to death. I mean, life-cycle events generally were  
20 a big focus of our discussions. But as Covid hit the  
21 population, and we started to see deaths, particularly  
22 issues around send-offs, the funeral arrangements were  
23 particularly brought up, and the restrictions were  
24 keenly felt by different members of the faith community.

25 I think also there was -- we started to get  
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1 obviously faith leaders were suffering particular  
2 issues, like the rest of the population, and some of  
3 them were facing increased deaths. There's one comment  
4 I give about a Buddhist chaplain who talks about a rise  
5 of funerals and rise of suicides and different things  
6 that he was dealing with.

7 So there was quite significant pressure on faith  
8 leaders and quite early on in lockdown. We were getting  
9 a number of reports of a, kind of, fatigue on faith  
10 leaders, as well. And I think particularly if you  
11 understand that there's some that -- there are some  
12 faith leaders obviously who are professional, but  
13 there's quite a lot of support that comes from  
14 volunteers, and that was therefore restricted in terms  
15 of how people could help in that way.

16 **Q.** Yes, just touching on the fatigue you mentioned, there's  
17 talk in your statement of moral injury which the Inquiry  
18 heard during evidence last week about. Can you say how  
19 that moral injury comes about through faith leaders? Is  
20 it being close to so many people being bereaved in those  
21 early stages?

22 **A.** I think it was being close but not being able to respond  
23 to people in the way that we would want to do from  
24 a human perspective. I think just the very nature of  
25 not being able to be in proximity, not being able to  
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1 console, not being able to pray, to embrace, and all  
2 those kind of things. Those are all issues that are  
3 faced to different degrees, and particular communities,  
4 obviously, were hit in particularly ways so therefore  
5 there were some that were hit more severely and  
6 therefore there was not respite.

7 **Q.** Perhaps one example of the provision of in-person  
8 pastoral care being affected actually appears in the  
9 Faith Groups and Places of Worship Roundtable which  
10 I think was attended by yourself, Mr Singleton, as well  
11 as representatives across various religions.

12 If I could just ask for that slide to be put up on  
13 the screen. It's page 12, paragraph 31, and I'll just  
14 read this out:

15 "Representatives described how in-person pastoral  
16 care is a core part of religious life for many faith  
17 communities. This includes faith leaders and other  
18 members of faith communities visiting people in their  
19 homes and hospitals when they are ill or need help.  
20 During the pandemic this was restricted, leaving people  
21 without the support that they would usually have had."

22 So the impact we see in that early stage on local  
23 faith leaders in turn is itself impacting the people who  
24 need that care even more, at that most important time.

25 **A.** Yeah, you have this situation where people are wanting

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1 Spiritual/Pastoral support" and this is a report which  
2 was exhibited to your statement. It details the results  
3 of a survey conducted by FaithAction covering what  
4 members did in 2020.

5 So are you able to, please, to talk us through what  
6 this page and this graphic shows?

7 **A.** Yeah. What we see here -- it is always difficult to  
8 split spiritual and mental health support within a faith  
9 setting because people often just get on and do it but  
10 what we were able to do in this survey was to actually  
11 see the significant growth in mental health support that  
12 was done during the pandemic. And what we see on the  
13 other side is a corresponding, slight decrease of what  
14 would be considered spiritual and pastoral. And as we  
15 explored that, what we saw is that in many ways, faith  
16 leaders and faith communities were responding to broader  
17 needs than just what could be termed "spiritual  
18 activity".

19 So, prayer and visiting, those kind of things, were  
20 down a bit, but there was a significant increase in  
21 different forms of mental health support and wellbeing  
22 and trying to link people to online cafes and different  
23 things like that. And some of our other statistics in  
24 this report show an increase in all of those kind of  
25 what you may call social -- I find it a difficult thing

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1 to help, wanting to reach other people, sometimes even  
2 to put themselves at risk, but they're unable to do that  
3 thing. And so there's a kind of double issue. You've  
4 got the people who need to receive the care and the  
5 people who want to give the care, and both are unable to  
6 give it.

7 One example that we were able to see in Brighton,  
8 the hospital trust worked together with faith groups to  
9 allow voluntary chaplains to come in, because in many  
10 hospitals, unless you were an employee, and many  
11 chaplains are volunteers, they were not allowed to go in  
12 but in Brighton they were allowed to work together with  
13 faiths to allow -- so people from, particularly from  
14 a minority faith were able to have a chaplain from their  
15 own faith and so that's a positive story of people  
16 working together in that sense.

17 **Q.** And then just moving on to the type of care that was  
18 being provided by members of faith communities in these  
19 early stages, I'm going to ask to be shown page 13 of a  
20 FaithAction report, this is entitled "First in, Last  
21 Out: How faith-based organisations have supported NHS  
22 services during the Covid-19 pandemic and what this  
23 means for the future".

24 And there, Mr Singleton, we can see on the screen  
25 a bar chart. This has the title "Mental Health and

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1 to separate social and spiritual in that sense but it's  
2 those different endeavours that we do as humans.

3 So we see an uptick of those.

4 **Q.** So very broadly speaking, then, this is a reflection of  
5 the fact that there is a greater impact on people of  
6 faith communities and we see in this bar chart people  
7 responding to that greater impact --

8 **A.** Yes.

9 **Q.** -- by the provision of social support?

10 **A.** That's right. That's right.

11 **Q.** You also have mentioned moments ago, and you mention in  
12 your statement, a decline in the numbers of volunteers.

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

14 **Q.** Could you help us, first, with quite what you mean by  
15 volunteers in this context?

16 **A.** Yeah, it's always difficult to kind of outline  
17 volunteering within a faith setting because many faiths  
18 have the position of not wanting to make a big noise  
19 about volunteering. People get on and do it, in that  
20 sense. But certainly what we saw was, although there  
21 was an increase maybe of people from a working age,  
22 furlough potentially helped that, and different  
23 restrictions that people volunteered in those ways,  
24 there was a reduction on those who potentially are more  
25 traditionally around, particularly temples and

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1 Gurdwaras, those that -- those people that are part of  
2 providing Langar and different things, so there was  
3 a drop-off, because they were considered part of the  
4 vulnerable, and because of the restrictions upon those  
5 things. So there was that kind of suppression of  
6 classic volunteering although for periods of time within  
7 lockdown there was an increase of new volunteers coming  
8 in.

9 **Q.** And so, bringing it back round to impact again, is the  
10 impact of that that there is less tailored volunteering  
11 in those early months to specific faith communities?

12 **A.** I think that the -- I mean, the very nature of physical  
13 restrictions meant that while we were in total lockdown,  
14 there was just not opportunities, and it took a little  
15 while for faith communities to start working around how  
16 they were going to provide food, how they were going to  
17 provide the community kitchen and things like that, so  
18 that people got there if they had the volunteer base.

19 And on some smaller settings, if you're a smaller  
20 Gurdwara, with an older population, then you'd not  
21 necessarily got the people -- people were shielding and  
22 people were -- and there's a fear factor as well I think  
23 we have to recognise. So there was -- there was a kind  
24 of initial shock in some settings, whereas others  
25 pressed on and increased.

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1 We see mentioned there in paragraph 13 of how  
2 religious communities supported vulnerable people,  
3 ensuring those in need received help with essentials  
4 such as food parcels and medication, emotional support  
5 via the phone to those isolated.

6 And then again, further down, paragraph 14, that  
7 faith leaders acted as a trusted source of information  
8 about key issues like government restrictions.

9 And I know that's something that you'll help us with  
10 when we talk about collaboration, Mr Singleton.

11 But while we have this deep sense of distress, then,  
12 in those early months of lockdown, and loss, for people  
13 from faith communities, we see here that people of faith  
14 were helping to mitigate that loss felt, and the losses  
15 felt by others in society, by helping?

16 **A.** Yes, yeah. I mean, we've often -- we used the term for  
17 our report to be First in, Last Out, and I think  
18 that's -- that's what we often see with faith, it's the  
19 first to respond to particular issues and the last to  
20 leave a situation, and we saw that definitely so  
21 within Covid.

22 I think the other -- the other factor is that people  
23 became much more aware in our daily lives of death and  
24 the desire to connect with something beyond -- beyond,  
25 kind of, where we are at the moment. So I think it kind

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1 So, in terms of tailored opportunities, there was  
2 restrictions. And when we talk about internet access,  
3 that was obviously an issue, but some of those -- there  
4 were issues there in terms of providing for people,  
5 because there was a lack of understanding of what was  
6 safe and what we could do and what regulations would  
7 allow.

8 **Q.** I'm going to move on now, Mr Singleton, to positive  
9 impact in those early stages, and much of this is taken  
10 from the Faith Groups and Places of Worship Roundtable.

11 I'm just going to read a few passages, and if you  
12 could then comment from there. Firstly, from  
13 paragraph 12:

14 "Representatives ... shared how the pandemic gave  
15 some people an opportunity to reconnect with their faith  
16 individually and with their community, and how this  
17 improved their sense of religious wellbeing. "

18 The quote there:

19 "It was encouraging to see how much faith meant to  
20 people and to see people reconnecting with church during  
21 the pandemic."

22 The following quote provided by the Muslim Council  
23 of Britain:

24 "The way people demonstrated their sense of  
25 godliness was their service to others."

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1 of focused people a bit more. And so therefore -- and  
2 they did gravitate -- opportune -- and there were then  
3 opportunities to gravitate and connect with faith in new  
4 ways. So there was -- there was a kind of mobilising  
5 and -- and there was a collective endeavour in terms of  
6 those things, and people could practically see what they  
7 could do, where there was the organising power to enable  
8 that.

9 And that was sometimes the restriction, where there  
10 was organising power to do that, particularly when we  
11 talk about smaller settings with older populations, that  
12 was -- that was often a restriction.

13 **Q.** I'm going to move on now to the impact on places of  
14 worship. And would it be right to say, firstly, that  
15 such a large impact for places of worship in that  
16 initial phase was the financial one?

17 **A.** It certainly -- it certainly was significant, because  
18 what we were led to understand was there -- there is --  
19 there was a lot of, I suppose, for want of a better  
20 term, trading that is done, so -- so a number of bigger  
21 venues will have -- a bigger place of worship will have  
22 conference facilities, they will have charity shops,  
23 they'll have different things where there can be income,  
24 but also as people come as part of their weekly  
25 attendance and people will give donations and therefore

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1 all that stuff slowed down.

2 Now, obviously there was a move for some of that to  
3 go online and to be done electronically, but again  
4 you're hitting the same part of the population,  
5 potentially the older people who are not necessarily  
6 used to doing that and are into more a kind of cash  
7 approach. So that, kind of, lack of footfall and you  
8 get that, kind of slight "out of sight, out of mind"  
9 thing, that did have a particular impact.

10 Q. And that would be across various faith communities?

11 A. Yes, pretty much, yeah. Yeah.

12 Q. There was a paper published and disclosed in Module 10  
13 called the Impact of the Covid-19 Pandemic on the  
14 Exercise of Religion in the UK, published in 2020, that  
15 states -- that has the INQ reference number  
16 INQ000657129. I'm not going to ask for this to be shown  
17 on screen, I'll just read a passage from it, but that  
18 says that income results not only from casual donations  
19 and admission fees to cathedrals and major churches, but  
20 also smaller churches and meeting houses which might  
21 ordinarily offer conference facilities for hire. And  
22 that's described as a critical source of income which  
23 evaporated with lockdown. And it adds, the article,  
24 that unfortunately some of the charity or small business  
25 grant schemes didn't apply to these places of worship?

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1 Q. And --

2 A. You can't do the appeals. You might do an appeal to  
3 your community to get finances in, but you can't do that  
4 as easily when you're not seeing people face to face.

5 Q. Then, what are the wider implications of these places of  
6 worship suddenly really starting to struggle  
7 financially?

8 A. Well, they're unable to provide some of the services.  
9 And some of them, it would probably speed up their  
10 closing in that sense. There is -- coming out of  
11 lockdown, there are issues with smaller locations,  
12 and -- and so that's kind of -- that obviously comes up.  
13 Whether that -- and I think, in that sense, maybe Covid  
14 has been an accelerator on -- on that, in terms of those  
15 fabrics -- those things that are in society. But once  
16 people fall out of the pattern of giving, it's sometimes  
17 harder to get that going again. But that certainly was  
18 something brought up at the time in particular  
19 locations.

20 Some locations moved online and electronic, and they  
21 saw little differences, but many of these that -- where  
22 their location was a key way of earning money, expressed  
23 concern.

24 Q. And I'll just read some extracts from some further  
25 reports which might illuminate the extent of the

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1 So, as you say, it's not the decrease in footfall  
2 necessarily, alone, that has the financial impact, but  
3 the extracurricular bookings.

4 A. Yeah, yeah. And the way the tax -- the way the money  
5 was funded back because of business rates and relief and  
6 that kind of thing. If you're not receiving those, then  
7 you don't get that relief as well. And that's what --  
8 and particularly in that paper, that comes out: that  
9 there's some of those mechanisms that were done  
10 according to small businesses and small charities,  
11 didn't work necessarily for places of worship.

12 And there is still obviously the cost -- you still  
13 get a main -- you still have insurance costs, you still  
14 have to maintain some of those things, even if a place  
15 hasn't been used. And obviously then there's increased  
16 cleaning costs as we come back into ...

17 Q. So, is it the case that, prior to the start of the  
18 pandemic, there might have already been a delicate  
19 financial situation with places of worship?

20 A. Yeah, for some -- for some that would definitely be the  
21 case. And particularly smaller venues. But on some of  
22 the larger things, if you're not getting those large  
23 conferences in, those particular events, then that all  
24 becomes a bit of an issue there. So it is a bit  
25 precarious.

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1 financial impact being had on places of worship.

2 Firstly, in a paper published by Dr Gladys Ganiel,  
3 at Queen's University Belfast, this is called 'People  
4 Still Need Us', INQ000596901, and this is from  
5 a Presbyterian in Northern Ireland who says:

6 "The big thing is how this is financially utterly  
7 devastating. My congregation estimates a loss through  
8 3 areas of estimated £20,000 income in the three-month  
9 period April, May, June. My congregation runs  
10 a separate charity ... [and for the charity] the effects  
11 of our closure of groups and activities are severe."

12 Before I ask you to comment, one more extract from  
13 a further article, 'The Covid cash crisis for religion'  
14 document INQ000660009 states:

15 "This shortage of money has also shrunk the funds  
16 available for social action. Other Muslim and Sikh  
17 leaders have told the RMC [Religion Media Centre] that  
18 charitable giving is being squeezed at both ends, since  
19 more of their congregations need help, and fewer  
20 worshippers have the money to give away."

21 Then, finally, there's a quote provided by  
22 a treasurer from a Catholic diocese in Birmingham, which  
23 reads:

24 "We are giving people the opportunity to exercise  
25 the charisma of giving by donating online, but I do

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1 believe [he says], [we] will survive with God's help ...  
 2 He fed 5,000 with a couple of loaves and fishes."  
 3 So that demonstrates, perhaps quite aptly, what  
 4 places of worship need resources for, they seek to give  
 5 what loaves and fishes they have to the many, but in the  
 6 pandemic, their loaves and fishes are depleting in  
 7 number and they're relying on a miracle to provide to  
 8 others.

9 **A.** Yes, and that's a good picture in that sense. You need  
 10 something to be able to give. And if you think back to  
 11 that social versus spiritual or pastoral thing, that  
 12 there was a need for food, there was a need for  
 13 medicines to be collected and transported and all those  
 14 kind of things, so we see faith groups stepping into the  
 15 gap often, and yet on less resources. And of course,  
 16 just because that happened during Covid, it doesn't mean  
 17 that that problem goes away. It becomes a place to  
 18 track to. And therefore, part of what we do from  
 19 a FaithAction side, we seek to enable those faith groups  
 20 to get funding from other resources, as well, but, you  
 21 know, we've moved from one crisis to another, pretty  
 22 much hot on an energy and then cost of living crisis,  
 23 there is not much -- there's not many loaves left, as  
 24 you said before, counsel.

25 **Q.** Well, I'll move on now to the next phase in the

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1 partly because maybe not being in a workplace or -- that  
 2 there was a good footfall. And I think particularly of  
 3 older people within the South Asian communities  
 4 particularly, at Hindu and Sikh settings. So there was  
 5 a fear factor, I think that government messaging was  
 6 quite successful in creating fear, but then to overcome  
 7 fear was a big issue.

8 And then how to apply the restrictions on places of  
 9 worship, that was difficult. The language often had  
 10 a kind of Anglican high church kind of backdrop which  
 11 didn't allow for more community-based activities from  
 12 maybe a Sikh and Hindu perspective but even from  
 13 a charismatic or Pentecostal setting. Often -- even the  
 14 term "private prayer" was a problem in itself, because  
 15 that doesn't necessarily -- it doesn't mean something --  
 16 people, I think, felt that they were releasing a whole  
 17 bunch of stuff, that they could come into cathedrals and  
 18 churches and have private prayer but actually in many  
 19 settings that has no real value, you don't necessarily  
 20 go to a place of worship for private prayer, you can do  
 21 that at home, it's more corporate activities.

22 So, therefore, there was a sense that there was a  
 23 kind of a two-tier or triple-tier system where some were  
 24 able to start having a significant degree of their faith  
 25 practice, they were able to move into, where others

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1 timeline, the easing of restrictions, and the differing  
 2 impacts experienced whilst those restrictions were  
 3 eased. Firstly, in relation to how groups experienced  
 4 the return to worship in person from May, June 2020, it  
 5 was different across different devolved nations, and  
 6 then we know that in July, restrictions began to ease  
 7 for public worship.

8 But you discuss in your statement, this is from  
 9 paragraph 4.2, the various groups that could not or did  
 10 not simply return with those initial easings in place.

11 Could you tell us who they were, please?

12 **A.** Well, there was obviously an issue with those who were  
 13 vulnerable coming back, and part of the issue was the  
 14 nature of regulation itself didn't always allow for  
 15 faith practices in themselves, and --

16 **Q.** Sorry, to cut you off, Mr Singleton, in fact on that  
 17 note we heard this morning from Ms Wong for the  
 18 Clinically Vulnerable Families explain how clinically  
 19 vulnerable people, as you were just referring to, felt  
 20 excluded from their faith as a result of not being able  
 21 to go back in in these initial periods of restrictions?

22 **A.** Yes, and I think it's probably -- it's worthwhile  
 23 recognising that often it was the clinically vulnerable  
 24 in particular communities, and older people, who were  
 25 more likely to be frequenting those faith locations,

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1 were -- felt completely restricted, still.

2 And I think one of the things it's worth noting is  
 3 that by this time, we knew that outside was pretty safe,  
 4 and there was not the corresponding intelligence or  
 5 literacy to realise actually there could be a bunch of  
 6 stuff that's done outside, and therefore there was these  
 7 constant restrictions about trying to do things inside.  
 8 So we had many discussions and people trying to find  
 9 ways round and work, and part of our desire was to try  
 10 to talk about what was safe and to try and give some  
 11 logic to sometimes restrictions that didn't seem to have  
 12 a great logic to them.

13 **Q.** I just want to expand a little on part of the answer  
 14 that you just gave in relation to private prayer, and  
 15 that not really transferring across different religions.  
 16 Could you just explain that and which religions in  
 17 particular might have been excluded by the use of that  
 18 terminology?

19 **A.** Well, within -- it's interesting to see how people  
 20 decided to interpret this, but I was working  
 21 particularly, I was running our group for Sikh  
 22 communities. And within Sikhism there is the concept  
 23 that you come into the Gurdwara to be in the presence.  
 24 Now, for maybe people from different faiths that could  
 25 look like silent prayer but that's not what it's called

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1 and not how it's regarded. So, therefore, in some  
 2 Gurdwaras they did do that, they allowed that, and  
 3 others wouldn't. And so therefore -- there's an example  
 4 there, and I think, again, private prayer within maybe  
 5 a West African Pentecostal setting, well, you can be  
 6 praying individually, but it's not going to -- it's  
 7 going to be potentially quite exuberant, quite  
 8 energetic, and in a Covid sense may be slightly more --  
 9 well, somewhat more dangerous because of the issue of  
 10 airborne ...

11 So those restrictions, if you were from a high  
 12 church Anglican perspective it made sense, but it didn't  
 13 make sense in other settings, and I think part of the  
 14 problem was that rather than describing what was safe,  
 15 the government got in to trying to be very prescriptive  
 16 about particular practices without really knowing what  
 17 they were.

18 **Q.** You also in your statement mention that some women  
 19 didn't feel that they could as easily return to  
 20 in-person prayer. Why would that have been?

21 **A.** Yeah, so I think one of the things within some settings,  
 22 we have to remember that faith, places of worship come  
 23 in all different sizes. And within some Muslim  
 24 communities, there was not the space given for safe  
 25 settings that women could attend as well as men, and

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1 do with it? What's going to happen with it?

2 The contact tracing and issues about the contents of  
 3 inoculations and all those kind of things, that all was  
 4 part of kind of the same concern which we were trying to  
 5 understand and get past, but there was, because of the  
 6 relationship that government has had with certain faith  
 7 groups and its kind of restricted view or lack of faith  
 8 literacy, as many people say, that there's a lack of  
 9 trust and I think that's one of the key factors here:  
 10 that part of the impact of Covid has been a decline of  
 11 trust, certainly within society, but definitely between  
 12 faith and government in that sense.

13 **Q.** And we'll come round towards the end of your evidence on  
 14 how faith communities can be well placed to challenge  
 15 that position that's emerged.

16 But ultimately, bringing this section back round to  
 17 impact, is it right, then, that despite this initial  
 18 easing of restrictions, there are still some people who  
 19 can't engage in their ritual or their worship so they're  
 20 still being impacted as though they were still in those  
 21 extreme early days of the whole lockdown?

22 **A.** Yeah, I think so, and I think it's to different degrees.  
 23 I think that's the thing, that some felt that -- we had  
 24 some feel that -- come back -- that they were going to  
 25 hang on, I think some of the initial restrictions

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1 then there were issues with children attending, as well.  
 2 So that creates further restrictions.

3 So partly we have to realise that not every faith  
 4 setting is a church surrounded by countryside. Some of  
 5 these are shopfronts, some of these are very small  
 6 locations, some are -- you know. So therefore it's  
 7 quite difficult for people to have different  
 8 restrictions, and also sometimes priorities are given to  
 9 one part of the faith community over another.

10 **Q.** And indeed in the roundtable, I won't ask for this to be  
 11 put on screen, there's discussion of certain  
 12 demographics feeling particularly affected even within  
 13 their religious communities. There's discussion of the  
 14 impact of measures like contact tracing. The roundtable  
 15 at paragraph 47 says that:

16 "... the representative for the Muslim Council of  
 17 Britain spoke about how providing details for contact  
 18 tracing was a barrier to practising faith for some of  
 19 those in their communities because of concerns about the  
 20 Prevent duty or immigration enforcement."

21 **A.** Yeah, and I think that was also picked up by parts of  
 22 the Jewish community, as well, a concern. I think we  
 23 have to remember the context in which we live in today  
 24 of a growing distrust of authority and, therefore, why  
 25 do people need this information? What are they going to

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1 started easing up over the summer. Some said, "We're  
 2 going to wait until September, we're not even going to  
 3 attempt to do things because if we can't all come back,  
 4 we don't want to just have one part of the community and  
 5 not the other part of the community." And certainly  
 6 that's what we pick up, even with the stuff about women  
 7 and older people, some faith communities said "Listen,  
 8 if we can't have everyone, we don't want to do it at  
 9 all, let's have the same amount of restrictions."

10 So it did affect different groups in different ways  
 11 and people dealt with it in different ways.

12 **Q.** And did FaithAction see any compound impact on these  
 13 people as a result of having been further excluded and  
 14 isolated, seeing other members of their community  
 15 engaging with their faith in a way that they couldn't?

16 **A.** I think there were levels of frustration and sometimes  
 17 there would be queries between one faith group and  
 18 another or even between parts of the same faith, some  
 19 discussion, and certainly we were -- part of the benefit  
 20 of having the roundtables we had is that we actually  
 21 gave a place within a single faith setting for people to  
 22 discuss and to talk, and we could then advise and say,  
 23 "Well, this is what -- this is how we understand the  
 24 regulations to be" and people could play it out. But  
 25 that's if they found their way to us and we were able to

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1 curate that discussion. But it wasn't always possible,  
2 in that sense.

3 And there was a sense that people were left behind.  
4 On the other side, there were people who had been  
5 restricted in attending places of worship because  
6 everyone went online during restrictions, there was  
7 a kind of equality of lack of access in that sense and  
8 therefore there was an "All in it together but not  
9 together" so to speak.

10 **Q.** And before we move on to those different experiences of  
11 restrictions in particular, I'd like to move on to how  
12 the easing of the restrictions was perceived among  
13 different faith communities.

14 Now, you explain from paragraph 12.1  
15 a disappointment across the board at the perceived  
16 prioritisation of places such as pubs, bars and  
17 restaurants over places of worship in the easing of  
18 restrictions?

19 **A.** Yeah, I mean, one of the issues -- I think we all  
20 understand that people need access to food, and that's  
21 essential, but I think it's the term "non-essential"  
22 that faith got lumped with, and what we have seen is  
23 that faith is pretty essential to people, and therefore,  
24 the perception that economy was to be prioritised over  
25 faith practice was something that people were

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1 of people's of faith's identity."

2 Then a quote on the following page:

3 "For many people, faith is essential. And it was  
4 being banded with non-essential things like swimming  
5 pools, it was offensive. It wasn't intended but that is  
6 how it came across."

7 **A.** Yeah.

8 **Q.** So thinking, again, of impact, Mr Singleton, what's the  
9 pandemic impact on religious groups of this feeling, the  
10 perception of deprioritisation?

11 **A.** Well, I think that that -- I mean, that's a good quote,  
12 it wasn't intended to be offensive, but it was, I think  
13 is a good way of putting it. And I think it just -- it  
14 compounds the view, the impact is that the government,  
15 public sector, doesn't understand faith, and then it  
16 does contribute to this -- to a lack of trust in that  
17 sense, and I think, during the -- that faith responded  
18 pretty strongly to try to prove itself as having been an  
19 asset, but I think there was a sense of yet again --  
20 because there were various restrictions at various  
21 points -- yet again, there's not an appreciation of  
22 that. So there was a sense of a kind of offence in that  
23 sense.

24 And I think there was -- and because faith was  
25 responding to things like mental health, to all those

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1 particularly upset and concerned about. And I think  
2 also, it showed a level of lack of understanding of the  
3 support and the social glue, and the wellbeing support,  
4 that faith could provide, that, actually, it's  
5 a one-stop shop for many of those things, certainly from  
6 a mental health perspective that could help people.

7 So the fact that restrictions were only eased up --  
8 and then there was quite a bit of discussion had to go.  
9 In the taskforce we had to write an open letter to the  
10 Prime Minister about releasing places of worship earlier  
11 on, and to present evidence on that.

12 So there was a reticence to allow places of worship  
13 to open, and then of course, as soon as you see pubs and  
14 bars, et cetera, open, you do see some spike around  
15 those locations which we didn't see around places of  
16 worship.

17 **Q.** Just to bring this back round to impact, Mr Singleton,  
18 I'm going to ask for a page from the same Faith Groups  
19 Roundtable to be put on screen. This is at  
20 paragraph 15. We see there:

21 "Representatives repeatedly emphasised the  
22 centrality of personal faith, religious practice and  
23 religious community for many people. Representatives  
24 felt frustrated by what they described as a lack of  
25 understanding that religious practice is a core aspect

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1 kind of things, where there was not the ability to  
2 access doctors and medical support in the same way, then  
3 there was this kind of lack of gratitude, lack of  
4 appreciation, in that sense.

5 **Q.** I'm going to ask you next about how specific practices  
6 and rituals were affected by the restrictions that  
7 remained in place. So we've touched on the fact that  
8 they were affected, but some particular examples.

9 You discuss in your statement, and you've mentioned  
10 already, the centrality of certain practices to people's  
11 religion to the extent that after an initial rise in  
12 attendances in July, that by late July, attendances were  
13 dropping, such is the importance of being able to carry  
14 out those rituals to the full.

15 **A.** Yeah, and I think there was -- I think, like anyone,  
16 people of faith -- there was a -- we'd all been locked  
17 up so any freedom was -- people were keen to use, and  
18 where places of worship could utilise some of the  
19 freedoms and there was an opening up, but then there was  
20 the dropping back because actually you couldn't express  
21 yourself the way you wanted to do it.

22 And I think there is an importance of understanding  
23 that -- I was in a briefing just before lockdown, and  
24 the -- I think it was the Deputy Medical Officer said at  
25 that point her concern was not the football match; it

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1 was the pub beforehand and the taxi afterwards. And  
 2 I think that was part of the -- what we realised is that  
 3 it's not always the -- what goes on in the church or the  
 4 mosque, those things can be controlled, but there's  
 5 a lot of the social activities that happen, the greeting  
 6 each other and all those kind of things, and if you  
 7 can't do that bit, it's not part of the full experience.

8 And then -- and that's if you can express your  
 9 faith. But if there's certain rituals and things you  
 10 can't do, then you're not really doing it at all. So  
 11 it's a kind of a half-cocked kind of experience.

12 **Q.** Yes, and some of the examples that you give, guidance  
 13 was that singing was not allowed in places of worship,  
 14 that would impact the practices of a number of  
 15 religions?

16 **A.** Yeah.

17 **Q.** In fact, as you've said already, some places didn't  
 18 consider opening until they knew that they could all  
 19 sing or chant properly?

20 **A.** Yeah.

21 **Q.** And you mention Buddhists being one of those religions,  
 22 religious people who weren't able to chant as a result  
 23 of the restrictions?

24 **A.** Yeah.

25 **Q.** There's an added issue for Muslims, who ordinarily would

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1 do?

2 **Q.** We then come to events. You started your evidence  
 3 saying how it was these life-cycle events that impacted  
 4 people the most, the loss of them, being able to carry  
 5 those out.

6 **A.** Mm-hm.

7 **Q.** The Inquiry has heard already of the disruption to  
 8 funeral practices, the impact that that had on the  
 9 bereaved, and we'll hear more about that next week, but  
 10 you discuss weddings as well, and religious practices  
 11 that tie in with these events. You label these as  
 12 important spiritual and community events for many  
 13 faiths. And you break this down from paragraph 7.2 of  
 14 your statement into how different communities' weddings  
 15 were impacted. Could you talk us through just a few of  
 16 those examples, please.

17 **A.** So, different groups have different practices and,  
 18 therefore, the limit of participants was always going to  
 19 be an issue. I remember particularly, in approaching  
 20 summer 2020, that there was a lot of discussion with  
 21 Jewish groups, because more for orthodox Jews, with  
 22 particular festivals hitting at particular points, there  
 23 were only very small windows of opportunity, and there  
 24 are certain rules within some communities about needing  
 25 to have at least ten men and therefore -- for the thing

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1 take off one's shoes before going into pray. There's  
 2 discussion in the roundtable of other practices such as  
 3 the Eucharist or Holy Communion that weren't able to be  
 4 carried out. So those are just a few examples of  
 5 specific practices.

6 **A.** Yeah. And singing was one of the key factors for many,  
 7 and chanting as well. And also, remember, that's one  
 8 that -- again, performance, singing was allowed before  
 9 worship singing was allowed, in that sense. So that --  
 10 that -- there was that disparagement between it.

11 Again, there was a little bit of research -- again,  
 12 as part of the taskforce there was some research done on  
 13 singing. We pressed the government to do that. It was  
 14 relatively inconclusive, but I don't think there was  
 15 sufficient understanding about the importance of  
 16 corporate singing, chanting, to do the investigation and  
 17 see what was safe or not.

18 Again, the suspicion would be outside -- you know,  
 19 we'd have the Black Lives Matter protests, there was not  
 20 a spike after that. There was chants and calls and that  
 21 kind of thing. So, therefore, outside should have been  
 22 appropriate for those things, but that didn't filter  
 23 through. So then you've got that, again, that offence  
 24 of: well, if this can happen and these people can do  
 25 this kind of thing, then why can't we do what we want to

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1 to be seen as a wedding. I think there's a quote there  
 2 about -- and this was, I think, from a more Christian  
 3 perspective -- about doing ceremonies before the sight  
 4 of god rather than waiting for a legal ceremony.

5 So there was some adaption that was used, but many  
 6 people held off doing those wedding services and those  
 7 kind of things, because it became quite a problem,  
 8 because of the restriction of numbers and all those kind  
 9 of things.

10 And sometimes, when people did try to do some stuff,  
 11 where people were living close to one another, sometimes  
 12 people would get together if their houses were next to  
 13 each other and do stuff in the gardens and try to do  
 14 stuff so they had their numbers together, sometimes that  
 15 was frowned on by authorities as well, even though  
 16 technically it was all right.

17 So there was some flexibility, but for many people  
 18 within faith settings, weddings -- obviously funerals  
 19 we'll come to, but weddings are important -- more  
 20 important to be done within a religious setting than  
 21 they are in a legal setting, so, therefore, restrictions  
 22 to those practices were felt more fundamentally.

23 And I know myself, within my faith community there  
 24 were a number of weddings done -- or I heard of friends  
 25 that did weddings on beaches, that people could drive

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1 up -- parts of Northern Ireland where you can drive on  
2 the beach and that kind of thing -- and I think they had  
3 fish and chips for their wedding breakfast. It probably  
4 saved them a lot of money but generally I don't think  
5 that worked that well.

6 So, therefore, you've had these key life events that  
7 you've not done in the sight of things, and you've  
8 got -- and life moves on.

9 If I can give a personal example, my father was  
10 diagnosed with motor neurone disease a week before  
11 lockdown. We were told it was already in the vulnerable  
12 stage. As we left the consultant, he turned to us and  
13 said, "You must hide from this disease." So I brought  
14 my brothers in to tell them the news and sat them in two  
15 corners of the room. And a couple of weeks later I was  
16 on the phone to my father and he said, "I'm looking  
17 forward to us having a hug", but Covid and restrictions  
18 meant that he was never able to hug me again because  
19 he'd lost the use of his arms.

20 Now, it's not a life-cycle event but it's an  
21 interesting thing about how these -- that was a personal  
22 impact: we were never able to embrace again. And  
23 I think, in life-cycle events, there is that need for  
24 that human contact. And because of the nature of the  
25 disease and because of the nature of things we had to

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1 religions, and -- and sometimes that was allowed,  
2 sometimes it wasn't allowed. Sometimes because  
3 different types of regulation, often because there was  
4 the interpretation at local level.

5 I think the biggest issue probably that came up that  
6 we were aware of was the desire within Jewish and Muslim  
7 communities to have a burial within 24 hours. And  
8 depending on the nature of the area, the nature of what  
9 was going on, in terms of funeral facilities, that often  
10 was not able -- we weren't able to do that. And I think  
11 that created -- you've got people who are parting, and  
12 you're unable to do the thing that you want to do and  
13 the thing that your community expects, and the thing  
14 that your relative expects you to do.

15 So I think that creates -- you can never have that  
16 time again, and I think that's -- that's a tricky thing.

17 In some ways, a wedding, hopefully those people will  
18 be around for you to celebrate and do something with,  
19 but a funeral, you know, it's your last go, and so -- so  
20 that was often something that we had quoted.

21 And some areas and some directors of public health  
22 were creative on that, but many -- many weren't able to  
23 do that. And obviously in some parts of the country  
24 there were greater rates of death about -- within  
25 particular communities than others, and that creates

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1 do, we were -- those opportunities were taken away from  
2 people. And we see that particularly obviously as we  
3 look at funerals as well.

4 **Q.** And on funerals, in fact -- I'll just ask, in fact, for  
5 a page to be brought up from the Faith Groups and Places  
6 of Worship Roundtable at paragraph 26. This states:

7 "Representatives across different religions felt  
8 that restrictions on funerals were one of the main  
9 impacts on their faith communities during the pandemic,  
10 affecting people's wellbeing and ability to grieve in  
11 a way that reflected the traditions of their faith."

12 So it comes back to faith, doesn't it, Mr Singleton?

13 Then the quote from Churches Together Scotland:

14 "The best parts of faith practice supporting people  
15 through bereavement were denied by Covid-19, which has  
16 left scars and has drained a lot of people's emotional  
17 energy along the way."

18 Now, again, focusing on the religious aspect to  
19 bereavement, because we will be discussing bereavement  
20 in the Inquiry in the next week or so, are you able to  
21 give some examples of specific, again, religious  
22 practices which would have been invariably impacted when  
23 it came to the pandemic and bereavement?

24 **A.** Yeah. I believe in our evidence we give some example  
25 of -- of ritual washing that is common with a number of

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1 issues.

2 **Q.** And an example, in fact, bringing that together with the  
3 issue of being buried within 24 hours of passing, comes  
4 up in the Bereavement Every Story Matters report.

5 My Lady, this is INQ000659894. I'm going to ask for  
6 page 32 to be put on screen.

7 That passage from a bereaved daughter in England  
8 reads:

9 "Culturally and religiously you're meant to be  
10 buried within 24 hours of passing away, and returned to  
11 the ground, kind of thing, to the earth, but with Covid  
12 that totally destroyed all of it, and it affected the  
13 Muslim community hugely ... [my father's] funeral was  
14 about 2 weeks later, maybe even 2.5 weeks later which is  
15 quite shocking, and unusual, and unheard of, and what  
16 was happening at that time is that there were loads of  
17 bodies just in, I guess, morgues."

18 And it's because of the faith ritual around  
19 bereavement that that has an added impact on this  
20 bereaved person in England?

21 **A.** Yes, yes.

22 **Q.** Moving on to an even broader event, religion festivals  
23 being affected.

24 **A.** Mm-hm.

25 **Q.** Now, the roundtable, I'm going to ask again for

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1 paragraph 44 to be put on screen.  
 2 This is the places of worship roundtable, again.  
 3 This is about the timing of restrictions in  
 4 December 2020, explains how this affected carol service,  
 5 midnight masses, Christmas Day services, and:  
 6 "Representatives explained that the timing of these  
 7 lockdowns was difficult and disappointing for those  
 8 preparing to observe these important festivals and for  
 9 religious leaders who had to change plans quickly."  
 10 There, at the end of the paragraph.  
 11 In your statement, from paragraph 8 you discuss the  
 12 timing of the local lockdowns in July 2020, and the  
 13 impact that had on the Muslim community. Could you  
 14 expand a little on that, please.  
 15 **A.** Yeah, different -- different announcements happened at  
 16 different stages, but certainly there was -- there was  
 17 a sense coming from our Muslim roundtable members that  
 18 there were -- there was a particular anti-Eid kind of  
 19 approach, and one of the things that we saw consistently  
 20 is the announcements and regulations always came out, it  
 21 felt, very late, and often without -- and I think the  
 22 example that you read about, the Christmas stuff, the  
 23 information comes out very late, and it gives very  
 24 little time for people to respond to it. And that was  
 25 certainly the case with Eid.

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1 are some who are doing better than others, within faith  
 2 communities, but often broader than faith communities.  
 3 **Q.** That leads me to the next set of questions,  
 4 Mr Singleton.  
 5 Looking at the perception of the prioritisation of  
 6 Anglo Christian traditions in either the making or the  
 7 easing of restrictions, now that's a concern that you  
 8 highlight in your statement that you were witness to in  
 9 your role at FaithAction during the pandemic. Was it  
 10 discussed at weekly meetings, did -- (overspeaking) --  
 11 **A.** Yeah, it often came up with the -- the consultations we  
 12 were doing with faith groups. There was a level of  
 13 discussion even in the taskforce and with individual  
 14 officials that were relatively well versed on what was  
 15 going on in faith communities that was recognised. But  
 16 it always felt that sometimes decisions were being made  
 17 somewhat further away than the information we were  
 18 getting through, and there was this kind of -- it felt  
 19 like there was always an assumption of an Anglo-Catholic  
 20 kind of religion, and therefore that meant that  
 21 particular groups felt neglected. And those potentially  
 22 were the groups that of course were most affected by  
 23 Covid itself, being those within particular ethnicities  
 24 and those that were often within the NHS and working and  
 25 taking risks in that sense.

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1 There was also a denial from government that there  
 2 was a restriction aimed at Eid, and yet Muslim members  
 3 of our group said they could see some issue, because  
 4 again that human contact thing again, that people want  
 5 to celebrate, they want to pray and hug and those kind  
 6 of things, but that was denied as a particular issue, so  
 7 you see that root of trust coming in there: the  
 8 government says one thing but the communities think  
 9 something else.  
 10 The other issue was, I felt, was about Christmas.  
 11 Christmas being allowed but New Year's not. What -- and  
 12 I think it's interesting, counsel, just to note that  
 13 there's religion and there's culture and they tend to  
 14 roll together, so that part of our feedback is that  
 15 Christmas could be regarded as a festival predominantly  
 16 for white communities, but actually that within, even  
 17 within Christianity, the black churches, the  
 18 Afro-Caribbean churches, the West African churches, are  
 19 much more likely to have a bigger celebration when it  
 20 comes to New Year's.  
 21 So then you had this pattern of it seems to be,  
 22 again, Anglo church basis that seemed to be doing all  
 23 right, although on this particular thing, late notice,  
 24 that was an issue.  
 25 So again, the impact is this perception that there

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1 So there was this, kind of, this constant discussion  
 2 going on, and most times you could point out the  
 3 regulations and how it made sense, but there were times  
 4 like the Christmas and New Year thing, it just didn't  
 5 make sense, and that's hard to justify.  
 6 **Q.** So if different members of different faith communities  
 7 are experiencing things differently across the board,  
 8 perhaps to Anglo-Christian traditions, then again the  
 9 impact on those other communities, for want of a better  
 10 word, is more exaggerates because they can't access the  
 11 coping mechanisms that they turn to faith for?  
 12 **A.** Yes, yes. So you've got that sense you feel neglected,  
 13 you're also feeling restricted in that sense, and it  
 14 seems that others are doing all right. I would say that  
 15 rarely did we have any tension between faith groups. So  
 16 we would do multi-faith settings, and we rarely had any  
 17 sense of tension between them. So it was directed  
 18 towards government in that sense, but there was -- there  
 19 was often the phrase, you know, "They don't understand  
 20 us, they're not interested", or those kind of things.  
 21 **Q.** And on that I'll ask for another page to be put on  
 22 screen, please, this time paragraph 39 of the Faith  
 23 Groups Roundtable. It reads:  
 24 "Representatives for the Muslim Council of Britain  
 25 and the Hindu Council UK felt that they had limited

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1 access to the government during the pandemic. The  
 2 representative from the Muslim Council of Britain felt  
 3 that having limited engagement with the government meant  
 4 that they had to do their own tailoring of guidance,  
 5 leading to concerns early on in the pandemic about  
 6 communicating the wrong message without government  
 7 reassurance."

8 So again, Mr Singleton, it's this perception of not  
 9 being catered for in the guidance, and the result, at  
 10 least here, appears to be that representatives are  
 11 having to interpret the guidance in a less clear way  
 12 than, say, perhaps, someone in the Anglo-Christian  
 13 community might.

14 **A.** Yeah, and it depends on the expertise that different  
 15 communities can draw on in that sense, as well. So  
 16 there are ... there are -- the Catholic Bishops have  
 17 great representation of people with public health  
 18 knowledge, and actually within the Muslim community,  
 19 BIMA is a very good medical organisation to connect to,  
 20 but part of what we see here, part of the impact is that  
 21 government did not have, and continues not to have,  
 22 consistent ways of connecting with faith groups and  
 23 getting under the surface of what's happening.

24 So, therefore, those routes through and testing,  
 25 even the nature of regulations, when you looked up faith

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1 Muslim community (whose gatherings had been said to have  
 2 spread Covid-19) resulted in negative comments within  
 3 the press and wider public discourse, leading to a sense  
 4 that their religion had been singled out."

5 So here, Mr Singleton, we have some examples how  
 6 simply being a member of a certain faith would have  
 7 impacted individuals.

8 **A.** Yeah, and we have to remember there was a -- people had  
 9 a lot more time and a lot more access to Internet and  
 10 various different, you know, rumours would spread very  
 11 swiftly and we'll see that when we go on to looking at  
 12 things like vaccinations. So there was, there was --  
 13 there were various conspiracy theories that were kind of  
 14 kicked around, but both the Jewish community and the  
 15 Muslim community were more victims of Covid in many  
 16 senses, as well, because of particular ways it hit  
 17 particular areas, and so it's tough when you're getting  
 18 conspiracy theories thrown against you and you're  
 19 suffering the real physical danger at the same time.

20 So there was a level to things flying around, and it  
 21 was difficult for particular groups within that time.  
 22 But when pressure comes, you tend to get those things,  
 23 as we see today.

24 **Q.** Well, I'll move on now to innovations among faith  
 25 communities.

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1 places of worship regulations, you had to jump from page  
 2 to page, going from business to education to all  
 3 different things because it wasn't put together in  
 4 a coherent fashion for faith in that sense.

5 So being able to double-check and go back is -- was  
 6 part of the problem, in that sense.

7 **Q.** And so the importance here is that greater  
 8 communication, collaboration between all groups and  
 9 agencies is key to ensuring that people don't feel left  
 10 behind, and allowing them to continue engaging in their  
 11 faith practices, which themselves are often coping  
 12 mechanisms?

13 **A.** Yeah.

14 **Q.** Before we move on to innovations, I'd just like to show  
 15 one more paragraph from the Faith Groups Roundtable,  
 16 this is paragraph 17, and this reads:

17 "Some representatives described how members of their  
 18 communities experienced racism and were targeted by  
 19 conspiracy theorists during the pandemic. The  
 20 representative for the Jewish Leadership Council shared  
 21 that there was a negative impact on the wellbeing of the  
 22 Jewish community caused by a conspiracy theory that  
 23 Covid-19 was a Jewish disease, and that this led to an  
 24 increase in antisemitism. The Muslim Council of Britain  
 25 representative described how political criticism of the

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1 Now, we've touched already on the move online, and  
 2 we've heard evidence of the move online and its impact  
 3 on people with mental health problems before, so I just  
 4 want to touch lightly on this, that invariably there was  
 5 a necessity to move things associated with people's  
 6 faith online, and there were worship services held  
 7 online; is that right?

8 **A.** Yeah, I mean, one of the issues with online is the --  
 9 you can't sing or chant together. There's a lag. It  
 10 can be performed, but you can't join in, or hear each  
 11 other in that sense. So -- and any call or response  
 12 would have that same lag, that same issue.

13 **Q.** So it's still exclusive of certain rituals --

14 **A.** Practices, yeah.

15 **Q.** -- practices, and certain communities. There's mention  
 16 in the roundtable report of technology itself not being  
 17 permitted on the Sabbath for orthodox Jews so they  
 18 couldn't --

19 **A.** No.

20 **Q.** -- have the move online the same way that other  
 21 communities did.

22 **A.** And I think it's important to note that you can have  
 23 a silver bullet theory. Everyone can do everything  
 24 online, and you look at the practice, and then forget  
 25 that no, orthodox Jews can't operate technology in that

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1 sense. So that, again, is a -- we often term that as  
2 faith literacy but it's actually working out that, okay,  
3 it can't happen for this reason. It's not as easy as  
4 opening a restaurant or a, you know -- there's different  
5 restrictions.

6 **Q.** And there's mention in your statement of the centrality  
7 of the place of worship itself and the importance of  
8 church to perhaps Christians' experiences of their  
9 faith?

10 **A.** Mm-hm.

11 **Q.** There's a specific example of the move online that you  
12 reference, enabling over 1.5 million people to watch  
13 teachings from the Dalai Lama, so there were positives  
14 to be taken from the move online?

15 **A.** Yes, yes.

16 **Q.** But perhaps not universal.

17 Moving on, then, to other innovations or action that  
18 we can learn from going forward. One thing that seems  
19 to come through your statement and the roundtable and  
20 throughout your evidence today is the increase in  
21 collaboration across the board and the positives that  
22 have been brought from that in the pandemic.

23 We've spoken already about the increase in certain  
24 volunteer social community activities, delivering  
25 groceries, supplying food parcels, so there's that

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1 necessarily in place, other means had to be taken up.

2 So, the chair of the All-Party Parliamentary Group  
3 at the time, Stephen Timms, talks about, in Newham, how  
4 he was contacted by the council and said if people  
5 contact the constituency office and ask for food,  
6 they're to phone this particular vicar and he will  
7 ensure that there's food by 10 o'clock at night.

8 So there was a swift response from faith to those  
9 kind of things, while, to some extent, the state took  
10 a while to come into place, because of the mechanisms,  
11 because they're already kind of light on their feet to  
12 respond.

13 **Q.** And again, bringing it back round to impact, that's as  
14 a result of there being a greater impact on people in  
15 the community, and people in faith communities seeking  
16 to step in and help where they can?

17 **A.** Yeah. And we have to remember that faith in itself,  
18 it's not -- it's not just a badge of identity; it's  
19 a set of beliefs in that sense. And all faiths pretty  
20 much have a duty to the widow and the orphan. The widow  
21 are those without economic independence in today's  
22 society, and the orphans, those without a place of  
23 belonging. So there's quite a broad area that faith  
24 would feel that it needs to respond, there's a duty to  
25 respond, there's not necessarily a choice there.

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1 increased sense of community and the importance of that.

2 Are you able to say how that ties in with faith?

3 **A.** So the -- faith being the first port of call in that  
4 sense and having access to communities and knowing  
5 what's happening at different areas. Already there is  
6 a strong network within the UK of food banks, most of  
7 them are located at places of worship. So there's  
8 already some factors there. And I think in our reports  
9 we talk about an increasing of help, people didn't  
10 necessarily innovate completely new things but they  
11 developed more of what they were doing. So that was  
12 extended.

13 And if you have a relational bridge, if you have  
14 some kind of mechanism already in place, if you're  
15 delivering food you probably can deliver medicines or  
16 you can go and visit people in their gardens and -- or  
17 do different things like that. So there was a case of  
18 retooling relationships. So -- and we saw that in  
19 particular areas which have got the Faith Covenant. So  
20 that was brought together. So, for instance, I think in  
21 Essex, it was brought together around mental health  
22 before Covid but then it was retooled for different  
23 things, because it already existed and people knew each  
24 other.

25 And to some extent, because officialdom wasn't

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1 There's a sense that because of -- because of our faith,  
2 we need to respond to these particular issues.

3 **Q.** And in terms of the increased collaboration that you've  
4 mentioned in the course of your evidence, you've also  
5 mentioned the impact that faith communities might have  
6 had around vaccines, and the impact that faith  
7 communities could have when it comes to a distrust of  
8 certain people in the country at certain times.

9 Are you able to help with how people in faith  
10 communities sought to mitigate those impacts during the  
11 pandemic?

12 **A.** Yeah, and it was a particular issue that -- that there  
13 was a distrust. Partly people were probably more  
14 subjected to conspiracy theories, having had more time  
15 to be online, but -- but there were issues. The turning  
16 around of the Covid jab so swiftly caused people  
17 concern. But there is -- I think what we came to  
18 understand as the positive impact of faith was actually  
19 helping people grow in trust. So, as I said earlier,  
20 initial response from NHS officials were "We don't need  
21 faith", because they were looking from a geographic  
22 response, "We've got this centres", but what they  
23 weren't really understanding is they needed to have that  
24 trust response, and that that anchor in institutions,  
25 faith institutions, the relationships that faith have,

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1 meant that they could walk people through, and deal with  
2 some of the queries that people had around -- around the  
3 Covid jab. Which, of course, in the -- first,  
4 everything was very successful, but we did have to bring  
5 into play, often, large churches, large mosques, at --  
6 which didn't just perform for those communities as well,  
7 they became points of safety and connection, and -- and  
8 therefore there is that great opportunity, one of the  
9 positive impacts could be to see faith as an asset to be  
10 utilised.

11 **Q.** And on that note, representatives in the roundtable --  
12 it may well have been you -- suggest that the  
13 strengthening of communication between government and  
14 faith communities would reduce impact on faith  
15 communities in any future pandemic. There is also  
16 mention of the impact of functioning of informal public  
17 health actors in faith community activities.

18 So are these things that chime with you in your --  
19 **A.** Yeah, and I think one of the -- one of the key phrases  
20 we say is that faith reaches the parts that nothing else  
21 can.

22 So it can get to people. People are more likely to  
23 connect with faith than they are with other official  
24 kind of connections, those kind of things. They are  
25 more likely to attend a mosque or a church or a temple

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1 help. And I have said it's comprehensive, but if  
2 anything else occurs to you, don't worry, I will be  
3 taking very much into account witness statements and, of  
4 course, the roundtable events. So -- and thank you for  
5 participating in that. Did you find it an interesting  
6 experience?

7 **THE WITNESS:** It was very interesting. Thank you, my Lady.

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

9 Very well, I'll take a break now and I shall return  
10 at 2.55.

11 (2.40 pm)

(A short break)

13 (2.55 pm)

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

15 **LADY HALLETT:** I can, thank you.

16 **MS BLACKWELL:** My Lady, the final witness for today is  
17 Francesca Humi. May she be sworn.

18 **MS FRANCESCA HUMI (affirmed)**

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

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

21 **A.** My name is Francesca Humi.

22 **Q.** Thank you very much. I know that you don't have it  
23 before you, but you have had a copy of your witness  
24 statement with our reference INQ000659851. Can you  
25 please confirm that that witness statement has been

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1 than they are to register with a doctor. Those things  
2 will happen first. And therefore those informal and  
3 trusted networks -- the power of the person you know  
4 recommending something is still something -- you know,  
5 despite all the information that's available, we still  
6 trust each other more than we do. So, therefore, the  
7 ability that faith has to reach those people that are  
8 furthest from services are key.

9 And one of the factors that we recognise very early  
10 on with the work that we were doing with the Health and  
11 Wellbeing Alliance is the prediction was that health  
12 inequalities would increase over Covid because the same  
13 people who had the worst outcomes would potentially be  
14 the most affected. And I think that's where we saw that  
15 faith had got a way of reaching those people and  
16 connecting and potentially getting the messages out that  
17 need to be got out, to help people overcome Covid and  
18 the pandemic.

19 **MR JACKSON:** Thank you very much, Mr Singleton.

20 My Lady, those are my questions.

21 **LADY HALLETT:** Thank you very much, Mr Jackson.

22 Thank you, Mr Singleton, for your help, an  
23 extraordinarily comprehensive review of so many  
24 different faiths and the problems that faced the faith  
25 communities. Thank you very much indeed for all your

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1 provided jointly on behalf of a number of organisations,  
2 making up the Migrants' Rights Consortium?

3 **A.** Yes.

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

6 **A.** Yes.

7 **Q.** Thank you.

8 I'd like to begin by setting out, please, the  
9 organisations who make up the Migrants' Rights  
10 Consortium. They are as follows: Doctors of the World  
11 UK, an independent humanitarian organisation which  
12 facilitates equitable access to medical services for  
13 marginalised and disadvantaged communities; the Joint  
14 Council for the Welfare of Immigrants, a charitable  
15 organisation dedicated to advancing justice, fairness  
16 and equality within immigration and asylum law;  
17 Kanluga, which you are a member of, a charity  
18 consisting of several Filipino and Southeast and East  
19 Asian community organisations, which work for the  
20 welfare and interests of migrants, refugees, and  
21 communities from the Philippines and east and south east  
22 Asia living in the UK; Medact, a collective of  
23 healthcare workers which focuses on investigating and  
24 analysing the social and environmental factors that have  
25 a detrimental impact on health; Project 17, a charitable

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1 organisation working to end destitution amongst migrant  
 2 children; JustRight Scotland, a human rights legal  
 3 charity which, during the pandemic, provided legal  
 4 advice and representation to refugees and migrants,  
 5 victims of trafficking and exploitation, and survivors  
 6 of domestic abuse in Scotland; Together with Migrant  
 7 Children, a charity supporting children and young people  
 8 and families where migration is a factor; United Voices  
 9 of the World, a member-led anti-racist campaigning  
 10 organisation supporting low-paid working class and  
 11 predominantly those from black, Asian and minority  
 12 ethnic backgrounds, as well as migrant workers across  
 13 the UK; and finally, the Independent Workers of Great  
 14 Britain which was established by Latin American cleaners  
 15 for better pay, pensions and working conditions in  
 16 London and now includes couriers, porters, security  
 17 officers and private hire drivers.

18 Thank you.

19 Terminology is important in your evidence, and I'd  
 20 like to just set out with you a couple of phrases that  
 21 we're going to use throughout the course of your  
 22 evidence.

23 The first is what's referred to as the hostile  
 24 environment. That broadly refers to measures which  
 25 identify and reduce the number of persons in the UK

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1 because they don't have valid leave to remain.

2 **Q.** All right. Well, let's look at the list of migrants,  
 3 because there are a number of different types of  
 4 migrant, aren't there, and there are subgroups within  
 5 that description?

6 And if we can look at page 13 and paragraph 55 of  
 7 your witness statement, please.

8 We can see that you here set out what you describe  
 9 as:

10 "... a non-exhaustive list of the different  
 11 sub-groups to which [Migrants' Rights Consortium] seeks  
 12 to give a voice [during the] evidence to the Inquiry  
 13 [including]:

14 "i) Asylum seekers whose applications remain  
 15 outstanding.

16 "ii) Asylum seekers who have received a negative  
 17 decision and who are appealing it, whose appeal rights  
 18 have been exhausted and/or who are seeking to submit  
 19 a fresh claim.

20 "iii) Asylum seekers whose application has been  
 21 refused facing removal (but who could not be removed  
 22 during the pandemic)."

23 And we'll come to look at why that might have been.

24 "iv) Destitute asylum seekers and unsuccessful  
 25 asylum seekers reliant on Home Office accommodation.

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1 without leave to remain, many of which, the provisions  
 2 of which were introduced by the immigration Acts of 2014  
 3 and 2016, and those measures include restrictions and  
 4 checks on the right to work, to rent accommodation, to  
 5 have a bank account, to hold a driving licence and,  
 6 indeed, to access benefits or other free treatment from  
 7 the NHS; is that right?

8 **A.** That's correct.

9 **Q.** Thank you.

10 Migrant people who do not have leave to remain in  
 11 the UK, including visa overstayers, those who have  
 12 entered the UK without permission, and asylum seekers,  
 13 do not have access to public funds.

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

15 **Q.** And is that often referred to as "no recourse to public  
 16 funds"?

17 **A.** So, no recourse to public funds is a specific condition  
 18 that is attached to visas that are issued. So you could  
 19 be a migrant on a Skilled Tier 2 visa and have a no  
 20 recourse to public funds condition attached to your  
 21 permission to be in the UK. So, essentially, migrants  
 22 in general are barred from accessing mainstream  
 23 benefits.

24 **Q.** Yes.

25 **A.** And sometimes it's through NRPF or sometimes it's

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1 "v) Asylum seekers who have been granted refugee  
 2 status or humanitarian protection.

3 "vi) Migrants with long-term (or 'indefinite') leave  
 4 to remain.

5 "vii) Migrants with fixed term (or 'limited') leave  
 6 to remain.

7 "viii) Migrants on a dependency visa or subject to  
 8 on-going eligibility conditions.

9 "ix) Migrants subject to [a no recourse to public  
 10 funds] condition.

11 "x) Migrant victims of human trafficking or modern  
 12 slavery.

13 "xi) Undocumented migrants with no lawful  
 14 immigration status (who either entered the UK without  
 15 permission, entered lawfully but overstayed their visa,  
 16 or did not leave the UK after an application for leave  
 17 to remain or their claim for asylum was refused)."

18 So it covers quite a spectrum of situations, from  
 19 migrants who have successfully been through the system,  
 20 and who have been -- who have a leave to remain, all the  
 21 way to those whose applications have entirely been  
 22 refused.

23 And is it right, then, that taking a migrant from  
 24 one end of the spectrum and one from the other, they may  
 25 have had a very different experience during the

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1 pandemic?

2 **A.** Yes, it would have varied according to the type of

3 immigration status that they had --

4 **Q.** Yes.

5 **A.** -- to the type of accommodation that they were in. So

6 whether they were in Home Office accommodation, in

7 barracks, or if they were in the private rented sector.

8 And also depending on whether they were healthcare

9 workers, social workers, because, as we know, many

10 migrants were at the front lines.

11 **Q.** Yes. Going back to no recourse to public funds, is it

12 right that at the end of 2020, so during the pandemic,

13 there were an estimated 1.48 million people who held

14 visas that come with a no recourse to public funds

15 condition?

16 **A.** Yes.

17 **Q.** And is it also right that the government didn't suspend

18 either hostile environment measures or the normal no

19 recourse to public funds rules during the Covid

20 pandemic, despite the fact that the government at

21 various times, and through various organisations, were

22 asked to do so?

23 **A.** That's correct.

24 **Q.** All right.

25 As of June 2021, is it right that the UK's

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1 characteristics of vulnerabilities specific to migrant

2 communities, please. There are five areas which are set

3 out within your witness statement, the first of which is

4 mental and physical health.

5 You tell us at paragraph 61 of your statement that

6 some individuals within the asylum seeking and refugee

7 community have experienced trauma arising from sexual,

8 physical, and psychological violence, torture,

9 trafficking, exploitation and/or loss in violent and

10 distressing circumstances, those circumstances often

11 having been what has led them to the UK.

12 So according to research, your research, were asylum

13 seekers five times more likely to have mental health

14 needs than the general population, going into the

15 pandemic?

16 **A.** Yes, that's correct.

17 **Q.** All right. Destitution and household overcrowding. You

18 tell us at paragraph 64 that more than a quarter of

19 destitute households in the UK, as of 2022, so at the

20 end of the pandemic, were headed by foreign-born

21 individuals; is that right?

22 **A.** Yes, and the risk of destitution for migrants is 35%

23 higher than the average.

24 **Q.** Thank you. And put in statistical terms, as well, in

25 the UK, migrants had a 22% higher risk of infection

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1 population was made up of an estimated 9.6 million

2 foreign-born people which at that time was the

3 equivalent of 14.5% of the population?

4 **A.** Yeah, that's correct.

5 **Q.** Thank you. Which groups that we have just looked at in

6 the list that you've provided at paragraph 55 did not

7 have access to public funds, then?

8 **A.** So it would have been the majority of people on that

9 list. The only migrants who are not given a no recourse

10 to public funds condition are people who are on a spouse

11 or partner visa, or people who have indefinite leave to

12 remain.

13 **Q.** Right.

14 **A.** Migrant access to the benefits system is quite

15 complicated, but broadly, migrants, including asylum

16 seekers, do not have access to the mainstream system,

17 but they might get specific support through specific

18 schemes or specific routes.

19 **Q.** All right. So it's not simply a question of looking

20 through the list and saying, "They would, they

21 wouldn't", it's more complicated than that?

22 **A.** Yes.

23 **Q.** Yes, all right.

24 Thank you very much, we can take that down.

25 I'd like to turn to look at some of the

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1 during the second wave of the pandemic, compared to the

2 UK-born population; is that right?

3 **A.** Yes.

4 **Q.** In addition to which, was poverty a driver that forced

5 people to continue to undertake frontline work,

6 including migrants, at increased exposure risk to avoid

7 further financial hardship, according to your research?

8 **A.** Yes.

9 **Q.** Thank you. And linked to that was the increased

10 exposure to Covid-19 infection through being reliant,

11 for example, on public transport?

12 **A.** Yes.

13 **Q.** Was it reported to you that between December 2020 and

14 February 2021, that those in the most deprived 40% of

15 the population were three to five times more likely to

16 use public transport, and up to eight times more likely

17 to use taxis compared to those in the top 20%?

18 **A.** Yes.

19 **Q.** Digital access linked to destitution. You tell us at

20 paragraph 69 that during and after the pandemic there

21 was a move to digitalisation of primary care with

22 virtual appointments replacing face-to-face

23 consultations. Did this cause particular problems for

24 some migrants and, if so, why?

25 **A.** Yes. So it did cause problems because there is an issue

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1 with digital poverty in the migrant population, because  
 2 there are higher rates of destitution and poverty within  
 3 migrant communities. So then, in terms of having the  
 4 right data or having the right phones in order to access  
 5 the digital services, that would be more difficult. But  
 6 on the other hand, a lot of migrants who tend to be  
 7 younger are -- might be more tech savvy and might have  
 8 a smartphone and so might find it easier to access  
 9 with -- in that regards. And it's also easier to  
 10 translate information that's digital.

11 **Q.** Do you mean translate into a different language?

12 **A.** To translate into a different language, yes.

13 **Q.** Thank you. Is there an overlap with black, Asian and  
 14 minority ethnic communities and the experience that we  
 15 know, during the evidence that the Inquiry has received  
 16 and considered, the experience that they had during the  
 17 pandemic?

18 **A.** Yes, definitely. And I believe about half of BAME  
 19 people in the UK are foreign born so there would be  
 20 a huge overlap in experiences.

21 **Q.** Thank you. And you tell us at paragraph 70 of your  
 22 statement that from 1 September 2020 to 22 May 2021,  
 23 Asian communities experienced up to double the rate of  
 24 infection in relation to Covid compared to those from  
 25 white British backgrounds?

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1 disproportionate number of Covid-19 deaths among  
 2 Filipino health and careworkers in the UK. For example,  
 3 you say that in May 2020, 22% of Covid deaths amongst  
 4 NHS nurses were Filipino?

5 **A.** Yes, and that's especially disproportionate when you  
 6 consider that only 3.8% of the nursing workforce were  
 7 Filipino, so that is a really big disproportionate  
 8 impact. And in general there was a disproportionate  
 9 impact on migrant healthcare workers, for example 83% of  
 10 ethnic minority healthcare worker deaths were  
 11 individuals who had been born outside of the UK, and  
 12 that was in April 2020. So with the Filipino statistic,  
 13 I think it shows an example of that extreme level of  
 14 disproportionate risk, but was symptomatic of a broader  
 15 issue of migrants being consistently pushed to the most  
 16 dangerous and the most frontline roles during the  
 17 pandemic.

18 **Q.** Thank you.

19 Moving to look at mortality rates of marginalised  
 20 communities due to Covid-19 transmission, you say at  
 21 paragraph 159 that:

22 "From the outset of the pandemic, migrants faced  
 23 a significantly higher risk of infection and death  
 24 compared to the general population."

25 Is that right?

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1 **A.** Yes.

2 **Q.** Thank you. Turning to frontline and essential work and  
 3 the frontline workforce. At paragraph 73 you say that  
 4 in 2020 and 2021 it is estimated that migrants comprised  
 5 18% of the employed workforce in the UK, and that  
 6 migrants were particularly overrepresented in the  
 7 hospitality sector, comprising 28% of workers; the  
 8 transport and storage sector, comprising 26% of workers;  
 9 the information and communications sector, comprising  
 10 25% of workers; and the health and social work sector,  
 11 comprising 21% of workers. Is that right?

12 **A.** Yes.

13 **Q.** Yes. East and Southeast Asian migrants, you say,  
 14 accounted for 23% of the health and social workforce in  
 15 2020 and were only exceeded by Sub-Saharan African  
 16 migrants who made up 27% of health and social workers;  
 17 is that right?

18 **A.** Yes.

19 **Q.** Right. At paragraph 76 you say that:

20 "Britain has one of the highest levels of  
 21 foreign-born nurses in Europe, with an estimated 40,000  
 22 Filipino staff employed in the NHS in 2020, for  
 23 example."

24 **A.** Yes.

25 **Q.** And you say that there was a devastatingly

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1 **A.** Yes.

2 **Q.** "The obstacles faced by migrant communities in accessing  
 3 healthcare, functioned [you say] as a contributing  
 4 factor to this disproportionate impact, leading to  
 5 increasing health inequality and worse outcomes for  
 6 migrants ..."

7 **A.** Yes. And it's not just the difficulty in accessing  
 8 healthcare, which -- obviously that is a huge factor,  
 9 and we know that, because of data sharing between the  
 10 NHS, the Department of Health and the Home Office, there  
 11 is a lot of fear ingrained in the migrant community  
 12 about accessing the NHS. And I supported people  
 13 directly who were too scared to go to the doctor when  
 14 they had suspected Covid, were even too scared to order  
 15 a test in their own name. I would have to order it my  
 16 name instead to my address.

17 **Q.** Why was that?

18 **A.** Because they were too scared that, you know, their name  
 19 and address would then be shared with the NHS, who then  
 20 would be able to share it with the Home Office, and that  
 21 the Home Office might undertake immigration enforcement  
 22 to remove them.

23 But the other reason why a lot of migrants died as  
 24 a result of Covid was because, you know, not being able  
 25 to access public funds, not having that social safety

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1 net that other people had, meant that people couldn't  
 2 afford to take sick leave. And yes, in some cases they  
 3 were eligible for Statutory Sick Pay, but Statutory Sick  
 4 Pay only kicks in after three days, and then after that  
 5 you're only paid £19.17 a day, which really isn't enough  
 6 to survive, and we know that a lot of people that we  
 7 supported, like across the Migrants' Rights Consortium,  
 8 simply couldn't afford to do that, because they needed  
 9 to be paid every day.

10 **Q.** Sorry, just to bring you back to impact. So the impact  
 11 of that three-day delay meant that people just didn't  
 12 have access to funds in order to live?

13 **A.** Yes.

14 **Q.** Right.

15 **A.** So that was the case for Emanuel Gomes, who was a member  
 16 of UVW, who are a member of the Migrants' Rights  
 17 Consortium. He was an agency cleaner with the  
 18 OCS agency, and he was working at the Ministry of  
 19 Justice since 2018. In April 2020, he got ill with  
 20 suspected Covid-19, but he couldn't afford to go on sick  
 21 leave because of the reasons that I've outlined, so  
 22 instead he kept on working, and it was reported by his  
 23 colleagues that he hadn't eaten in the five days before  
 24 he eventually died, after a shift at the Ministry of  
 25 Justice.

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1 on those who are most marginalised in society?

2 **A.** Yes.

3 **Q.** Right. You say at paragraph 78 that:

4 "Pursuant to Charging Regulations introduced  
 5 in 2015 ... overseas visitors ([including] migrants)  
 6 must pay for 'relevant NHS services' ..."

7 Those provisions were lifted, were they not, during  
 8 the course of the pandemic?

9 **A.** No. So, basically Covid-19 was added to a list of  
 10 exemptions.

11 **Q.** Exemptions, yes.

12 **A.** Yes, for -- I believe it's communicable diseases.

13 **Q.** Yes.

14 **A.** And so it meant that even if you hadn't paid your  
 15 international health surcharge or if you were a visitor,  
 16 and, yes, were not usually supposed to be accessing the  
 17 NHS, then any primary care that you needed from a Covid  
 18 infection would have been covered.

19 However --

20 **Q.** Well, just before you go on to the however, isn't that  
 21 then an example of the government considering the effect  
 22 of Covid on the marginalised in society?

23 **A.** Yes, I suppose it could be an example of that, but they  
 24 didn't clearly communicate it. It was down to community  
 25 organisations like Kanluga, medical organisations like

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1 **Q.** Can I take you back to the sharing of data, please, and  
 2 reflect on evidence that was given to the Inquiry  
 3 yesterday.

4 **A.** Yeah.

5 **Q.** The Inquiry heard that some organisations were  
 6 campaigning to the government for there to be a firewall  
 7 set between the police and health agencies. And  
 8 although that didn't eventually come to fruition and  
 9 that wasn't installed, is that something which you would  
 10 promote in order to encourage the provision of  
 11 information by those who were sick during the pandemic,  
 12 in circumstances where they could be confident that that  
 13 data wouldn't be shared with, for instance, Immigration  
 14 Enforcement agencies?

15 **A.** Yes.

16 **Q.** Thank you.

17 Moving to access to healthcare then, please. Do you  
 18 say that it was foreseeable from the outset of the  
 19 pandemic that some of the measures put in place in  
 20 response would have a disproportionate impact on, and be  
 21 devastating for, some marginalised sections of society?

22 **A.** Yes.

23 **Q.** And do you say that, going forwards, it's important for  
 24 governments to consider the impact of measures such as  
 25 those that were input during the course of this pandemic

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1 Doctors of the World, Medact, to make that communication  
 2 really clear.

3 And the problem as well was that for any secondary  
 4 healthcare needs that could arise from Covid, for  
 5 example a long-term disability or Long Covid, that would  
 6 not have been part of the exemption.

7 I think we also can't underestimate the amount of  
 8 damage was done in terms of trust from that pre-existing  
 9 data sharing. So, even if people knew that they could,  
 10 you know, go to the doctor or go to the hospital, even,  
 11 because they had Covid and, later on, once the  
 12 vaccinations became accessible, that they didn't need to  
 13 show proof of residence or proof that they'd paid the  
 14 international health surcharge in order to access the  
 15 vaccine, people were still scared. They were scared  
 16 that, down the line, that data would be shared and they  
 17 would be found out.

18 And so that's why organisations like Kanluga and  
 19 Doctors of the World stepped in and we had to actually  
 20 organise vaccination clinics to make sure that people  
 21 could get access to the vaccine.

22 **Q.** Thank you. Well, we're going to look at some of the  
 23 effects of the restriction in access to the health care  
 24 now?

25 I'm going to ask that over the course of the rest of

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1 your evidence we look at three sections of the  
 2 Justice Roundtable summary report. The first is at  
 3 pages 43 and 44, please. Thank you very much.  
 4 So this is the report from the Justice Roundtable  
 5 where:  
 6 "The Immigration Law Practitioners Association noted  
 7 that government guidance about Covid-19 and its impact  
 8 on the immigration system was not provided in formats  
 9 that migrants could understand, with literacy skills  
 10 being a significant barrier. This created significant  
 11 information gaps concerning Covid-19 measures,  
 12 healthcare access [as we've been discussing] policy  
 13 changes and vaccines. Consequently, many migrants were  
 14 unaware of the healthcare resources available to them  
 15 during the pandemic so did not access them.  
 16 "The NHS exempted anyone living in the UK without  
 17 permission from charges for Covid-19 healthcare,  
 18 including testing for Covid-19, treatment for Covid-19  
 19 and vaccinations. Healthcare staff were also instructed  
 20 not to conduct the usual immigration checks when  
 21 providing Covid-19 healthcare services. However,  
 22 representatives felt that migrants and asylum seekers  
 23 remained fearful about accessing services due to their  
 24 mistrust of authorities."  
 25 And that's what you've just been explaining,

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1 well as services like libraries.  
 2 "Project 17 explained that migrants with [no  
 3 recourse to public funds] were often employed in minimum  
 4 wage jobs or the informal economy (jobs that are not  
 5 taxed, monitored, or regulated by the government), and  
 6 that they often lived in overcrowded conditions.  
 7 Despite government guidance, many felt that they had no  
 8 choice but to work through the pandemic, risking  
 9 Covid-19 infection and transmission within their  
 10 households. Project 17 also noted an increase in  
 11 domestic abuse and homelessness among migrants with [no  
 12 recourse to public funds] during the pandemic."  
 13 And finally there's a quote from Project 17:  
 14 "Because they had no access to public funds, they  
 15 faced the real impact of starvation and not being able  
 16 to feed their kids."  
 17 So does that encompass, really, all the aspects of  
 18 difficulties that you've explained so far in your  
 19 evidence, affecting those migrants particularly who had  
 20 no recourse to public funds?  
 21 **A.** Yes.  
 22 **Q.** Thank you. We can take that down, please.  
 23 Access to primary care services, including GP  
 24 services and the impact of digitalisation. We've  
 25 touched upon this. Were there barriers to GP

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1 Ms Humi.  
 2 "This was driven by fears that the immigration  
 3 status might be reported to the Home Office. The  
 4 Immigration Law Practitioners Association also suggested  
 5 that many migrants were not registered with GPs and did  
 6 not have an NHS number and therefore could not access  
 7 Covid-19 healthcare."  
 8 And there's then an example from the Joint Council  
 9 for the Welfare of Immigrants.  
 10 "Migrants who were discouraged from accessing  
 11 healthcare for a long time were cynical at the prospects  
 12 of accessing it suddenly during the Covid-19 pandemic."  
 13 And:  
 14 "The representative for Bail for Immigration  
 15 Detainees also described a lack of clarity surrounding  
 16 who was eligible to access a Covid-19 vaccine, which  
 17 created uncertainty for migrant detainees about whether  
 18 they could get a vaccine and protect themselves from  
 19 Covid-19."  
 20 It then goes on to discuss people without recourse  
 21 to public funds.  
 22 "Representatives highlighted the detrimental impact  
 23 of the pandemic on migrants living without recourse to  
 24 public funds (NRPF), exacerbated by not having access to  
 25 usual support networks, such as friends and family, as

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1 registration for migrants going into the pandemic and  
 2 did those remain during the pandemic?  
 3 **A.** Yes. Doctors of the World research shows that in 2018,  
 4 for example, one in five registrations were refused, and  
 5 so during the pandemic, those kinds of patterns of  
 6 refusal were maintained with the added difficulty that  
 7 you couldn't go in person to advocate to be registered.  
 8 It was all done digitally or over the phone.  
 9 **Q.** Thank you. Was there an impact of housing instability  
 10 and deregistration of continuing care?  
 11 **A.** Yes, there was. And I think it was especially difficult  
 12 for people who were in Home Office accommodation where  
 13 the -- essentially the problem was that it varied  
 14 according to the hotel and if you had a manager at  
 15 a hotel who was willing to support the registration of  
 16 other people living in the hotel with the local GP  
 17 surgery, then that would be great, and that would be  
 18 facilitated. However, most of the time these hotel  
 19 managers were not trained to be healthcare providers or  
 20 to be sort of advising people on their rights to access  
 21 healthcare, so --  
 22 **Q.** What was the impact of that?  
 23 **A.** So the impact was that people were not able to register  
 24 with the GP or if they did register in one hotel, after  
 25 they were dispersed, they would end up in a completely

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1 different area and then that care would be disrupted and  
2 so it would make it very difficult for them to continue  
3 to be seen and then, in terms of vaccination, for them  
4 to get that vaccination.

5 **Q.** Was there, in addition, a disruption to non-essential  
6 appointments including a reduction in drop-in  
7 facilities, and how did that impact upon migrants?

8 **A.** So that also had quite a negative impact on migrants.  
9 Again, for similar reasons around, like, instability  
10 with housing or people being dispersed in different  
11 accommodation.

12 **Q.** Thank you.

13 Moving to the impact on mental health and wellbeing,  
14 and access to mental health services, please.

15 At paragraph 141, you report that:

16 "A survey conducted in April 2021 found that ethnic  
17 minority and migrant populations experienced  
18 disproportionately higher levels of depression and  
19 anxiety during the pandemic compared to White British  
20 and UK-born populations. 15% of migrants reported  
21 symptoms consistent with depression ..."

22 Is that right?

23 **A.** Yes, that's right. And actually Kanluga conducted its  
24 own research in 2020 and 2021 and found that 50% of our  
25 service users said that their mental health had been

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1 hear later this week from other organisations, such as  
2 the Howard League for Penal Reform, the Prison Reform  
3 Trust and the Legal Aid Practitioners Group. Focusing  
4 specifically on those within the immigration and asylum  
5 system and the challenges that they faced, is it the  
6 case that the pandemic led to considerable delays and  
7 backlogs in the immigration and asylum system?

8 **A.** Yes, there were huge delays in terms of decision making,  
9 and there had already been a backlog. I mean, the  
10 asylum backlog is quite infamous at this point, but what  
11 also added to the difficulty in access to justice was  
12 that solicitors, barristers, other people working in  
13 community organisations were having to take instructions  
14 over the phone, over video.

15 If people didn't have stable internet connection,  
16 for example if they were in asylum accommodation and  
17 didn't necessarily have access to wi-fi or didn't have  
18 a smartphone, then that made those meetings really,  
19 really difficult.

20 And I think a lot of the work that we do in the  
21 migration sector is being able to talk with people in  
22 person and really trying to assess how they're doing so  
23 that we can help -- you know, really, really help  
24 people. And so doing that onscreen made it much more  
25 difficult.

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1 greatly affected.

2 And I think it's important to note on the mental  
3 health that it's -- mental health is the -- poor mental  
4 health is exacerbated by a difficult migration journey.  
5 Whether that is as an asylum seeker or even as  
6 a migrant, it's very difficult to come to the UK. And  
7 so then the restrictions that were placed during the  
8 pandemic, which limited social contact, which limited  
9 also people's ability to see family from back home, to  
10 go visit them, and to make sure that they were okay,  
11 that really made things much worse and much difficult.

12 And on top of that, because of this difficulty with  
13 accessing healthcare in general, migrants also found it  
14 difficult to access mental health support services that  
15 were culturally appropriate, that were maybe in the  
16 language that they preferred. So, as a result, for  
17 example, Kanluga actually set up three separate mental  
18 health programmes supporting specific communities within  
19 our broader service user base. So we did one programme  
20 for elderly people, one for young mums and then one for  
21 healthcare workers.

22 **Q.** Thank you.

23 The Inquiry has heard about access to justice  
24 insofar as it relates to other vulnerable groups and  
25 victim-survivors of domestic abuse, and we will also

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1 **Q.** Yes.

2 **A.** And I also heard from, for example, Together with  
3 Migrant Children, one of the Core Participants, that,  
4 you know, it did affect the -- I guess, the quality --

5 **Q.** Quality --

6 **A.** -- in legal support. Because if you're meeting with,  
7 for example, the council, the housing team, safeguarding  
8 team, the immigration solicitor and the person  
9 advocating for the family, if you're not all meeting in  
10 person and you're not confronted to that person, who  
11 needs accommodation right now, it's much easier to  
12 refuse. It's much easier to miss signs of additional  
13 vulnerability or additional safeguarding needs. So it  
14 really had a very detrimental impact on people.

15 And there were some cases, like with a JCWI client  
16 who basically didn't understand that, because of  
17 the lockdown, the JCWI office would be closed. She  
18 missed that appointment and she misunderstood and  
19 basically thought that her application had been filed,  
20 but actually it hadn't. And thanks to a mental health  
21 support worker that she had, that support worker was  
22 able to contact JCWI and notify them, like, "Hey, she's  
23 under, kind of, the wrong impression that this  
24 application has been filed. Has it been filed? Can you  
25 please, like, confirm what the next steps are?" And

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1 they were able to support that person.

2 **Q.** Right. And that was something that had been created by  
3 a situation where there wasn't face-to-face contact? Is  
4 that what you're saying?

5 **A.** Yes, yes. And also, around a general lack of clarity  
6 around the temporary concession that had been granted to  
7 migrants. So the Home Office put out a, kind of,  
8 statement saying that if you were in the UK on  
9 a temporary visa or if your leave to remain had expired,  
10 basically there was a concession so that if you couldn't  
11 travel, couldn't leave the country because the border  
12 was closed because of the pandemic, then you wouldn't  
13 get into trouble for that, basically.

14 **Q.** Right.

15 **A.** But that directive wasn't communicated very well, and it  
16 was quite unclear how long that concession would remain  
17 in place.

18 **Q.** Right. And the impact of unclear messaging such as that  
19 is that people didn't understand, and thought, in that  
20 example that you've just given, that an application had  
21 been filed when it hadn't?

22 **A.** Yes, yes.

23 **Q.** Right. Returning to the Justice Roundtable, please, and  
24 having a look at what was said during that procedure  
25 about delays in case progression, at page 35 and on to

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1 ability to carry out essential tasks such as compiling  
2 documents or collecting evidence. The representative  
3 for the Joint Council for the Welfare of Immigrants  
4 highlighted delays in processing subject access  
5 requests, impacting on the ability to collate relevant  
6 material."

7 So -- thank you very much, we can take that down.

8 So there was a difficulty in accessing legal advice  
9 and legal representation because of the number of  
10 available lawyers. There was a difficulty in whether or  
11 not those lawyers were properly assessed as key workers,  
12 and then there was the impact of that situation on the  
13 migrants themselves.

14 **A.** Yes.

15 **Q.** Thank you. Access to benefits, food and other services.  
16 Just touching upon this briefly, please. At  
17 paragraph 197 you say that:

18 "Additionally, school closures during the Covid-19  
19 pandemic meant that children were at home for extended  
20 periods, removing a key source of regular meals for many  
21 migrant families."

22 Is that right?

23 **A.** Yes.

24 **Q.** And was that the position at all times of lockdown  
25 throughout the pandemic?

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1 page 36. In fact, I think we only need to look at the  
2 first two paragraphs so it's just these two and then  
3 over on to the next page.

4 The Justice Roundtable was told that:

5 "The pandemic negatively impacted the quality of  
6 service provided to migrants navigating the immigration  
7 process according to representatives. The Immigration  
8 Law Practitioners Association explained that some  
9 immigration lawyers were furloughed during the pandemic,  
10 leaving migrants without legal support for their  
11 immigration cases.

12 "There were difficulties in accessing immigration  
13 case documents during the pandemic which, according to  
14 representatives, delayed the progression of cases and  
15 was distressing for migrants. The Immigration Law  
16 Practitioners Association expressed that there was  
17 a significant lack of clarity regarding whether and when  
18 immigration lawyers were considered key workers, other  
19 than when they were attending or working on court and  
20 tribunal hearings. They highlighted an example of  
21 a practitioner working on an application to the  
22 Home Office and it being unclear if the practitioner was  
23 a key worker, and was able to go and collect physical  
24 documents from the office to progress these types of  
25 cases. The requirement to work from home impacted the

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1 **A.** Yes, I believe so.

2 **Q.** When schools were closed, yes.

3 Housing security and conditions. We've touched upon  
4 some of these already, but looking for a moment at rent  
5 arrears, you tell us at paragraph 212 that:

6 "The economic fallout of the pandemic led to  
7 widespread job losses and reductions in income, hitting  
8 migrant workers particularly hard as they were more  
9 likely to have precarious and informal jobs. With  
10 little or no savings and no access to public funds, even  
11 a short disruption in earnings would translate ... into  
12 rent arrears. [That some] households were forced to  
13 prioritise basic survival needs, and for those  
14 supporting family members abroad the pressure was even  
15 greater."

16 **A.** Yes, and there's a JCWI study that found that the impact  
17 of Covid-19 was most severe on workers with no recourse  
18 to public funds, and 14% reported being unable to pay  
19 their mortgage or rent on time compared to 2% of the  
20 rest of the population.

21 I think another kind of element that is really  
22 important in housing security and conditions for  
23 migrants is for migrant survivor-victims of domestic  
24 abuse, which we heard from yesterday, but also in  
25 particular for domestic workers who lived in with their

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1 employers.

2 **Q.** Yes.

3 **A.** At Kanluga we had a lot of members who were live-in  
4 domestic workers for private -- for private employers.

5 **Q.** Families -- yeah.

6 **A.** -- for families and because they lived in with them, if  
7 they lost their job or sometimes if they got Covid-19,  
8 then they would lose their accommodation, and we had  
9 some cases of people being made street homeless by their  
10 employers because they had gotten Covid-19 or because  
11 they were locking down and they didn't want the worker  
12 to be part of the household. Or similarly for a care  
13 sector that we spoke to, and who has given evidence,  
14 written evidence, in a previous module, she was working  
15 for a care home, she worked for a week. She got Covid  
16 in the process and then the care home shut down because  
17 too many of the patients had died, and she was made  
18 street homeless and she spent the night on a bench  
19 because she didn't know who to turn to, and couldn't get  
20 any support. And then she got in touch with Kanluga  
21 after that.

22 **Q.** Thank you. At paragraph 216 you explain that:

23 "As growing numbers of migrants struggled to keep up  
24 with rent payments during the pandemic, the government's  
25 temporary stay on evictions was a critical

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1 that a lot of migrants were not -- were left out,  
2 basically.

3 **Q.** Thank you. Access to accommodation support. You tell  
4 us at paragraph 243 that:

5 "Local authorities faced major challenges supporting  
6 people with [no recourse to public funds] during the  
7 pandemic."

8 **And:**

9 "In Scotland, migrants faced similar problems.  
10 JustCitizens ... urged the Scottish Government to  
11 encourage consistency across local authorities in their  
12 response to housing migrants ..."

13 Does that indicate that there was an uneven  
14 application across different local authorities of  
15 accommodation support?

16 **A.** Yes. And I think that comes from the fact that,  
17 typically, a migrant household would only have access to  
18 local authority housing if their need fell under  
19 section 17 of the Children's Rights Act, in which there  
20 is a child whose needs can't be met by the family  
21 directly so the state, in this case the local authority,  
22 has a legal obligation to support.

23 **Q.** Yes.

24 **A.** But not every migrant household is going to have  
25 children.

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1 intervention", but, you say, it didn't reach all those  
2 that were at risk.

3 **A.** Yes. So, for example, for people who were living in  
4 with their employers, there wouldn't have been the same  
5 application.

6 **Q.** Yes. Thank you.

7 The Everyone In scheme, which -- about which the  
8 Inquiry has heard, provided considerable benefits for  
9 those who were accommodated, including the opportunity  
10 to support people recently made homeless back into  
11 housing swiftly, and to protect them from the challenges  
12 that people experiencing homelessness long term often  
13 face. But you go on to say, again, that there was an  
14 uneven application in terms of undocumented migrants; is  
15 that right?

16 **A.** Yes. Well, the government didn't provide additional  
17 resources in order for the local authorities to apply  
18 this Everyone In directive or scheme, and so it really  
19 depended on local authority funding. It wasn't clear  
20 how it applied to migrants. Some migrants were still  
21 denied housing as a result. And, for example, at  
22 Kanluga we weren't even aware of the Everyone In scheme  
23 because it didn't even make it to migrant communities in  
24 terms of that communication. So, you really have to  
25 question how effective the messaging was. So, it meant

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1 **Q.** In terms of those who were accommodated in hotels during  
2 the pandemic, the Housing and Homelessness Roundtable  
3 heard about the No Accommodation Network's experience,  
4 who said that those in hotels gained better access to  
5 immigration advice, as some hotels provided immigration  
6 support services on site, so they -- that enabled them  
7 to ask questions about the migration system, understand  
8 their rights more clearly, and, in some cases,  
9 regularise their immigration status.

10 **And they said that:**

11 "The access to immigration advice, in a lot of  
12 hotels ..."

13 Was good. That:

14 "People had access and time to engage with it.  
15 [They] saw some really good outcomes in terms of people  
16 who could regularise their status ..."

17 **Once they knew what their rights were.**

18 **A.** Mm.

19 **Q.** But that wasn't the case for everybody?

20 **A.** No, that wasn't. For example, Project 17, Together with  
21 Migrant Children, in particular, reported really  
22 difficult access for people in hotel accommodation to  
23 appropriate legal advisers and also to healthcare, as  
24 we've noted. And a huge issue they highlighted as well,  
25 was that sometimes their clients would get dispersed and

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1 they literally wouldn't know where they would have gone.  
 2 And sometimes they wouldn't have been able to keep their  
 3 phone with them, or maybe they just lost touch with  
 4 them. So that made it really difficult to keep that  
 5 provision consistent.

6 **Q.** Yes. I want to turn now, please, to look at impact on  
 7 working conditions, and in particular key workers,  
 8 who -- you may know, Professor Marmot, who gave evidence  
 9 last week, described the frontline key workers as the  
 10 heroes of the pandemic.

11 Could we have a look, please, at the Public Health  
 12 England report, 'Understanding the Impact of Covid-19 on  
 13 [Black, Asian and Minority Ethnic] Groups'. Thank you  
 14 very much.

15 Can we go, please, to page 35, noting that this  
 16 report was made in June of 2020.

17 And look at:  
 18 "Risk assessments  
 19 "The issue of occupational risk assessments came up  
 20 repeatedly in engagement sessions involving  
 21 professionals as well as community representatives. It  
 22 was felt that evidence-based tools that could help  
 23 employers to understand risk and to identify employees  
 24 who may be at increased risk of acquiring or  
 25 transmitting infection would be helpful. Many

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1 worse outcomes and all these factors need deeper  
 2 examination before we can draw valid conclusions.

3 "Increased risk of complications and death from  
 4 COVID-19  
 5 "Stakeholders felt that once infected, many of the  
 6 pre-existing health conditions that increase the risk of  
 7 having serious infection (such as having underlying  
 8 conditions like diabetes and obesity) are more common in  
 9 [British and Asian minority ethnic] groups and many of  
 10 these conditions are both socio-economically patterned.  
 11 For many [British Asian and minority ethnic]  
 12 communities, especially in economically deprived areas,  
 13 there is a higher risk of having high incidence of  
 14 chronic diseases and multiple long-term conditions and  
 15 these conditions occurring at younger ages."

16 So is it your experience and those of the other  
 17 organisations that make up the Migrants' Rights  
 18 Consortium that many of your members fell within the  
 19 people who were being described here?

20 **A.** Yes, but can I check that you meant black, Asian and  
 21 minority ethnic and not British -- (overspeaking) --

22 **Q.** I'm sorry, did I say "British"? I meant "black".

23 **A.** Okay.

24 **Q.** Black, Asian and minority ethnic. Please accept my  
 25 apology for that.

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1 participants called for an evidence informed  
 2 standardised risk management tools. However, it was  
 3 also recognised that support and guidance must accompany  
 4 the use of these tools to ensure that workers do not  
 5 feel discriminated against and ensure that they feel  
 6 safe to identify risks and issues without fear of losing  
 7 their job.

8 "Other factors indicating exposure risk  
 9 "Stakeholders highlighted other factors that may be  
 10 contributing to the increased risk of exposure including  
 11 the important role of culture, including places of  
 12 worship, multigenerational households, and variation in  
 13 social interactions. Some BAME groups have been  
 14 segregated in overcrowded urban housing centres and  
 15 workplaces, the conditions of which can make physical  
 16 distancing and self-isolation difficult, leading to  
 17 increasing risks for the spread of COVID-19.  
 18 Stakeholders were also concerned that [British and Asian  
 19 minority ethnic] groups exposed in crowded places and  
 20 becoming seriously ill might be [further] infected from  
 21 multiple sources and a comparatively large infectious  
 22 dose of COVID-19, further driving onward transmission  
 23 and influencing the severity of their disease. These  
 24 complicated social determinants of health might explain  
 25 the increased risk of infection, but not necessarily

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1 Yes. But is it your evidence, Ms Humi, that those  
 2 who come within the Migrants' Rights Consortium umbrella  
 3 fall within the difficulties that we see described here?

4 **A.** Yes, and in fact a lot of migrants who are BAME will  
 5 have even worse conditions than the ones described here  
 6 because of the kind of compounding effects of  
 7 immigration control, visa conditions, and those kinds of  
 8 things. So for example, around the risk of -- around  
 9 the fear of losing a job when raising risks, that was  
 10 something that Filipino nurses reported to us many  
 11 times. They were really concerned that they would be  
 12 labelled as a troublemaker, that the managers of, you  
 13 know -- at work wouldn't want to assign shifts to them  
 14 anymore and they were worried that if they lost their  
 15 job, then that would mean that they would have to find  
 16 a new sponsor for their visa because if you are on  
 17 a work visa, you only have 60 days to find a new  
 18 sponsor, which would have been really difficult and  
 19 incredibly stressful during the pandemic.

20 So a lot of them felt really that they couldn't push  
 21 back even though they felt that they weren't being given  
 22 equal access to PPE, and that they were being overly  
 23 exposed to the pandemic. Some of them were told, you  
 24 know, "You're Filipino, you're hardworking, you can take  
 25 it. You can go on the Covid ward and you can be exposed

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1 without adequate PPE because you're a hard worker." And  
2 so there was a complete manipulation of migrant workers  
3 and really taking advantage of their vulnerability and  
4 exposing them to Covid.

5 **Q.** I was going to say, what was the impact of what you  
6 described on those workers?

7 **A.** Yeah. Well, the impact was the 22% death rate amongst  
8 NHS nurses being Filipino, despite Filipinos being only  
9 3.8% of the nursing workforce. We really saw it  
10 repeatedly, and it was really, like people were  
11 messaging us, contacting us constantly about this at the  
12 time.

13 **Q.** Before turning to lessons learned, and summarising what  
14 you say in your report, I just want to touch upon  
15 financial insecurity. And could we have a look, please,  
16 at the report from Doctors of the World UK, which is  
17 entitled "A Rapid Needs Assessment of Excluded People in  
18 England During the 2020 Covid-19 Pandemic", and it's  
19 dated May 2020. Thank you.

20 And can we go to paragraph 10.4.1, relating to job  
21 losses and destitution.

22 "The Covid-19 pandemic comes at a time when many in  
23 the UK are already living in poverty or destitution.  
24 During Covid-19, due to pressures on businesses and  
25 temporary closure of many workplaces, many have lost

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1 their means of support, and have become homeless. They  
2 have been washed out."

3 "Another group that has been heavily impacted by job  
4 losses are the Gypsy, Roma and Traveller community.  
5 This is because many are self-employed, or the work  
6 undertaken is informal or seasonal. The manager of  
7 Southward Travellers action group explained how this  
8 loss of employment is not only concerning for the  
9 immediate household but for extended families and  
10 communities: 'What I am really worried about is that the  
11 people who work, they very much share their income with  
12 the poorer people on the sites, so they have been there  
13 almost as a safety net on the site, and I'm really  
14 worried they won't be able to support the community as  
15 much as they used to'.

16 So does that really encompass all of the  
17 difficulties in terms of financial insecurity and a lack  
18 of access to funds during the course of the pandemic  
19 that Migrants' Rights Consortium members and those that  
20 they represent were facing?

21 **A.** Yes, and I think it also -- kind of the implication of  
22 this as well is people staying in exploitative or  
23 insecure work. So, for example, we represent a lot of  
24 gig workers or couriers, who were exposed to  
25 disproportionate risk to Covid-19 through their delivery

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1 their jobs. Many examples were reported during  
2 interviews."

3 And then:

4 "A number of people in the UK are formally employed  
5 on temporary visas that do not permit the bearer to any  
6 access to public funds such as housing or employment  
7 benefits. This means that some people have lost their  
8 jobs during Covid-19 but have no access to public funds  
9 or savings and have become newly destitute [as we have  
10 discussed this afternoon]. These temporary residents,  
11 who may have ordinarily returned to their country of  
12 origin after a job loss, are currently unable to do so  
13 due to international travel restrictions."

14 Which you've also set out, Ms Humi.

15 "Some people, such as sex workers, or those with  
16 irregular immigration status, make an income through  
17 informal work in order to survive. People working  
18 informally, who have lost their jobs or can no longer  
19 work, are not eligible for the benefits, protections and  
20 entitlements offered to others during the pandemic.

21 Many of these people, previously managing to support  
22 themselves, have become newly destitute.

23 "Now the highest number of people we see, they are  
24 not our usual service users, but are people who have  
25 lost employment, illegal employment, they have lost

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1 work, and weren't considered necessarily frontline  
2 workers, so weren't being given access to the same level  
3 of PPE as others.

4 One medical courier describes going into a room in  
5 a hospital to pick up Covid-19 specimens for testing and  
6 not even being given a face mask or gloves to handle the  
7 specimens. And that was because he was working for an  
8 agency that just simply didn't prioritise him.

9 And a lot of these gig workers, couriers, drivers,  
10 felt -- faced really, really difficult working  
11 conditions. Some workers weren't even allowed to use  
12 the restrooms when they went into restaurants to pick up  
13 food that they were then going to take to the person  
14 who'd ordered it. And some women drivers and couriers  
15 reported having to change their sanitary pads in the  
16 street because restaurant owners wouldn't allow them to  
17 use the toilets because of Covid restrictions.

18 **Q.** Thank you.

19 Turning then to lessons learned and recommendations.  
20 You begin by saying that there needs to be a recognition  
21 of the disproportionate impact of the impact on the  
22 health, wellbeing and mortality of migrant communities.

23 That, in anticipating the next public health  
24 emergency, it's critically important to identify the  
25 needs of marginalised and migrant communities and to

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1 take robust and expeditious remedial steps.  
 2 That there were gaps in public health messaging and  
 3 an overreliance on community organisations to meet basic  
 4 needs, to overcome barriers to accessing essential  
 5 services and daily necessities such as food.  
 6 There needs to be a conscious minimising of the  
 7 impact on migrant communities, and a properly funded,  
 8 language-specific and accessible public messaging  
 9 campaign on the next occasion, which needs to be  
 10 implemented to ensure that public health messaging  
 11 reaches migrant communities. Is that right?  
 12 **A.** Yes. Ultimately, what we found during the pandemic is  
 13 that immigration enforcement was prioritised over public  
 14 health. And Kemi Badenoch herself admitted that in  
 15 Module 4 of this Inquiry. She said that it was right  
 16 for the government to have prioritised immigration  
 17 enforcement over public health, and --  
 18 **LADY HALLETT:** Sorry, we're not going into decision making.  
 19 I'm really sorry, Ms Humi, but I think you're now  
 20 stretching a point, (a) you're going political, and (b)  
 21 stretching into decision making.  
 22 Can we keep to the question that Ms Blackwell asked  
 23 you, please.  
 24 **MS BLACKWELL:** Are there any other issues that you want  
 25 raise in terms of impact and what needs to happen next  
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1 time -- other than those that I've already set out?  
 2 **A.** I think all of the evidence that we've shown is how  
 3 damaging the no recourse to public funds condition is  
 4 and how devastating it is for people to be locked out of  
 5 the mainstream benefit system. So I would really urge  
 6 for the government to reconsider the no recourse to  
 7 public funds condition.  
 8 **MS BLACKWELL:** That concludes my questioning. We don't have  
 9 any questions from any other core participants, my Lady,  
 10 and indeed that concludes the business of today.  
 11 **LADY HALLETT:** Thank you very much.  
 12 Ms Humi, thank you very much for your help, both in  
 13 this module and the other one, and I'm sorry I had to  
 14 intervene but I think you understand that I've got  
 15 a difficult tightrope to walk here, and I can't get too  
 16 political. But thank you very much indeed to you and to  
 17 your colleagues in the other organisations in the  
 18 consortium that you have represented today. I'm very  
 19 grateful to you.  
 20 **THE WITNESS:** Thank you.  
 21 **LADY HALLETT:** In which case I shall return for 10.00  
 22 tomorrow morning.  
 23 **MS BLACKWELL:** Thank you, my Lady.  
 24 **(3.53 pm)**  
 25 **(The hearing adjourned until 10.00 am the following day)**  
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<p><b>W</b></p> <p><b>we've... [18]</b> 45/16 70/21 74/20 76/16 78/20 85/9 99/16 105/21 116/7 132/1 132/2 133/23 136/22 157/12 159/24 168/3 172/24 182/2</p> <p><b>wear [12]</b> 59/23 80/17 80/22 81/3 81/6 81/10 81/14 81/17 83/9 83/11 83/12 85/23</p> <p><b>wearing [3]</b> 80/19 81/8 83/14</p> <p><b>website [1]</b> 2/12</p> <p><b>wedding [5]</b> 54/11 120/1 120/6 121/3 123/17</p> <p><b>weddings [8]</b> 57/16 58/20 119/10 119/14 120/18 120/19 120/24 120/25</p> <p><b>week [15]</b> 3/17 3/23 4/13 21/12 66/23 75/9 88/23 88/23 92/18 119/9 121/10 122/20 163/1 169/15 173/9</p> <p><b>weekly [5]</b> 58/2 58/7 88/16 100/24 127/10</p> <p><b>weeks [3]</b> 121/15 124/14 124/14</p> <p><b>welcome [2]</b> 37/15 38/10</p> <p><b>welfare [6]</b> 28/8 88/8 140/14 140/20 158/9 167/3</p> <p><b>well [71]</b> 5/5 11/19 12/1 12/9 12/20 14/18 16/8 23/24 24/1 29/25 32/8 32/12 33/23 34/10 35/3 35/19 37/8 49/23 50/7 66/1 66/5 70/15 70/24 72/2 74/10 80/12 86/20 89/7 92/10 93/10 97/22 102/7 103/8 105/20 105/25 106/12 108/19 109/5 109/9 109/25 110/1 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