

Witness Name: Andrew Phillip

Langford

Statement No.: 1

Exhibits:1

Dated: 18/12/25

## UK COVID-19 INQUIRY – MODULE 10

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### WITNESS STATEMENT OF ANDREW PHILLIP LANGFORD

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1. I, Andrew Phillip Langford of Cruse Bereavement Support, 5 Kew Road, Richmond, TW9 2PR, and I am the Clinical Director for Cruse. I have previously held the positions of Operations Director and Chief Operating Officer within the charity. I have worked within the voluntary and private health sectors in strategic and service delivery roles since 1997, in the areas of mental health, multiple needs, substance misuse, older persons' services, palliative care, and bereavement. I have a Master's degree in voluntary sector management at Bayes Business School, a post-graduate diploma in integrative counselling/therapy with the London School of Counselling and Psychotherapy, and diplomas / advanced certificates in cognitive behaviour therapy, life coaching trauma informed therapy and clinical supervision. I also have a Bachelor's degree in English with Lancaster University. I am currently in the process of completing a Doctorate of Philosophy (PhD) with The Open University. This is European Social Research Council funded, focusing on the grief experiences of bereaved men, and how they have been influenced by telephone support.
2. I have produced this statement in my capacity as Clinical Director for Cruse Bereavement Support. I have relied upon my own knowledge and recollection, and data that Cruse Bereavement Support has collected concerning the items below.

## **A history of Cruse**

3. Cruse Bereavement Support (referred to from here on in as 'Cruse') was incorporated on the 5<sup>th</sup> of October 1959 as Cruse Clubs Ltd and registered with the Charity Commission during 1962. In the years since then, we have expanded to help all bereaved people, grown a network which includes over 3,500 volunteers, and responded to national disasters and emergencies.
4. In the 1960s, widows faced considerable financial and practical challenges and there was very little information available to help them understand and cope with their grief. Our founder – Margaret Torrie – established Cruse Clubs (small support groups) from her house in Richmond upon Thames, as a safe space for widows to talk about their grief and seek mutual support. We continued to expand, ending the 1970s with 53 branches over England, Scotland and Wales. In 1980, we began to support widowed men as well as women. By the end of the decade our name had changed again, this time to 'Cruse Bereavement Care' and extended services to all bereaved people, whoever has died and whenever the death took place. During the 1990s, understanding of the process of grief developed further. By 1999, we had a new development plan and launched telephone and email support. Shortly after 2000, we launched its first websites for adults and young people, and the journal Bereavement Care was published online.
5. In recent years, we campaigned for bereavement benefits, bereavement leave, and against funeral poverty. We also played an important part in raising the standards of bereavement care, working with partners to publish the first set of national Bereavement Care Standards, and guidance on managing bereavement in the workplace.
6. In 2021, we relaunched a new website following a branding review which took on board the views of bereaved people, and changed our name to Cruse Bereavement Support, updating our mission statement and values.

## **Cruse's structure, governance mechanisms and how we are funded**

7. Cruse Bereavement Support is a company limited by guarantee. We are governed by a Board of Trustees who are also Directors of the company. All Trustees undergo a detailed induction programme as a Trustee of Cruse and are given the opportunity to attend additional external training in charity governance. New Trustees can be appointed by resolution of the Board. However, they must be elected to the Board at the next Annual General Meeting for a term not exceeding three years after which they must be re-elected. No Trustee is eligible for election to the Board on more than two occasions. The Articles of Association provide for a minimum of 8 and up to a maximum of 25 Trustees. In the event of the company being wound up the members have undertaken to contribute a sum not exceeding £1. Cruse is governed by Articles of Association adopted 3 December 2016 as amended 23 December 2021.
8. The Board decides our strategic priorities and monitors its performance, meeting regularly through the year.
9. The Board has three sub-committees:
10. Audit and Finance Committee - Oversees finance, digital, audit, and risk, including review of budgeting, financial and management reporting, systems and controls, annual audit and risk management.
11. People and Culture Committee - Oversees the appropriateness and effectiveness of the people plans that support our strategic purpose. The Committee also ensures that the remuneration, culture and people policies and practices are designed to support our strategy and promote long-term sustainable success.
12. Operations Committee - Oversees the reach, performance and quality of services and other activities provided by Cruse to deliver outcomes for bereaved people. This includes oversight of influencing and campaigning activities and the implementation of policies and procedures to safeguard volunteers and employees and maintain safe delivery of services.

13. We also have a Volunteer Council which is an advisory body of volunteers. It consists of members from Wales, Northern Ireland, Regions across England and National Services. Meetings of Council also include members from the Board of Trustees and are attended by senior executives of Cruse. The Board of Trustees is the legal decision-making body, and its work is informed by the views of Council. Three Council members sit on the Board of Trustees. Council members along with the Board of Trustees are the Company members of Cruse and have a vote in the election of Board members and on resolutions put to Annual General Meetings and/or Extraordinary General Meetings.
14. The Chief Executive and their colleagues on the Senior Leadership Team comprise the key management personnel in charge of directing and controlling Cruse on a day-to-day basis.
15. We are registered with the Fundraising Regulator and are compliant with the standards set out by the Regulator in its Code of Fundraising Practice. Funding to Cruse is a mixture of contracts for the provision of bereavement support services (to alleviate emotional distress brought about by bereavement), charitable grants, individual donations and legacies, and the trading of training and consultancy services to other organisations.
16. Fundraising activities are organised by staff and volunteers of the Charity. We do not engage third party professional fundraisers to raise funds on our behalf. Cruse works with Sterling Lotteries to raise funds through a lottery using the Unity lottery. Fundraising is approached with sensitivity and compassion. We are not unreasonably persistent nor is undue pressure applied on anyone. Potential and actual donors' privacy is protected. No telephone or doorstep fundraising is undertaken, and the buying and selling of mailing lists does not take place.

### **Cruse's purpose, and our primary aims and objectives**

17. Our vision is that we live in a world where everyone grieving is supported, respected and understood.

18. Our mission is that we support people through one of the most painful times in life – with bereavement support, information and campaigning.
19. We want to ensure bereaved adults, children, young people and families can recognise grief and are empowered to manage their grief and to be in control of their lives. Furthermore, that bereaved people are connected to the individuals and communities that support them to improve mental and physical wellbeing. Finally, we aim for people to be able to access good quality services and information when someone dies and are supported to challenge poor services. A key focus of our strategy is ensuring bereaved people are at the heart of all that we do.
20. Our values of kindness, inclusivity, ambition and genuineness underpin everything the Charity does.

**The main methods adopted by Cruse and systems in place to help us achieve our aims and objectives**

21. We provide a wide range of support and information, run a number of specialist funded projects, and deliver grief and bereavement training. People who used our services have given positive feedback that we support helped them understand their grief is normal, process their grief and better adjust to their loss, and improve their wellbeing and mental health.
22. Expert bereavement and grief information – our high-quality information service on the website is available to all bereaved people, whenever they need it, and is often the first source of support and information through Cruse. Our website was viewed by over 1 million people in 2024/25. Information covering bereavement and grief helped to build resilience, empower people to make informed decisions, and provided tools to self-manage grief. People accessed a variety of online resources including personal stories, expert blogs and content covering many forms of bereavement and loss. Topics included the death of a partner, parent, or child,

anticipatory grief, loss of a loved one to suicide, losing a sibling, and experiences of traumatic grief.

23. Social media – We have fostered a growing community of people interacting with us and each other over social media. We have a presence of Facebook, Instagram and LinkedIn. We provide useful information focused on helping people understand how to cope with grief. This is designed to foster resilience, to assist people in being in a more robust position to cope in the future. We have also encouraged positive and supportive interactions between people interacting on these channels, and there is evidence of people growing in their support of each other.
24. Cruse’s national helpline – Our Helpline answered over 28,000 calls and emails in 2024/25. we continue to see high levels of demand for this service, and the helpline team is unable to answer all the calls received. We have recently reviewed the helpline and continues to seek funding to increase support for telephone and email services, and pilot new pathways to support more bereaved people when they need help.
25. Bereavement groups - Over 3,000 people were supported through Cruse Bereavement Groups in 2024/25. Our Understanding Your Bereavement sessions were delivered online and in local communities by trained Bereavement Volunteers. We continue to develop Understanding Your Bereavement group support, and insights from funded projects evidenced the benefit of this type of support for bereaved people.
26. One-to-one bereavement support – In 2024/25, our trained Bereavement Volunteers supported over 24,000 adults, young people, children and families virtually via online video calls, by telephone and in person. Usually, six weekly sessions of support are provided to each person. This can be extended up to twelve sessions, depending upon the acuteness of grief and complexity of needs.
27. Training and consultancy – We have continued to lead on providing expert bereavement and grief awareness training, with training courses and consultancy

services including our Manager's Guide to Grief in the Workplace, Grief First Aid and Supporting those Bereaved by Suicide.

28. Specialist projects – We run a range of projects, usually for set durations, that focus on a particular need or group of bereaved people within the wider population. Examples include Armed Forces personnel and veterans, prisoners, people in fuel poverty, isolated men at risk of additional and increased vulnerability, and people bereaved by suicide. A selection of interventions (detailed above) is provided based on the best mix for the specific group.
29. Major incident response – We provide support during local and national major incidents, that have involved bereavement. In the past, this has included giving support to people impacted by the King's Cross station fire, Lockerbie, Hillsborough, 9/11, 7/7, the Manchester Arena bombing, the Borough Market attack, and the Grenfell Tower fire. Most recently, Cruse has provided support to those affected by the Air India flight incident.

#### **A high-level overview of the specific roles that Cruse played during the pandemic**

30. We provided bereavement support throughout the period from the 1<sup>st</sup> of January 2020 to the 28<sup>th</sup> of June 2022. This was with the aim of alleviating emotional distress caused by the death of someone close. This support continued through every period of lockdown and beyond, when the lockdowns were lifted. This was made possible by the early decision made by the Senior Leadership Team, ratified by the Board of Trustees, to transition from a model of providing most of the one-to-one and group support in-person support, to providing this support using a mix of telephone and remote video provision. To meet increased need for bereavement support, due to the nature of the Covid-19 pandemic and associated rising mortality rates, we expanded our volunteer recruitment activities, increased provision on the national helpline, and sourced additional funding to open new services. The largest initiatives were an online video support service covering all geographical areas where we did not have a local branch, a synchronous written chat service provided by qualified counsellors, and online psychoeducational groups, to help people gather, learn more about grief, and how to cope.

31. Our supported extended to train more organisations in how to manage the growing need for them to have compassionate conversations with their staff, volunteers, clients and customers, concerning grief – particularly of a sudden and traumatic nature (given how rapidly people’s conditions could deteriorate due to the onset of Covid-19). Training extended to equipping many Local Authorities and financial services sector organisations, both of which reported to us that there was an increase in demand for their services, and elevated likelihood that grief would feature as a predominant topic in discussions with their clients and customers.
  
32. As part of our national role within the voluntary sector, as an initial member of the Voluntary and Community Sector Emergencies Partnership (VCSEP), we continued to advise other non-bereavement specialist organisations. This centered on how to support their activities, considering rising mortality rates, resultant increases in numbers of bereaved people, and the growing complexity and acuteness of grief due to the rapidity of Covid-19 symptom onset resulting in death and chronic loneliness and isolation. Associated with this support in an advisory capacity, there were increased requests from the media, for interviews and input focusing on how to inform the public about coping strategies when experiencing grief, and how to support close family and friends. In response, we provided increased numbers of online and telephone interviews for radio and print.
  
33. We continued to provide the above support throughout England, Northern Ireland and Wales, and maintained communication with Cruse Scotland (a separate organisation, providing bereavement support to people exclusively in Scotland).
  
34. In addition to the direct support detailed above, we were part of the steering group for the UK Commission on Bereavement. This group submitted a detailed response to the consultation on the Covid-19 inquiry draft terms of reference. We were informed that this feedback contributed to an expansion of the inquiry’s remit, to include mental health and wellbeing of the UK population, and how this had been impacted by the pandemic.

**An overview of experiences of those to whom we provided support, concerning any attempts to access information support, or mechanisms of redress following the death of a loved one during the pandemic**

35. According to the data that we hold concerning bereaved people seeking our support during and after the pandemic (including within the dates of the 1<sup>st</sup> January 2020 and 28<sup>th</sup> June 2022) did not access us to talk specifically about attempts to access information, support or mechanisms of redress following the death of a loved one, such as the examples listed in the question above. We cannot locate any evidence of conversations about these process within the records we keep for recording individual support interactions. Please note that each support note is kept brief, included on our database primarily as a means of recording that the support interaction has taken place.

**An overview of the experiences of those to whom we provided support when engaging with investigations, complaints and accountability mechanisms which were available to bereaved families during the pandemic**

36. According to the data that we hold concerning, bereaved people seeking our support during and after the pandemic (including within the dates of the 1<sup>st</sup> of January 2020 and 28<sup>th</sup> of June 2022) did not access us to talk specifically about engagement with investigation, complaints and/or other accountability mechanisms. We cannot locate any substantial evidence of conversations about these mechanisms, within the records we keep for recording individual support interactions. Please note that each support note is kept brief, included on our database primarily as a means of recording that the support interaction has taken place.

37. What we can discern is that bereaved people have contacted us in the date window, concerning access to Health Trust complaints processes. The most predominant theme emerging has been around concerns that families have experienced, about when their loved ones have died alone, and the families and close friends could not pay their respects in those last moments. We don't hold any records concerning specific complaints or issues raised. Often commented

upon was the exemplary support, kindness and compassion that Health Trust staff exhibited when providing care to those who were ill and to people close to them.

**An overview of the experiences of those to whom we provided support concerning their ability to access emotional or psychological support during or after the pandemic and the impact of this**

38. According to the data that is possible to access, we were unable to discern any numerical data or qualitative data available through case notes, that informs about bereaved people's attempts during the pandemic, to access forms of psychological support other than those provided by us. However, for the period of 1<sup>st</sup> of January 2020 to the 28<sup>th</sup> of June 2022, we could determine several trends involving how bereaved people were engaging with our services. This data is predominantly taken from two Cruse Annual Reports - year ending 31<sup>st</sup> of March 2021 (Exhibit AL/05 [INQ000659957]) and year ending 31<sup>st</sup> of March 2022 (Exhibit AL/06 [INQ000659958]) – as these provide two full sets of annual data. Elements of Cruse Annual Reports – years ending 31<sup>st</sup> of March 2020 (Exhibit AL/04) [INQ000659956] and 31<sup>st</sup> of March 2023 (Exhibit AL/07) [INQ000659959] – are also included to provide a full statistical picture.
39. Following the initial lockdown in March 2020, we paused all in-person services (this included all 1-1 and group support in people's homes, our offices and community venues). We continued to provide helpline support and extended the hours of provision to encapsulate 8am – 8pm Monday to Friday, and 10am-2pm Saturday and Sunday. Helpline support included telephone and email provision for bereaved people to access. Following the announcement of the initial lockdown, we then went through a rapid training process, to reorientate all our staff and volunteers, to provide telephone and (to a limited extent) online video support on a weekly basis to bereaved people who needed more than a single session of helpline assistance. This process included establishing the relevant policies, processes and governance structures to be in place for working with adults, young people and children, using these mediums.

40. When additional funding became available, we increased our capacity to support individual bereaved people and organisations in five ways – (i) through increasing volunteer and staff numbers on the helpline, (ii) establishing a synchronous chat service that bereaved people could reach out to receive immediate support, (iii) developing a psychoeducational group session that could be offered online, called Understanding Your Bereavement, (iv) diversify our 1-1 support model, by launching a virtual support service covering all areas of England, Northern Ireland and Wales that did not have a Cruse branch located to serve them, and (v) diversifying our training offer to companies, organisations and other services.
41. Increasing capacity through our national helpline saw an increase in calls answered, from 15,469 in 2019/2020, to 30,861 in 2020/2021, and then to 34,857 in 2021/2022 (expressed in calendar years). Email responses also increased, from 940 people supported in 2019/2020, to 3,904 in 2020/2021, and then to 6,749 in 2021/2022. The volunteer team on the helpline increased from approximately 35-40 volunteers and staff, to approximately 140. Helpline support provided relatively prompt access point for a bereaved person to have a conversation when they felt desperate, and grief became overwhelming. The helpline also fulfilled vital roles of service navigation and signposting to other resources.
42. In 2020, we established a synchronous chat service called Cruse Chat. Bereaved people were able to access our website and then through a link move on to receiving text-based counselling support, for as long as they needed it. In 2020/2021, we supported 24,709 people. In 2021/2022, this rose to 35,686 people. In 2022/2023, this reduced to 28,768, as we needed to close Cruse Chat. The service was enabled by funding made available during the pandemic, and so this service needed to be stepped down once the pandemic subsided and lockdowns were no longer instituted. Whilst the service was functioning, it provided a viable alternative for bereaved people to access, other than longer term online or telephone 1-1 or group support. This helped manage demand, thereby providing bereaved people with a prompter service.
43. Through 2021 and 2022, we developed a psychoeducational group session that we provided on-line, called Understanding Your Bereavement Online (UYBO).

This was previously offered in-person before the first lockdown took effect. The purpose of these sessions was to help people attending understand more about grief and give them some practical strategies about how to support themselves and support others when grief is being experienced. Furthermore, information was provided about other means of support and helpful resources, as well as who to contact if grief becomes more complex and troubling for them. In the calendar year 2022/2023, 158 UYBO sessions were delivered, supporting 3,684 bereaved people. Although the full extent of this provision falls outside of the main timeframe, we are focussing on in this evidence submission, UYBO was being developed during the period of the pandemic. Furthermore, UYBO has achieved positive results shortly after the pandemic for many people bereaved within this report's target timeframe. Over a 12-month period, the average percentage of bereaved people deciding they needed further 1-1 or group support was 32%. This showed that many people were relatively comfortable with brief support, not requiring longer-term interventions. This has then helped us tackle waiting lists and reduce waiting times, shortly after the pandemic.

44. Our ongoing 1-1 support (in which bereaved people usually have up to six 1-hour weekly sessions) was shifted from delivery largely in-person, to telephone or online video. In 2019/2020, we supported 2,452 people over the telephone, and none over video. In 2020/2021, we supported 24,535 people over phone and video. In 2021/2022, we supported 23,669 people over phone and video. In addition to these figures, we provided single sessions of support and assessment to a further 6,538 people in 2019/2020, 7,528 in 2020/2021, 8,018 in 2021/2022, and 8,415 in 2022/2023. This single session support was all conducted over the telephone or through online video. This total activity was possible through Cruse's existing branches and the new virtual support service. An evaluation conducted in October 2022 by Cruse and the University of Birmingham found that health outcomes were strikingly similar, when comparing in-person support prior to the pandemic, and telephone support provided during the pandemic (Exhibit AL/08) [INQ000661993].
45. Training other organisations and services increased as an activity. Prior to the pandemic, all this training was conducted in-person in a variety of venues (mostly the premises of the contracting organisation). Upon the first pandemic lockdown,

this activity shifted over to online video delivery. In 2020/2021, we delivered training to 6,820 delegates. In 2021/2022, we delivered to 5,700 delegates. This delivery was through a mixture of small group courses attended by 8-12 people, through to large seminar-style events, delivery to nearly 100 people. Delivery partners were predominantly Local Authorities, private sector finance companies, educational providers, Health Trusts, faith-based organisations and other voluntary sector organisations. It became clear with the pandemic, that grief literacy, when promoted, helped people support each other, and reduced distress (Exhibit AL/09) [INQ000661986].

46. In addition to the direct support and training summarised above, we invested in our website, to make it more user-friendly, reviewing content to ensure that it was up to date and responding to current issues, of which there were many publicly within the field of bereavement and grief. These changes contributed to an overall rise in the numbers of people visiting the main home webpage, with 708,300 in 2019/2020, 971,970 in 2020/2021, 1,329,900 in 2021/2022, and 1,324,477.

47. From these interventions, we perceived that it was possible to shift mediums of support so that more support was provided remotely. Furthermore, that a small diversifying of remote support enabled more people to access the help they needed. However, whilst we experienced an overall increase in the amount of people we could support year on year (for instance, a 23% rise from 2020/2021 to 2021/2022), waiting times increased for 1-1 ongoing support. In some branches, 58% more people were waiting for this support. Our observations at the time helped us conclude that diversifying support offers only partially helped us manage some of the waiting time issues. In many ways, diversifying support offers simply increased the number of people who could access our services. This was fruitful in itself, but also a valuable learning point – that channel shift cannot in this case deal with an overarching need for a particular type of support.

48. Most bereaved people, particularly in the early days of the pandemic, were very comfortable with being supported over the telephone. Comments submitted indicated that using a familiar tool to speak with their Cruse volunteer was popular. Less popular was online video. At the time, use of this was less common societally.

However, as online video platforms became more intuitive, bereaved people started to gravitate over to using video as a means of engaging in their support sessions. Where people needed help to do so, guidance was offered prior to sessions commencing. In one Co-op funded project called The Bereavement Supporter Project, groups of bereaved people gathered in care homes, observing pandemic conditions, and received training on digital access as a group (Exhibit AL/02) [INQ000661984].

49. Throughout our service response to bereaved people during the pandemic, we were acutely aware of the prospect and actuality of digital exclusion. We made the strategic decision to continue providing both remote telephone support and online video support to bereaved people requiring ongoing sessions on a weekly basis. Selection of which medium of support was used, was selected by the bereaved person. Many people who did not have access to the internet, or a substantial internet connection, were able to access the telephone for a phone call. In all instances, bereaved people when approaching our services, could choose between accessing us online or via a phone call, to receive this continuing support. Where possible, we worked with organisations to mitigate some of the digital exclusion that could have emerged. For example, in our partnership with ExtraCare, in which we trained care provider staff and residents to support each other when a bereavement was experienced, we organised group sessions in which bereaved residents could log in to a group session with Cruse, with the help of ExtraCare staff. However, this type of activity was only possible where such partnerships existed. Two outstanding concerns remained for us, throughout the pandemic, that featured heavily in our assessing of overall risk for individuals seeking our support. Firstly, what became apparent for us early in the first lockdown, was the struggle for some people to locate a quiet and confidential space within their home, to engage with us online or over the phone. This was exacerbated by for many people the additional family members who understandably needed to occupy the home too (both adults working from home and children who needed home-schooling for a time). The lack of space to have a supportive and private conversation was particularly notable for some people. Secondly, those most isolated, vulnerable, and in need of not solely (but including) bereavement support, may not even have tried to access our services in the first

place. Our capacity to reach out into communities was limited by the nature of lockdowns during the pandemic. Our concern still is that those in most need, became more vulnerable and isolated because support and health services (including Cruse) could not reach them.

50. In terms of issues with stigma or cultural barriers around accessing support, we have not managed to amass any data on these important topics. However, we were involved in a study that examined the apparent shortage of available bereavement services to everyone, and it is clear from that research, that there was (and continues to be) a substantial gap between the need/demand for services, and the availability of bereavement support, due largely to the lack of consistent and sustainable funding for bereavement services across the UK. This is expanded upon in more detail later in this evidence report. To consider stigma, cultural barriers, and access to support, it may be useful to draw upon Pearce et al. (2021) (Exhibit AL/16) [INQ000650070], Suleman et al. (2021) (Exhibit AL/19) [INQ000280416], and Selman et al. (2023) (Exhibit AL/18) [INQ000659960].

**Our insight or analysis as to how any differences impacted those to whom you provided support**

51. As it is expressed elsewhere within this document, bereavement during the pandemic was often symptomatically more complex and challenging for the bereaved to deal with, in terms of its initial impact and then the ongoing ramifications of the death. Each vulnerability in a bereaved person's life compounds complexity of need, on top of the experience of the grief, plus any historical, immediate or ongoing contextual factors. In the case of the pandemic and associated lockdowns, this context provided bereaved people with the additional challenges often of loneliness and isolation, not being able to observe mourning rituals, a lack of social cohesion in their families, friendship groups, and close communities, difficulties in accessing support services due to heightened demand, and in the case of bereavement through Covid-19, the death was often sudden. Not being able to say goodbye was also a key factor that evidently complicated many people's grief, when they could not spend the final moments of their loved one together with them (Exhibit AL/10) [INQ000661987].

**Cruse's insight and analysis on longer-term emotional consequences that have impacted bereaved people, who were bereaved during the pandemic**

52. The information presented here is an overview of what bereaved people have communicated to us, about how their mental and emotional health has been impacted by experiencing the death of someone close during the pandemic. The themes expressed below are predominantly emotions that have arisen from these bereavement experiences (Exhibit AL/11) [INQ000661988]. These experiences and emotions have then driven longer term negative consequences for the bereaved, in terms of their mental and emotional health. Evidence we have encountered indicates a greater prevalence of higher levels of grief and support needs amongst people bereaved during the pandemic in the UK (Exhibit AL/17) [INQ000661995] and (Exhibit AL/20) [INQ000650073].

53. Anger has been a predominant feature for those bereaved during the pandemic. This anger has originated from the circumstances around the death. Circumstances feeding into anger include loved ones dying alone or in clinical environments (e.g. hospitals or nursing homes) when no relatives or close friends were allowed to visit, to share their last moments. Some bereaved people have talked about how their experience of grief has been made more acute by the thought of what those moments would have been like for the person who died. Not only is this experience of anger fuelled by not being able to say goodbye, but also by deep concerns about how frightening it may have been for the person who was essentially without anyone to comfort, reassure and support them in their final moments. The understanding that some of the bereavements were preventable (for example, a person dying who had not yet received a vaccine) has also fed into a heightened experience of anger for many bereaved people.

54. Guilt is another predominant feature that continues to impact upon the health and wellbeing of many people bereaved during the pandemic. Driving this guilt are factors such as not being able to be present during their loved one's final moments, not being able to carry out mourning rituals in a manner that the loved one would have wanted, and not being able to observe faith-based and community-based

rituals. Some bereaved people have also talked about 'surviving' the pandemic, in the wake of their loved one's death. The experience of "why them and not me" is a live issue for some bereaved people, that continues into their lives post-pandemic. This in turn can feed into further guilt.

55. The experience of increased isolation during the pandemic has resonated through the lives of many bereaved people into the present day. Many bereaved people were unable to meet with close family, friends and community groups during and shortly after the death of their loved one. Facing grief alone at this point meant that for many, the time when they needed people with them who they can trust, was not possible. This cannot be replayed, and so opportunities to share narratives about the loss and the immediate aftermath with trusted people are either not possible, or in themselves become traumatic.

56. Finally, not being able to share in mourning rituals that were needed and desired, has left people feeling bereft. Mourning rituals play a key role in bringing people together at a time of loss, enabling a space to remember a loved one together, and creating a shared sense of purpose and community. This was made not possible for many practical reasons beyond the control of those who were bereaved. Many bereaved people have indicated a feeling of emptiness twinned with the guilt described above.

57. At Cruse, we continue to see a higher proportion of people presenting with more complex and prolonged grief reactions. This includes people seeking support from Cruse, who have been bereaved during the pandemic. The themes expressed above, of anger, guilt, isolation, and a lack of necessary mourning rituals, have brought about long-term impacts for many bereaved people. These impacts include increased anxiety and worry, persistent low mood, a reduction in physical health, and persisting isolation and loneliness. These experiences in turn lead to interruptions in education, difficulty in sustaining employment, and a lack of trust in societal support systems, which then leads to further disengagement. In such instances, we also perceive an increase in the propensity to undertake maladaptive coping strategies, such as engagement in substance and/or alcohol misuse. This is often an attempt to manage what can be the unbearable pain

caused by the persisting guilt, anger and longing for things to have been different - whether that be for the bereaved to be alive now, their death to have been less sudden, or for the bereaved to have been accompanied in their last moments. We are also seeing that many people bereaved during the pandemic have experienced or are experiencing thoughts of suicide, largely in response to the fatigue of living with the emotional consequences of being bereaved. All the above is exacerbated further if trauma is experienced during the bereavement (which is more likely if someone has been bereaved during the pandemic). If this is the case, the propensity and severity of negative consequences significantly increase.

58. The emotional consequences explained here appear to drive further negative impacts on the lives of people bereaved during the pandemic. These include relationship breakdowns, longer term worklessness, and for bereaved children and young people, diminished educational achievement and thus reduced life chances (Exhibit AL/21) [INQ000661998]. We believe this clearly demonstrates significant links between the long-term emotional consequences of bereavement during the pandemic, the emergence of support needs new to a person, and the exacerbating of existing vulnerabilities.

**An outline of Cruse’s insight and analysis on how any impacts and experiences identified in this section differed between England, Wales and Northern Ireland, as well as compared to Scotland, across different demographic groups in England, Wales and Northern Ireland**

59. We provide support to bereaved people across England, Northern Ireland and Wales. A separate organisation – Cruse Scotland – supports bereaved people in Scotland (<https://www.crusescotland.org.uk/>). We are therefore unable to comment on the experiences of bereaved people in Scotland.

60. We were funded to assemble a report entitled *Collective Healing Through Honouring Loved Ones* (Exhibit AL/03) [INQ000661985], about the lived experience of people bereaved during the pandemic, who live in Northern Ireland. This report was constructed by Dr Katrina Collins (an independent researcher experienced in the area of mental health), and a copy has been included within

this evidence submission. 164 bereaved people took part in the research that is included in the report. The report was presented at Stormont in December 2025. The purpose of the report is to better understand the needs of people bereaved during the pandemic, and the impact that restrictions had on people's bereavement journeys. The report expands upon the support people received for the grief they were experiencing, during and after the pandemic, and also the support that they feel would have helped them had they received it. Memorialising the death of loved ones during the pandemic is also covered, accompanied by the expressed need for permanent memorials to be established. Several themes are evident from the report. Most prominent is the traumatic impact of experiencing death during the pandemic. The absence of opportunities to perform traditional mourning rituals associated with death (whether they were religious or cultural, or a mix) was cited often in the feedback from bereaved people. Saying goodbye to their loved one was vastly important, as is the public recognition of bereavement, and how bereavements could have potentially been prevented. When this was not possible, it took a significant toll on the family and close friendship group.

61. Three key messages emerging from the report are (i) the need for a lasting national memorial, (ii) the importance of capturing people's stories of bereavement during the pandemic, and including them within the history of Northern Ireland and the school curriculum, and (iii) the need for continued funding to co-produce tailored support to meet the ongoing needs of people bereaved during the pandemic.
  
62. No funding has been available to us, to conduct research and produce a similar report for people bereaved during the pandemic, who lived in England and Wales. Following the pandemic, we transitioned to using a new database to store the data of our volunteers and the bereaved people they support. The data we have archived pertaining to people bereaved during the pandemic does not present detail fine enough to distinguish particular characteristics or details regarding the grief of people living in England and Wales. A summary of the data we do have is derived from Cruse Annual Reports covering the dated period, and some additional data we have available that provides a picture of volumes of service delivery across England, Northern Ireland and Wales.

63. Given the context of our data that is described above, we don't have access to fine enough detail to present distinct numerical information about different demographic groups. However, it is possible to offer some anecdotal information from reflections provided by volunteers working with bereaved people and feedback from those bereaved during the dated period.
64. People generally present to us in a heightened state of emotional arousal, as grief has often been born for some time, to the point at which it is experienced as unbearable, and/or it has become difficult for the bereaved person to cope in their lives, due to the emotional and practical ramifications of the death of the loved one. This severity of grief is often described within research literature as 'acuteness' of grief and is generally heightened within the first three to six months following a bereavement. For some, this continues to be the case, and in those circumstances, it is more likely that additional psychiatric intervention will be needed, as depression and anxiety are more likely to develop.
65. During the pandemic, we noted that those bereaved people presenting to us who reported having pre-existing mental health issues (particularly depression and anxiety) were more likely to experience an even heightened level of acuteness of grief, for longer. This then compounded to result in even deeper levels of depress and heightened anxiety, unless it was possible to mobilise a constellation of support structures that included the person's community and family, primary care and/or mental health services, and interventions from Cruse.
66. A further group that we noted as being particularly adversely affected were bereaved people who presented indicating considerable degrees of loneliness. This took two forms – either this experience of loneliness was present before the death of the loved one or appeared with rapidity following the death (this was often the case when a partner had died, leaving the remaining partner alone in a dwelling, during a lockdown). The loneliness often perpetuated the experience of acute grief, and the severe experience of ongoing grief presented an obstacle for the person, to engage with further support and activities that may increase their mood and enable them to stabilise, establishing a meaningful routine following their bereavement. More intervention from us over a longer time period would

often help to assuage this, usually in form of extending the number of weekly structured support sessions, and targeted signposting to resources that were available.

67. Prior to, during, and after the pandemic, we work with many people who present with thoughts of suicide. Some are in the process of making an attempt when they contact us, and so we need to take appropriate safety actions depending upon risk. The frequency of contacts to our services increased, of people who were experiencing thoughts of suicide following a bereavement during the pandemic. In many cases, it was difficult to discern whether these thoughts were present prior to the bereavement, or whether they resulted from the bereavement. However, it was evident that the death of a loved one had brought about a rapid deterioration in emotional wellbeing, and in some cases considerably reduced mental health. These factors then seemed to increase the frequency and intensity of suicidal thinking, which was symptomatic of decreased mental health and wellbeing. This conglomeration of experiences increased the likelihood of loneliness, and often deepened and perpetuated the acuteness of grief that is described above.

68. Prior to and following the pandemic, older people (aged 65 and over) have been more likely to experience the death of someone close, in comparison to people in other age groups. This continued to be the case during the pandemic and increased in proportion. Loneliness was a significant factor that increased the severity of the grief experience, exacerbated by not being able to observe the mourning rituals required, and in situations when the person who had died was alone, and the bereaved did not have the opportunity to express their farewells. In some cases, the bereaved were the carers of those who had died. In some instances, we observed that not being able to continue in their carer role constituted an additional significant loss. Whilst caring responsibilities may have been challenging to bear, loss of purpose and change to prior routines, coupled with the absence of the cared for person who had died, tended to bring about lower mood, a sense of hopelessness, and chronic loneliness and isolation. This constellation of issues further exacerbated acuteness of grief. These issues have also been flagged in evidence of adaption to bereavement in other infectious disease outbreaks (Exhibit AL/14) [INQ000661991].

**Recommendations and observations that Cruse has on measures that bereavement support services might have done to reduce the adverse impacts on the bereaved during the pandemic**

69. Learning from the experience of providing support during the pandemic is vital, so that we can better equip ourselves to support people as and when the next pandemic takes effect. This learning also has wider application, particularly in terms of how different mediums can be used to provide bereavement support, such as via telephone conversation, text, and video calls. This is in the context prior to the pandemic, when much emotional support for bereavement was provided in-person.
70. Firstly, increased preparedness for a national major incident could have elevated our adaptability as a sector. Cruse was a founding member of the Voluntary and Community Services Emergencies Partnership (VCSEP), when it was established in 2017 following the spate of major incidents in 2017 ([VCSEP | Voluntary & Community Sector Emergencies Partnership - Bringing a Coordinated Response to Emergencies | UK](#)). Prior to the pandemic, the VCSEP was in its infancy, and much of the work undertaken to facilitate for the sector's response to a major incident, had a focus on town, city, borough or county-based incidents. Only relatively recently have we been focusing on how to prepare for and act during a national incident. Preparedness exercises such as scenario enactments could have helped organisations within the bereavement sector, to consider what they would do if a national incident involving a pandemic was to take place. There could have been consideration given to how organisations work in partnership, whether that be between charities or cross-sector, with partners in the public and private sectors. Being more prepared in advance may well have enabled us to then respond and adapt our plans based on the idiosyncrasies of the pandemic, as they emerged. An example of this would have been how to accommodate paid and voluntary workforces from their own homes, delivering support entirely remotely.
71. Secondly, an ongoing scoping of which parts of society are most in need, could have facilitated for a highly targeted approach to provision. It is clear from available

statistics, that some segments of society were disproportionately impacted by the pandemic (Exhibit AL/12) [INQ000661989], experiencing higher mortality rates. Many support services, Cruse included, invested what time, people hours and finances we had, in reaching out to those in need. However, we were more likely to continue to support groups who were already in contact with us. Whilst this is positive, it doesn't necessarily mean that those most needing help actually get it. In fact, it may mean that the inequity within our health and social support structures may be exacerbated, as those groups more in need of support, become more disengaged. At Cruse, since the pandemic, we have been able to foster a highly supportive environment on our social media channels. This has increased the diversity of people being equipped to help themselves and others. In hindsight, this could have been possible during the pandemic. Therefore, to adopt a strategic approach, an ongoing sector-wide scoping, could have enabled some repositioning within the sector, focusing on groups and communities most in need of support (Exhibit AL/13) [INQ000661990].

72. Thirdly, a more targeted approach to partnership working may have helped bereavement support charities reach those most in need of support. It became evident, as the pandemic unfolded, that particular groups within our society were being disproportionately impacted – whether through illness, death, grief, or other social issues (such as economic, employment or housing). Working strategically, in a more proactive manner, with other sectors and organisations within them, may have helped us both enable those organisations more readily to support their members, and more promptly provide their members with direct support. Examples include the education sector (schools, colleges and universities), medical professionals, and the funeral sector. Capacity building with organisations and contact points could have helped them support people before they even needed access to more specialist forms of intervention, such as that of Cruse. This capacity building could have also helped manage service demand.

73. Fourthly, having more immediate public messaging, that was adapted to the inherent changes of context, could have further reduced distress, by helping people better understand how they can support each other. Throughout the pandemic, there are examples of good and bad practice regarding public

messaging, and it is clear that a lack of information only contributes to confusion and disorientation. Many bereavement support organisations with an online presence already had public messaging available over the internet. Smaller, more local, bereavement support groups (mostly community and faith based) had hard copy information available. Some of this was focused on the services provided, but there were and are good examples of public messaging about how to cope when grieving, and how to support others. This is the case for children, young people, and adults. Cruse's public information in this regard is better than it was, and we continue to improve this. However, as a sector, the quality, veracity and availability of this information was variable. Furthermore, a member of the public is more likely to be accessing this information if they are already involved with the organisation. For people who had not experienced a bereavement before, access due to a lack of previous need, was often minimal or non-existent. If there was more consistency, and information was made more readily available to all groups and communities, it may have been more possible to help more people help each other. This would include access to information translated into key languages, available in several formats (written, audio and visual) to increase accessibility. Evidence derived from before, during and after the pandemic indicates that having a community of people supporting the bereaved, can help reduce how onerous grief can be.

74. Fifthly, associated professionals could have been targeted and trained on how to provide some level of bereavement support, in response to needs arising from the pandemic. Early in the pandemic, it was evident that bereavement support organisations would experience capacity difficulties, as the quantitative amount of need rose. Whilst many organisations engaged in actions to increase capacity (such as the deploying of new services such as Cruse's text-based support, or the growing of current services such as our National Helpline), other associated sectors and functions within them could have been harnessed. This could have sped up an increase in capacity, in a relatively cost-effective manner. For instance, as the British Association for Counselling and Psychotherapy provided free online training on conducting remote therapy, bereavement support organisations could have developed some means of sharing learning with therapists to equip them in the bereavement space (with an approach tailored to grief as a result of a

bereavement during the pandemic). Another example could have been providing bereavement awareness training to Mental Health First Aiders throughout the UK. These initiatives would have required some resourcing. However, some funding was available, at least for the duration of the pandemic and for a short time thereafter.

75. Finally, operating a sustainable financial model was a challenge. Additional funding for support organisations was available during the pandemic. Indeed, Cruse applied for some and utilised this to establish remote services that were able to support people across England, Northern Ireland and Wales, with video, telephone and text-based bereavement interventions. This enabled us to reach people in geographical locations where there was previously no bereavement support. However, once it had been decided that the pandemic had subsided, funding ended and, in most cases, was not renewed. However, as is expressed earlier in this statement, we are now seeing grief manifest in long-term consequences resulting from bereavements during the pandemic. These have societal impacts, and a negative impact on the public purse. If we could have worked with Local and National Government to consider a more sustainable model of universal grief support, then some of those emerging needs may have been possible to address. This may have also prevented some people needing to access mental health services for support, when community-based bereavement support was not available, and so their needs escalated to a clinical level. There are profound indications that society is changing in the way that it respond to grief (Exhibit AL/15) [INQ000661992].

76. In addition to this learning, it is important to understand that bereavement support services, prior to the pandemic, were not universally funded throughout the UK, and were facing needs that could not be matched by their capacities. Nor is there an accepted way of commissioning services on the basis of calculating county, city or borough-based need, although the National Bereavement Alliance has published a guidance document on this (Exhibit AL/01) [INQ000661983]. Some funding was allocated via Health Trusts and Local Authorities, via contractual arrangements, and to a lesser extent, grants. This lack of parity between need and provision remains today, with no indication that the funding situation will

improve. Whilst we prepare for another pandemic, as it is clear that it is highly likely one will emerge, there remains no statutory financial support for preparedness.

**Documents that Cruse considers relevant to the Inquiry's investigation into the provision and experience of bereavement support and services during the pandemic**

77. You will find accompanying this statement, the following documents which are the core source material for the information in this statement:

78. A Guide to Commissioning Bereavement Support in England – 2023 (Exhibit AL/01) [INQ000661983]

79. Bereavement Supporter Project Evaluation – November 2021 (Exhibit AL/02) [INQ000661984]

80. Collective Healing Through Honouring Loved Ones Report – December 2025 (Exhibit AL/03) [INQ000661985]

81. Cruse Annual Report and Financial Statements, Year Ending 31<sup>st</sup> March 2020 (Exhibit AL/04) [INQ000659956]

82. Cruse Annual Report and Financial Statements, Year Ending 31<sup>st</sup> March 2021 (Exhibit AL/05) [INQ000659957]

83. Cruse Annual Report and Financial Statements, Year Ending 31<sup>st</sup> March 2022 (Exhibit AL/06) [INQ000659958]

84. Cruse Annual Report and Financial Statements, Year Ending 31<sup>st</sup> March 2023 (Exhibit AL/07) [INQ000659959]

85. Outcomes for Bereaved People – October 2022 (Exhibit AL/08) [INQ000661993]

86. This is a list of academic papers that we at Cruse have used to support how we have adapted services to respond to people bereaved during the pandemic. Please also find these in pdf format, accompanying this statement:
87. Harrop, E. and Selman, L., (2022). Bereavement during the Covid-19 pandemic in the UK: What do we know so far?. *Bereavement*, 1. (Exhibit AL/09) [INQ000661986]
88. Harrop, E., Medeiros Mirra, R., Goss, S., Longo, M., Byrne, A., Farnell, D.J., Seddon, K., Penny, A., Machin, L., Sivell, S. and Selman, L.E., (2023). Prolonged grief during and beyond the pandemic: factors associated with levels of grief in a four time-point longitudinal survey of people bereaved in the first year of the COVID-19 pandemic. *Frontiers in Public Health*, 11, p.1215881. (Exhibit AL/10) [INQ000661987]
89. Johnson, C.C. and Aldea, M.A., (2021). Impact of the COVID-19 pandemic on mental health: potentially vulnerable groups and comorbidities. *Journal of Emergency Management*, 19(9), pp.9-15. (Exhibit AL/11) [INQ000661988]
90. Kaur-Aujla, H., Lillie, K. and Wagstaff, C., (2022). Prognosticating COVID therapeutic responses: Ambiguous loss and disenfranchised grief. *Frontiers in public health*, 10, p.799593. (Exhibit AL/12) [INQ000661989]
91. Maddrell, A., (2020). Bereavement, grief, and consolation: Emotional-affective geographies of loss during COVID-19. *Dialogues in Human Geography*, 10(2), pp.107-111. (Exhibit AL/13) [INQ000661990]
92. Mayland, C.R., Harding, A.J., Preston, N. and Payne, S., (2020). Supporting adults bereaved through COVID-19: a rapid review of the impact of previous pandemics on grief and bereavement. *Journal of pain and symptom management*, 60(2), pp.e33-e39. (Exhibit AL/14) [INQ000661991]
93. Millar, K.M., Han, Y., Bayly, M.J., Kuhn, K. and Morlino, I., (2020). Confronting the COVID-19 pandemic: grief, loss, and social order. (Exhibit AL/15) [INQ000661992]

94. Pearce, C., Honey, J.R., Lovick, R., Creamer, N.Z., Henry, C., Langford, A., Stobert, M. and Barclay, S., (2021). 'A silent epidemic of grief': a survey of bereavement care provision in the UK and Ireland during the COVID-19 pandemic. *BMJ open*, 11(3), p.e046872. (Exhibit AL/16) [INQ000650070]
95. Selman, L.E., Farnell, D.J., Longo, M., Goss, S., Torrens-Burton, A., Seddon, K., Mayland, C.R., Machin, L., Byrne, A. and Harrop, E.J., (2025). Factors associated with higher levels of grief and support needs among people bereaved during the pandemic: Results from a national online survey. *OMEGA-Journal of Death and Dying*, 91(2), pp.904-931. (Exhibit AL/17) [INQ000661995]
96. Selman, L.E., Sutton, E., Medeiros Mirra, R., Stone, T., Gilbert, E., Rolston, Y., Murray, K., Longo, M., Seddon, K., Penny, A. and Mayland, C.R., (2023). 'Sadly I think we are sort of still quite white, middle-class really'—Inequities in access to bereavement support: Findings from a mixed methods study. *Palliative Medicine*, 37(4), pp.586-601. (Exhibit AL/18) [INQ000659960]
97. Suleman, M., Sonthalia, S., Webb, C., Tinson, A., Kane, M., Bunbury, S., Finch, D. and Bibby, J., (2021). Unequal pandemic, fairer recovery. *Health Foundation*. (Exhibit AL/19) [INQ000280416]
98. Torrens-Burton, A., Goss, S., Sutton, E., Barawi, K., Longo, M., Seddon, K., Carduff, E., Farnell, D.J., Nelson, A., Byrne, A. and Phillips, R., (2022). 'It was brutal. It still is': a qualitative analysis of the challenges of bereavement during the COVID-19 pandemic reported in two national surveys. *Palliative care and social practice*, 16, p.26323524221092456. (Exhibit AL/20) [INQ000650073]
99. Weinstock, L., Dunda, D., Harrington, H. and Nelson, H., (2021). It's complicated—adolescent grief in the time of COVID-19. *Frontiers in Psychiatry*, 12, p.638940. (Exhibit AL/21) [INQ000661998]

## Statement of Truth

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

Signed: **Personal Data**

(Andrew Phillip Langford)

**Dated:** 18<sup>th</sup> December 2025