

Monday, 2 March 2026

1
2 (10.32 am)
3 **LADY HALLETT:** Good morning. Bit of a squeeze; are you all
4 right? Sorry you had to squeeze into that.
5 Ms Rahman.
6 **MS RAHMAN:** My Lady, the next witnesses to be called are
7 Mr Dan Shears, Mr Mike Short, Mr John Leach and
8 Ms Joanne Thomas respectively. They are representatives
9 from the unions GMB, UNISON, the National Union of Rail,
10 Maritime and Transport, or RMT, and the Union of Shop,
11 Distributive and Allied Workers, or USDAW.
12 May they be sworn, please.
13 **MR JOHN LEACH (affirmed)**
14 **MS JOANNE THOMAS (sworn)**
15 **MR MICHAEL SHORT (affirmed)**
16 **MR DANIEL SHEARS (affirmed)**
17 **Questions from COUNSEL TO THE INQUIRY**
18 **MS RAHMAN:** Thank you very much indeed to all of you for
19 attending to give evidence today.
20 There should be a statement in front of each of you
21 dated 10 December 2025 with a reference number
22 INQ000659898.
23 If I could start with Mr Short.
24 Can you give your full name, please.
25 **MR SHORT:** My name is Michael Short.

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1 **MS THOMAS:** Yes, that's correct.
2 **Q.** And can you confirm that any facts stated within the
3 statement are true to the best of your knowledge and
4 belief?
5 **MS THOMAS:** Yes, I can.
6 **Q.** Finally, Mr Shears, could you give your full name,
7 please.
8 **MR SHEARS:** Certainly. It's Daniel Stuart Shears.
9 **Q.** Mr Shears, you should have an additional statement in
10 front of you dated 26 February 2026 with a reference
11 number INQ000660164 in which you adopt the contents of
12 the statement of 10 December that was provided by the
13 other witnesses.
14 **MR SHEARS:** Yes.
15 **Q.** Can you confirm that any facts stated within these
16 statements are true to the best of your knowledge and
17 belief?
18 **MR SHEARS:** I can confirm that, yes.
19 **Q.** Many thanks.
20 I'll deal briefly now with your professional
21 backgrounds and the unions you represent here today.
22 Mr Shears, you are the Health and Safety Director at
23 GMB?
24 **MR SHEARS:** That's correct, yes.
25 **Q.** And GMB, in summary, is a general union that represents

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1 **Q.** Could you confirm that the statement in front of you is
2 one to which you have contributed for the purposes of
3 the Inquiry.
4 **MR SHORT:** Yes, it is.
5 **Q.** And can you confirm that any facts stated within the
6 statement are true to the best of your knowledge and
7 belief?
8 **MR SHORT:** Yes, absolutely.
9 **Q.** Now, if I could turn to Mr Leach. Could you give your
10 full name, please.
11 **MR LEACH:** Mr John Leach.
12 **Q.** And can you confirm that the statement in front of you
13 is one to which you have contributed for the purposes of
14 the Inquiry?
15 **MR LEACH:** I have.
16 **Q.** And can you confirm that any facts stated within the
17 statement are true to the best of your knowledge and
18 belief?
19 **MR LEACH:** They are.
20 **Q.** Thank you.
21 Ms Thomas, could you give us your full name, please.
22 **MS THOMAS:** Joanne Thomas.
23 **Q.** And can you confirm that the statement in front of you
24 is one to which you have contributed for the purposes of
25 the Inquiry.

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1 members working across multiple sectors including
2 retail, security, schools, distribution, utilities and
3 local government?
4 **MR SHEARS:** Yes, that's correct, around 90% of our members
5 during the pandemic were key workers.
6 **Q.** Thank you.
7 Mr Short, you were the National Secretary for
8 Education and Local Government at UNISON?
9 **MR SHORT:** Yes.
10 **Q.** And they're also a general union whose members include
11 those working in a range of public services and
12 utilities?
13 **MR SHORT:** Yes, that's right.
14 **Q.** Thank you.
15 Ms Thomas, you are the General Secretary of USDAW
16 and members include those working in the retail sector,
17 road transport, warehouses, and distribution and food
18 and manufacturing; is that correct?
19 **MS THOMAS:** That's correct.
20 **Q.** Thank you.
21 Finally, Mr Leach, you are the Senior Assistant
22 General Secretary of the RMT and that represents workers
23 across the transport sector?
24 **MR LEACH:** That's right.
25 **Q.** Thank you.

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1 Mr Shears, I will, for convenience, essentially,
2 direct general questions arising from the statement to
3 you, but the other witnesses should of course indicate
4 if there is anything that they want to add on such
5 questions. And that also applies on areas where there
6 may well be crossover between the unions and the members
7 of the unions in relation to any significant point
8 relevant to the impact on key workers.

9 First, then, Mr Shears, starting with the beginning
10 section of this statement, it's right that it's been
11 produced on behalf of the Trades Union Congress, or TUC,
12 with input from a number of other unions in addition to
13 those of you here today and they're set out at
14 paragraph 1; is that correct?

15 **MR SHEARS:** Yes, that's correct, yes.

16 **Q.** And I will list them now. We have input from the
17 Associated Society of Locomotive Engineers and Firemen,
18 or ASLEF; the Bakers, Food and Allied Workers Union,
19 BFAWU; the Communications Workers Union, CWU; the Fire
20 Brigades Union, FBU; and the National Association
21 of Head Teachers, NAHT; the National Association of
22 Schoolmasters Union of Women Teachers, NASUWT; the
23 National Education Union, NEU; the Prison Officers'
24 Association, POA; and the Transport Salaried Staffs'
25 Association, TSSA; and Unite the Union, or Unite.

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1 support trades unions of which there are 48 members, all
2 of which, as you've described, were affected by the
3 pandemic. I'll touch briefly on how the TUC operates
4 across the UK. Is it right that for England and Wales,
5 the TUC has an integrated formal structure for TUC
6 Cymru?

7 **MR SHEARS:** Yes, that's correct, yeah.

8 **Q.** But it also collaborates with the Scottish TUC and the
9 Irish Congress of Trades Unions on UK-wide issues?

10 **MR SHEARS:** Yeah, absolutely and that was very evident
11 during the key part of the Covid pandemic, extremely
12 close collaborative working.

13 **Q.** And it's right that that relationship between all four
14 nations, the TUC organisations, is formalised through
15 a body known as the Council of the Isles?

16 **MR SHEARS:** Yeah, that's correct, yeah.

17 **Q.** Thank you.

18 Now, we will not be able, I should stress, to cover
19 all the documentation and material that the TUC have
20 provided to the Inquiry today. However, the statement
21 and the exhibits are before the Inquiry. What I'm going
22 to cover with you are four main areas in relation to the
23 impact on key workers. I'll list those now.

24 One, health outcomes, including infection,
25 mortality, and impact on mental health and wellbeing.

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1 And we see in the statement references to a number
2 of those unions, do we not, in several places with those
3 abbreviations?

4 **MR SHEARS:** Yes.

5 **Q.** All right, with the extensive introductions over, let's
6 proceed to hear from you about the impact on key
7 workers.

8 Now, the Inquiry has already hearing from the TUC in
9 earlier modules so I'll touch on that only briefly and
10 again, if I may, with you, Mr Shears.

11 In section A at paragraphs 3 and 4 of the statement,
12 it's right that it is noted that many of those who died
13 in the pandemic were key workers, and many of those
14 workers were TUC affiliate members; is that correct?

15 **MR SHEARS:** Yes, that's correct. Almost every union will
16 have lost members during the pandemic.

17 **Q.** As well as the deaths of key workers, issues such as
18 inadequate PPE, poor workplace safety and adverse mental
19 and physical outcomes are highlighted in summary at the
20 beginning of that statement as some of the ways in which
21 key workers were impacted; is that right?

22 **MR SHEARS:** Yes, absolutely, yeah, and those are very
23 typical again for all of the unions.

24 **Q.** Thank you.

25 In section B it's noted that the TUC exists to

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1 Two, workplace safety. Three, other impacts such as the
2 impact of experiencing abuse. And four, any inequality
3 of impact among key workers.

4 A final point to note is that the Inquiry has heard
5 some evidence on some of those areas earlier in the
6 hearing, so I'll touch on those areas in less detail.

7 Topic one, health outcomes: infection and mortality
8 and mental health. Mr Shears, as I've discussed, I'm
9 going to ask you about some general issues. Looking at
10 section C of the statement, this area is covered first
11 under the subheading "Transmissions and death", and
12 there is reference at paragraphs 16 and 17 to ONS and
13 other data and that data showed what's described as
14 a correlation between certain occupations and Covid-19
15 exposure and fatality.

16 And it's said there that's because some were less
17 able to work at home or socially distance at work; is
18 that correct?

19 **MR SHEARS:** Yes, absolutely.

20 **Q.** Now, the Inquiry has obtained a statement from ONS,
21 which has already been adduced, but I will refer to some
22 parts now which may well reflect the points that you are
23 making there.

24 First, in relation to infection rates, if we could
25 get on screen that statement at page 37. It's

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1 INQ000659855. And paragraph 143, which I shall read
2 out. It says:

3 "Adjusting for a wide range of demographic and
4 health-related factors, the authors found that some
5 groups of 'essential workers' consistently experienced
6 elevated levels of infection compared to non-essential
7 workers. That means that even after removing the
8 expected effect of factors [such as] age, sex, and
9 health conditions, bus and coach drivers, people working
10 in police and protective services, education and social
11 care were still more likely to get infected ..."

12 And the ONS statement goes on to say this, same INQ
13 number, at page 40, paragraph 149(b):

14 "For most industries, increased physical proximity
15 in the workplace was associated with increased risk of
16 Covid-19 outbreaks".

17 So that is infection.

18 Moving on to mortality, if we can have page 41 of
19 the same document up, and paragraph 152, that refers to
20 an analysis of age-standardised mortality rates by
21 occupation, and the period was between 24 January 2020
22 and 28 February 2022, and it highlights there particular
23 groups of care workers including teaching and
24 educational professionals, protective service
25 occupations, caring personal service occupations, sales

9

1 Q. Thank you very much.

2 The ONS statement also goes on to say this at
3 paragraphs 145 to 5, it says:

4 "It is important to note that the analysis does not
5 account for factors that are likely to be associated
6 with occupation and risk infection such as living in
7 deprived conditions and health status and therefore it
8 is not possible to say that a particular occupation is
9 causally related to the risk of Covid-19 mortality."

10 And it also says:

11 "We did not break this down by any other demographic
12 characteristics. The relatively low number of deaths by
13 occupations groups did not allow us to derive accurate
14 rates broken down further by factors such as age group,
15 ethnicity, disability, or other measures -- or measures
16 of clinical vulnerability."

17 So, Mr Shears, there are certain caveats and limits
18 to the data but the broad points still remain; is that
19 correct?

20 MR SHEARS: Yes, I would say so, yes.

21 Q. I, finally, want to briefly pick up on a point that you
22 make in this section of the statement, quite
23 prominently, about early guidance that required
24 employers to report cases where there was reasonable
25 evidence to suggest occupational exposure, and that was

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1 occupations, transport and mobile machine drivers and
2 operatives.

3 The analysis is on table 6 on the following page,
4 42, and we can see there that one of the highlighted key
5 worker groups, transport and mobile machine drivers, is
6 at the top of the table.

7 That then is noted on the next page, paragraph 153,
8 and it also notes that teaching and educational
9 professionals, by that analysis, had the lowest
10 age-standardised rates according to the research.

11 Now, I know that there will be another point to make
12 on that which I'll come back to with Mr Short in
13 a moment, but taking all of that that I've put up there
14 on screen from the ONS, is it correct, Mr Shears, that
15 what we've looked at within that statement about some
16 groups of essential workers consistently experiencing
17 elevated levels of infection compared to non-essential
18 workers, and the mortality rates for some key worker
19 groups that we've seen, that's consistent with what
20 you've explained in your statement?

21 MR SHEARS: Yes, absolutely, the combination of close
22 proximity to the public and close proximity and close
23 contact to fellow workers in closed workplaces
24 absolutely reflects experiences of our members in terms
25 of their infection and mortality rates.

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1 under certain health and safety regulations, which are
2 the Reporting of Injuries, Diseases and Dangerous
3 Occurrences Regulations, or RIDDOR.

4 Again, in summary, that requirement changed later,
5 but I believe that the point that you're making is that,
6 for the period when it applied, when you look at the
7 recorded deaths from the ONS, they're high compared to
8 the reported deaths over the same period under those
9 regulations; is that correct?

10 MR SHEARS: Yes, the interpretation of the RIDDOR
11 regulations changed several times during the course of
12 the pandemic, and at the period -- at the earliest
13 phase, when there was really no workplace testing being
14 done, there was no method of recording deaths unless
15 they were by almost laboratory exposures, and therefore
16 the number of recorded RIDDOR deaths is very low
17 compared to those witnessed by ONS.

18 Q. And that's why you suggest at paragraph 20 it's not
19 unreasonable, I think is the way you put it, that more
20 deaths than were reported may have been as a result of
21 exposure in the workplace, and that's particularly
22 because of the reports you were getting about workplace
23 safety, which we'll come back to; is that correct?

24 MR SHEARS: Absolutely. Because, as I said, 90% of our
25 members are key workers, I think 10.6 million workers

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1 are at work during this period. If their family members
2 are isolating at home, if they're locked down, it stands
3 to reason, we think, that most of that exposure is
4 coming in the workplace, and therefore that does not
5 really reflect what was happening in the real world.
6 **Q.** That is the suggestion you make, but you do acknowledge
7 that there are numerous other ways that the infection
8 could have been contracted, for instance by travelling
9 to work, socially or otherwise, as you make clear?
10 **MR SHEARS:** Absolutely, yes.

11 **Q.** Thank you.

12 And it's also correct that this is a point that is
13 not specific to key workers that you're making, it's
14 a broader point you're making about workplace exposure
15 and underreporting?

16 **MR SHEARS:** Yes.

17 **Q.** Thank you.

18 As we're on the ONS statement, I will touch now on
19 the section that deals with mental health and wellbeing
20 at paragraphs 159 to 162. Reminding ourselves, we're
21 looking at health outcomes, both mortality, infection
22 and mental health. I don't need to put those up on
23 screen. We have had a lot of evidence about mental
24 health and wellbeing, and we'll deal with specific
25 sectors in due course.

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1 In terms of support for key workers' mental health
2 and wellbeing during those circumstances of the
3 pandemic, the roundtable report on key workers, which
4 I know that TUC attended and some of the unions attended
5 as well, contains comment on that particular issue,
6 which I was going to ask you about.

7 If we could get the report -- it's INQ000659704 --
8 up at page 51.

9 And it says there:

10 "Many sectors described how inadequate mental health
11 and wellbeing support for workers exacerbated feelings
12 of being undervalued. It left many feeling isolated,
13 struggling to cope with the pressures they faced and at
14 risk of burnout ...

15 "In some cases, support was on offer, but it was
16 felt that employers could have taken more responsibility
17 to ensure staff made use of it. Without adequate
18 support, workers had to rely on peer support or had no
19 support at all."

20 So, again, Mr Shears, as a general point, do you
21 have any comment about what you understood about the
22 availability of support for key workers' mental health
23 during the pandemic?

24 **MR SHEARS:** Yes, absolutely. That statement, I would say,
25 is typical in many respects. Mental health support was

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1 Just to cite some of the statistics, though, that
2 are set out there, in one survey, covering the period
3 24 April to 3 May 2020, around three-quarters of key
4 workers reported being very worried or somewhat worried
5 about the effect of Covid-19 on their life.

6 And it goes on to say that, among key workers who
7 reported that, the most common reasons were being
8 worried about health and safety at work, an increase in
9 work, or sometimes the decrease caused by a place of
10 work being closed. That impacted mental health.

11 And there are also issues with following social or
12 distancing advice, lack of protective clothing, PPE,
13 and, finally, concerns about colleagues contracting
14 Covid-19.

15 So that's from the ONS statement.

16 Mr Shears, in broad terms, would you agree that
17 these are some of the main issues that impacted key
18 workers that were TUC members, in terms of mental health
19 and wellbeing.

20 **MR SHEARS:** Absolutely caused huge anxiety for our members.

21 These were the issues that we were being contacted about
22 on an hourly basis, certainly during the first few weeks
23 of the pandemic. They absolutely are the right list,
24 I would say.

25 **Q.** Thank you very much.

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1 not considered to be appropriate or a concern for
2 employers. The concern was getting people into work and
3 ensuring they were Covid free.

4 In many of those sectors, especially the ones
5 referenced there, where we've had longstanding
6 membership, there would not have been generally good
7 levels of mental health support pre-pandemic, so this
8 was not something that workers could easily tap into.
9 It was very much something that was being considered
10 after a lot of lobbying and an awful lot of evidence
11 from our members to say that the anxiety that they were
12 facing into every day was cumulative, and it was really
13 very negatively impacting both their mental and physical
14 health. So it was a real struggle to actually get
15 employers in some sectors to take this seriously.

16 **Q.** Thank you.

17 A final general point, and a recurring one, is on
18 the subject of recognition for key workers. The Inquiry
19 heard from Professor Marmot, who said this of people
20 working in frontline occupations:

21 "... the heroes who are coming to collect your
22 garbage, who were serving as cashiers in the
23 supermarkets, these were the heroes in the pandemic,
24 putting themselves at risk by helping society ..."

25 I'm sure you agree with that sentiment?

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1 **MR SHEARS:** (The witness nodded)

2 **Q.** However, a lack of recognition, bearing on the mental
3 health and wellbeing of key workers we are looking at in
4 this module has been a recurrent theme. So, I'll take
5 you to some parts of what we've already heard on this
6 before, asking for your view.

7 If I could have INQ000659763 up on screen at
8 page 44, please. It says this:

9 "Everyone was clapping the NHS, quite rightly, but
10 other essential workers were give a momentary passing
11 glance, returning to business as usual, assumptions that
12 we would just get on with it unseen ..."

13 That's from an HGV driver in Scotland.

14 A retail worker said this:

15 "Key workers are not just the people that worked in
16 the NHS."

17 And finally, a security worker from England said
18 this:

19 "I was working day shifts and night shifts doing
20 security in central London. The biggest risk was my
21 commute. But my industry was not recognised."

22 Mr Shears, was a lack of recognition an important
23 part of adverse impact on key workers' mental health and
24 wellbeing, in your view?

25 **MR SHEARS:** Yes, absolutely, absolutely. A huge number of
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1 phenomenal. A lot of them didn't have sick pay to start
2 with, but they kept coming to work. So there was a real
3 resonance to this right across the trade union movement,
4 I think. And in particular with RMT, all of our members
5 who were right in the front line -- I can't name them
6 all; I want to, because I'm here today representing
7 them -- but they felt that they were not part of that,
8 and they felt utterly disregarded afterwards. So,
9 that's our -- that's me trying to summarise all of it.

10 **Q.** You summarise it very well, if I may say so.

11 Ms Thomas?

12 **MS THOMAS:** Thank you. I think it's really important that
13 we focus on the mental health and wellbeing and the
14 impact that that had in particular on the workers that
15 we represent. But -- you said yourself, with the high
16 level of reports which I think indicate the anxiety that
17 was being felt, but just to make specific reference in
18 retail, you had our members, in particular, working very
19 long hours in incredibly busy environments, while trying
20 to implement social distancing, and that was extremely
21 stressful.

22 You know, the worries that our members reported to
23 ourselves wasn't just about their own safety as well; it
24 was about the safety of the customers they were trying
25 to serve. And then, of course, if they were going home
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1 our workers work in retail, logistics, security. They
2 absolutely felt themselves to be on the front line of
3 this pandemic as much as any health worker. And they
4 knew that they were putting themselves and their
5 families' healths at risk, and they felt very badly let
6 down, because they weren't recognised.

7 Where I live, in Epsom, there's a lovely set of
8 benches that recognise the heroes of the pandemic. They
9 are all emergency service workers depicted, there is
10 no one else on those benches. Which doesn't really
11 reflect the work that was done by our unions to keep the
12 country running during this period. A huge number of
13 our members feel badly affected by it, they are very let
14 down by it. They do feel that they weren't recognised
15 for their sacrifices during the whole of the pandemic
16 period.

17 **Q.** I can see that all of the witnesses have something to
18 say on this, so if I could turn to the first person who
19 raised their hand, I think it's Mr Leach?

20 **MR LEACH:** Well, absolutely, yeah. I mean, I think all of
21 our members right across transport, on road, rail, the
22 people who support them, they felt devalued and unheard
23 during this period, and they still do. It's like as if
24 they were never there, but they were there from the
25 beginning to the end. The impact on them was
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1 on an evening, actually potentially spreading the virus,
2 had they become infected, sometimes without even
3 knowing, to other members of their family.

4 And actually, when they were trying to implement the
5 social distancing, the legislation in particular, that
6 would often cause flashpoints.

7 And I know we'll talk about abuse later on, but
8 I think, linking this to the mental health and wellbeing
9 of the workers at that time, when they were just doing
10 their job, that would cause really big issues of abuse,
11 and sometimes violence, which, of course, had a real
12 negative impact on their general wellbeing, and felt
13 extremely frightened, extremely frightened and extremely
14 worried at that period in time. And it was awful to
15 hear some of the stories that our members shared with us
16 of how they felt every single day.

17 And like my colleague --

18 **Q.** Ms Thomas, we will have some of those accounts both from
19 your statement and also from Every Story Matters, and
20 indeed the roundtables.

21 **MS THOMAS:** Yeah, just to conclude, then, they felt very
22 regularly dehumanised, and that's an awful feeling when
23 you're trying to do the best for society.

24 **Q.** Thank you. And we will come back to some of those
25 points in more detail. It's extremely helpful to have
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1 it set out at the outset from your sector.
 2 Mr Short?
 3 **MR SHORT:** Thank you. I'll try to be brief. The link
 4 between the lack of recognition for workers in schools
 5 and the mental health impact is -- it's very real, and
 6 evident. And from day one, there was a narrative that
 7 schools were closed. They actually weren't closed. And
 8 it was the lower paid, the school support staff, who
 9 were keeping them open. And the children who came in,
 10 because they were the children of key workers or they
 11 were vulnerable, were in what were called bubbles. The
 12 teaching assistants were not in those bubbles, and at
 13 the same time the teaching assistants were going to
 14 work. And it wasn't just a lack of recognition for
 15 them; they felt at times they were being vilified by
 16 their own government, because, you know, their unions,
 17 their representatives were calling for greater safety in
 18 schools.
 19 If I may, one teaching assistant has told us that
 20 the teaching assistants were getting so ill from all the
 21 bubble mixing, and it was seen as okay, it was
 22 absolutely terrifying. Teaching assistants were treated
 23 as replaceable when we all caught Covid multiple times.
 24 **Q.** Mr Short, thank you very much for that. Again, it's
 25 really helpful to have an introduction and a bit of

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1 country running and although people were very anxious
 2 and scared, they genuinely felt like they were doing
 3 their best for the public good and they took huge pride
 4 and strength from that.
 5 **Q.** Thank you.
 6 Do either of you -- any of you have anything further
 7 to add?
 8 **MR LEACH:** The same.
 9 **Q.** Mr Leach?
 10 **MR LEACH:** The same as what my colleague has just said.
 11 **Q.** Oh, the same, I'm sorry I missed that, yes.
 12 **MR LEACH:** They did but they kind of knew it anyway because
 13 these -- they were just doing what they do: which is
 14 come to work, and put in a shift, but now they were
 15 doing it under great risk and under great anxiety. But
 16 they jumped to it and they served the nation well, and,
 17 you know, we will forever be grateful.
 18 **Q.** Thank you.
 19 Mr Shears, I'm now going to go through health
 20 outcomes in individual sectors. Again, looking at
 21 infection, mortality, and mention.
 22 Mr Short, first, education. There's a lot of detail
 23 about this sector in the statement, and I'll pick up
 24 some of the main ones. First, I mentioned that I would
 25 briefly cover something that is said on the topic of

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1 flavour of, you know, what people were experiencing and
 2 telling you. We'll deal with the things in due course
 3 in a little more detail, but that's extremely helpful.
 4 If I could have now another aspect, a very different
 5 one, that comes from some of the evidence that the
 6 Inquiry has heard, INQ000659763.
 7 The report on key workers, a roundtable,
 8 highlighted, on the other hand, a sense of pride and
 9 fulfilment that key workers experienced, for instance
 10 this example:
 11 "I continued to work as delivery food driver. That
 12 made it easy for me but hard for others that were
 13 homebound, including my customers. I was sometimes the
 14 only person they saw for days on end. It was
 15 a privilege to listen to them and reassure them that
 16 everyone was feeling the same."
 17 Do you -- again, starting with Mr Shears, do you
 18 also recognise that positive impact of the contribution
 19 made by key workers on their mental health?
 20 **MR SHEARS:** Yes, absolutely. There was a great sense of
 21 pride in the initial stages of the pandemic, a sense for
 22 the first time that workers themselves were being
 23 recognised for their actions and their effort as opposed
 24 to managers and shareholders. Very strongly a sense
 25 that actually this was something that was keeping the

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1 infection rates as represented in the ONS figures on
 2 education workers.
 3 Mr Short, at paragraphs 138 to 140, there's
 4 reference there to a high risk of infection and reported
 5 cases of infection amongst those working in schools; is
 6 that correct?
 7 **MR SHORT:** Yes, that's right.
 8 **Q.** And, for instance, NASUWT obtained figures from three
 9 local authorities suggesting that infection rates were
 10 four times higher among school staff than in average in
 11 those locations; is that correct?
 12 **MR SHORT:** That's right, yes.
 13 **Q.** What you say in relation to the ONS figures is that
 14 there is some concern that impact on support staff in
 15 schools was not adequately captured due to there being
 16 no specific data for cleaners, technicians and office
 17 staff specifically working in schools; is that correct?
 18 **MR SHORT:** That's right, yes.
 19 **Q.** And there's also reference to higher rates of sickness
 20 absence and Long Covid being reported in the sector.
 21 Just to clarify from some of the exhibits that you've
 22 produced, the reported symptoms included chronic
 23 fatigue, breathlessness, loss of taste and smell, and
 24 heart palpitations; is that correct?
 25 **MR SHORT:** Yes.

24

1 Q. You also note broader concerns merely than individual
2 health outcomes, which is our focus, but you say that
3 education unions were concerned about the impact on the
4 sector's ability to recover, particularly the cost of
5 supply teachers; is that correct?

6 **MR SHORT:** That's right and that's an ongoing problem in the
7 education sector now which has never gone away since
8 Covid.

9 Q. I will, then, get up on screen again an account shared
10 with Every Story Matters, INQ000659763, at page 43. It
11 says:

12 "As a result of my experiences with Long Covid,
13 I was forced to take a year off work in my job as
14 a secondary English teacher. I then returned on
15 a part-time basis. Three years in, I have only just
16 been able to return full time."

17 So, Mr Short, does that illustrate the two points
18 that you make in the statement; first, the long legacy
19 of the infection on the teacher, and second, the impact
20 of the loss of their skills, cost of replacing those
21 skills when the teacher was unable to work for an
22 extended period?

23 **MR SHORT:** That's right. I'd only add that it's about the
24 whole education workforce. Teaching assistants,
25 cleaners and so on who, in many senses were even more

25

1 coughing."

2 And I take it that's one of the main problems with
3 infection control in the sector?

4 **MR SHORT:** Yes, that's right. In the early days of Covid
5 there were PPE problems as well, but the reality is, in
6 that kind of environment it's very difficult. The
7 example of this caretaker, the individual in question
8 requested flexibility to do as much of their job as
9 possible when children weren't there, but that was
10 declined. And that kind of story was, sadly, typical.

11 Q. We'll come back to infection control in the next
12 section, thank you.

13 Finally again, back to the issue of mental health.
14 It was also discussed at the Key Workers Roundtable.
15 Can we get INQ000659704, at page 47, up. It says:

16 "Education representatives discussed the significant
17 impact Covid had on staff's physical and mental
18 wellbeing. The NEU raised the high prevalence of Long
19 Covid among staff in education settings. They suggested
20 that unsafe workplaces led to staff contracting Covid-19
21 and experiencing long-term health problems. And NASUWT
22 also highlighted that the mental impact on those losing
23 colleagues was massive."

24 So, Mr Short, is this account consistent with the
25 sorts of concerns that you were aware of that were being

27

1 susceptible to infection because of the proximity and
2 often one-to-one care that teaching assistants have to
3 deliver in particular.

4 Q. Thank you.

5 I'll now turn in more detail to the impact on
6 wellbeing and mental health in the sector, noting, of
7 course, that you've already given some initial thoughts
8 on that.

9 It's covered at paragraphs 124 to 125 of the
10 statement. There's reference to a National Education
11 Union survey, and it was noted that there were
12 "dangerously high stress levels among educators and
13 unmanageable workloads". It's noted that support staff
14 were required to take on work outside their usual roles,
15 and that impacted on them in terms of workload and
16 emotional toll. Is that a fair summary of what's set
17 out there?

18 **MR SHORT:** Yes, it is. And the example I gave before used
19 the word "terrifying" and that's not uncommon from our
20 experience of talking to our members.

21 Q. There's also a report included in the statement from
22 a school caretaker at paragraph 124, and that notes
23 that:

24 "There is little chance of social distancing in
25 a primary school -- you can't stop kids kneeling and

26

1 raised by education workers about the impact on their
2 mental health and wellbeing?

3 **MR SHORT:** Yes, absolutely. The picture is right -- our
4 members in schools and elsewhere in the education system
5 was one of constant anxiety.

6 Q. Thank you.

7 Mr Leach, if I could turn to you now on some
8 specific impacts on the transport sector. You note at
9 paragraph 175 data from a period in 2020 that showed
10 Covid-related mortality for bus and coach drivers
11 outstripped all other transport workers with the
12 exception of taxi and private hire vehicles; is that
13 correct?

14 **MR LEACH:** Yes.

15 Q. So, all of those types of transport workers experienced
16 a particular impact in that case, including the taxi and
17 private hire drivers? Because we've talked about bus
18 and coach drivers before.

19 **MR LEACH:** Yeah.

20 Q. Would those workers, the drivers, also have those risk
21 factors of increased proximity to others in their
22 occupations?

23 **MR LEACH:** They would do, yeah, in their -- where they
24 report to work and in and around those surroundings.

25 Q. Thank you. And you note in the statement there was

28

1 a more fragmented approach for unions in the bus
2 industry with unions having to deal with individual
3 operators rather than the more joined-up approach that
4 was achieved in the rail sector.

5 In terms of the mental health impacts, you've
6 described transport workers being described as heroes,
7 and I'm asked by one of the core participants to put
8 this particular question to you: are you able to give an
9 insight into how workers themselves perceived the gap
10 between being publicly praised whilst simultaneously
11 experiencing a lack of protection?

12 **MR LEACH:** Well, yeah, because on a day-to-day basis they
13 were expected just to come to work and pretty much,
14 especially in the early days, carry on as they were
15 before. And, you know, we were watching the
16 Prime Minister on television with saucepans, and all the
17 rest of it, and everyone being praised to the hilt, but
18 it was like a fingers-crossed approach coming to work.
19 And I say that, on the basis that it was kind of like
20 there was like a league scale of where that would be
21 worse, so the privatised bus sector where you just have
22 these individual companies, particularly where our
23 membership is mainly in the west of England, it was, you
24 know, it was not the priority it should have been.

25 And, as you say, you referenced the rail industry,
29

1 **Q.** And again, you recount the sense of lack of recognition
2 that their roles as key workers weren't properly
3 appreciated?

4 **MS THOMAS:** That's correct.

5 **Q.** Thank you.

6 Mr Short, I'll now ask you some questions of
7 specific relevance to the police, probation officers and
8 emergency responders. We've already heard some evidence
9 from the roundtable report about the unique position of
10 police and the impact on them of enforcing restrictions
11 on the public.

12 Paragraph 144 of the statement reflects those same
13 concerns and it refers to mixed messages, confusing
14 guidance -- we'll come back to that in a later topic.

15 At paragraph 146 there's reference to a UNISON
16 survey of police staff in England and Wales. And is it
17 right to say that there were concerns about, in
18 particular, being unable to socially distance, a lack of
19 protective screens or any effective screens and PPE,
20 with many respondents being worried about their health
21 and safety?

22 **MR SHORT:** Yes, that's right. The nature of the work among
23 our members in police staff is that socially distancing
24 is naturally difficult, but also the service was pretty
25 slow with getting appropriate PPE online.

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1 where there was a more joined-up approach.

2 **Q.** Thank you.

3 **MR LEACH:** So that would be my answer to that.

4 **Q.** Thank you very much.

5 Moving back to the retail sector, Ms Thomas, I want
6 to come back to you now. Again, we've talked about the
7 mortality rates for those with more exposure. I want to
8 come back to what you describe at paragraph 158 in terms
9 of mental health outcomes, as I say, in this sector.
10 We're going to look at workplace safety and abuse in due
11 course.

12 There's an USDAW report that was published in
13 April 2020 on the impact of coronavirus on the
14 workforce. And I think you've covered this in your
15 earlier comments but it's right to say that that study
16 reported immense pressure and rising anxiety caused by
17 higher risk of exposure to the virus, higher rates of
18 illness, job insecurity, issues with the benefits
19 system, and the closure of schools. Those were factors
20 that particularly affected people in the retail sector?

21 **MS THOMAS:** That's correct, yeah.

22 **Q.** You also refer to a survey in 2021, and that found that
23 the -- that 80% of members said that the pandemic had
24 negatively affected their mental health; that is right?

25 **MS THOMAS:** That's correct.

30

1 **Q.** Yes, we'll come back to that on the workplace safety and
2 developments in that particular sector because I believe
3 there were some positive developments in that sector,
4 but we'll come back to it.

5 But moving to probation workers, at paragraph 149,
6 there's reference, again, to positive engagement with
7 union representatives, but there were ongoing issues
8 with sickness levels and the impact on mental health; is
9 that correct?

10 **MR SHORT:** That's right.

11 **Q.** Then, finally, concerning emergency responders, the
12 Inquiry has already heard some evidence about the
13 impact, the very particular impact on their mental
14 health, and that was from the CEO of the charity Mind,
15 Sarah Hughes.

16 Now, she explained the results of quite an extensive
17 survey of emergency responders, and it included the
18 impact of moral injury on such workers. In other words,
19 the negative impact of feeling that they weren't
20 providing help, which is what they're supposed to be
21 doing in their profession. Have you got any views on
22 that?

23 **MR SHORT:** I mean, it's natural that our members and
24 workers, public service workers in particular, would
25 feel like that at times. They were restricted in many

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1 ways from doing the full range of their jobs. They
 2 wanted to do a good job.
 3 **Q.** She also indicated that such workers were, they found,
 4 likely to delay seeking the help they really needed for
 5 their mental health issues, putting themselves last. Is
 6 that something you recognise in that sector?
 7 **MR SHORT:** It's something I recognise in all the sectors but
 8 also I think there's some evidence of workers being
 9 discouraged in some cases by more senior management from
 10 taking that support, and just there was a sense of "Get
 11 on with it, we're all juggling", to use the phrase that
 12 was used, "Just make the best of it", and that was not
 13 helpful.

14 **Q.** Thank you.

15 Mr Shears, turning back to you for some of the
 16 remaining occupations under this topic.

17 First, I believe GMB has workers in the fire and
 18 rescue sector and this is one comment from that sector
 19 drawn from the Key Workers Roundtable report, that's
 20 INQ000659704, at page 42 to 43. It says:

21 "The pandemic put an additional strain on
 22 firefighters as they were in direct contact with other
 23 people when responding to incidents, potentially
 24 increasing their risk of contracting Covid-19.

25 "So many firefighters were worried about spreading

33

1 understand it.

2 Certainly our members that work in the fire services
 3 reflected very strongly that they felt that their
 4 colleagues that were operational were incredibly
 5 stressed and then very scared, actually, for what was
 6 happening.

7 **Q.** Thank you very much for that insight.

8 Prison officers are also within your remit, I
 9 believe. At paragraph 207 there's a reference to
 10 a study of prison officers, and is it correct that 81%
 11 of them reported that their mental and physical health
 12 deteriorated since the pandemic?

13 **MR SHEARS:** Yes, that's correct, yeah.

14 **Q.** And were there any particular issues relevant to that
 15 sector?

16 **MR SHEARS:** Again, high understanding that they were at high
 17 risk because of lack of ventilation, old prison
 18 buildings, coming into contact with people that were
 19 potentially symptomatic, were not overly concerned about
 20 not passing the disease on, saw that as a form of
 21 punishment towards those staff. Again, huge pressures
 22 in terms of overall staffing because of people that were
 23 off with sickness absence, which meant that there was
 24 increased pressure to get work done and, unfortunately,
 25 not an availability of colleagues to come in and

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1 the virus to their family, which had a knock-on impact
 2 on their mental health, because you are working every
 3 day in a frontline environment but the risk that you
 4 could bring something home was so high and scary. It
 5 was such a build up of pressure and there wasn't an end
 6 to it. Workers had to be ultra conscious and sensitive
 7 to how they were feeling."

8 So with that example from this sector, is there
 9 anything you would like to add about the impact on that
 10 sector?

11 **MR SHEARS:** Certainly from talking to colleagues in the Fire
 12 Brigade union, this was particularly difficult and
 13 challenging for their members in two respects: one was
 14 the fact that they were very concerned about bringing
 15 Covid from their experiences out in the field back into
 16 fire houses, talking to colleagues and cross-infecting,
 17 which meant they would have fewer colleagues able to
 18 respond in future, but also keeping focus on the job at
 19 hand when they were constantly concerned in the back of
 20 their minds about the potential for Covid exposure, it
 21 was extremely challenging. This is obviously work that
 22 needs to be done with a very, very high degree of
 23 precision and the kind of stressors that we've heard
 24 about from other sectors were really quite acute here.
 25 So it was, I think, very, very difficult for them, as I

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1 replenish and reinforce.

2 So, overall, a very negative situation. Mental
 3 health support not always easily available, a sense,
 4 actually, that the workers should be mentally tough,
 5 they were going into an environment that was understood
 6 in terms of violence and aggression risk, and this had
 7 been layered on the top in a way that really challenged
 8 those workers.

9 **Q.** Thank you.

10 Staying with you, Mr Shears, only briefly, you also
 11 cover local government workers. However, the Inquiry
 12 has already heard from representatives from the Local
 13 Government Association about the impact on that sector.
 14 There is, within the TUC statement, the firsthand
 15 account of one such worker at paragraph 235. And that
 16 talks about frustrations about employers' rules around
 17 Covid and then sick leave following the infection.

18 Unless you have anything to add under that sector,
 19 I don't have any further questions about it.

20 **MR SHEARS:** The only point I would make with that was we did
 21 have some members working in jobs that didn't need to be
 22 done. We had members that were out cutting grass,
 23 looking after parks, at a time when people weren't using
 24 those facilities. There was absolutely no need for them
 25 to be out in public potentially exposed to harm. So

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1 again, that caused huge anxiety because people could see
2 very clearly, members knew that this was political
3 decision making, that it wasn't really necessary, and
4 they felt very threatened by that.

5 **Q.** On funerals, the roundtable report, and the other
6 research that we've shared with you, described staff
7 feeling overwhelmed and fatigued by the changes and
8 restrictions, and having to explain those in particular
9 to families. We've heard evidence about it. And in
10 fact one of the issues raised was the delay in lack of
11 recognition of them as key workers.

12 **MR SHEARS:** Yeah.

13 **Q.** That's been a recurrent theme. So again, I don't have
14 any questions for you on that sector.

15 **MR SHEARS:** No. Again, I think the evidence there speaks
16 for itself.

17 **Q.** Thank you.

18 Mr Shears, finally, I want to take you to the
19 statements/comments on the manufacturing and food
20 processing sector, in particular paragraphs 202 and 204.
21 There is reference there to shocking workplace safety in
22 that sector, and that's the next topic that we'll cover.
23 But on health outcomes, you refer to reports in May 2020
24 and October 2020 of multiple cases at particular
25 warehouses being reported and some deaths; is that

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1 hygiene and safety, which we'll come on to, but they
2 acutely knew that they were absolutely needed to be at
3 work as much as possible, to make sure that food was
4 able to be supplied.

5 At the same time, they're not being viewed in the
6 public, they're not being seen in the press, they're not
7 being referred to more generally. It's very clear that
8 we were, you know, hugely receptive to key workers in
9 terms of nurses, social care. None of that's being fed
10 back to these workers.

11 They start to become ill at a really alarming rate,
12 because they can't do the social distancing, the PPE
13 isn't really appropriate for them, the ventilation isn't
14 known about yet, and there is literally no recognition
15 of that.

16 They are, to make the point that was stressed
17 earlier on, effectively replaceable, in terms of brining
18 people in very quickly, because this work isn't being
19 viewed as being skilled work, though it is key work, and
20 as a result the prevalence now, to this day, of poor
21 mental health, PTSD, in that sector, amongst our
22 membership, is extremely high as a result.

23 **Q.** Thank you very much for that insight.

24 At paragraph 204, you say that in response to
25 a survey, when asked what the hardest thing had been

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1 correct?

2 **MR SHEARS:** Yes, absolutely.

3 **Q.** And on mental health, again, you refer to a sense
4 amongst workers across the food production and
5 distribution sectors that the public did not recognise
6 the importance of their roles, the critical nature of
7 the work they were carrying out. Is it right that they
8 in particular felt, and perhaps were, unseen?

9 **MR SHEARS:** Yes, absolutely unseen. Completely hidden from
10 public view.

11 **Q.** In that particular sector, can you expand on the
12 feeling? Because, of course, it's an extremely
13 important role, to keep the country fed and --

14 **MR SHEARS:** Yes, absolutely --

15 **Q.** -- yet you don't get the same recognition?

16 **MR SHEARS:** The workforce are very clear that the majority
17 of people are at home, they're reliant on home food
18 deliveries, they're not able to come out and go to
19 restaurants to eat. So there was an absolutely
20 critical, essential need for that food to be produced.

21 At the same time, they were working in very
22 difficult conditions, working much longer than they
23 perhaps normally would do, social distancing is
24 impossible, the standards that are in place are designed
25 around food hygiene and safety rather than worker

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1 about working on site during the pandemic, there were
2 four major themes: (1), Covid-19 health risks to them
3 and their families; (2), the uncertainty of work, wages
4 and personal finances; (3), the wider impacts of
5 lockdown measures; and (4), mental health concerns.

6 That also seems, Mr Shears, to be quite a reasonable
7 summary of some of the major themes we've discussed --

8 **MR SHEARS:** Yes.

9 **Q.** -- on the health impacts on key workers across sectors;
10 would you agree?

11 **MR SHEARS:** Yes, absolutely. That would be typical across
12 the piece.

13 **Q.** Thank you very much. That's topic 1. Unless there's
14 anything else under that sector that any of you want to
15 raise, I'll move on to workplace safety.

16 **MS THOMAS:** Can I just add, because I think this reflects
17 all of the members that we represent, that there was
18 a real feeling and, actually, a lack of evidence -- that
19 there was no plan at the start of the pandemic to
20 protect retail workers and, in fact, workers from the
21 whole supply chain, and that was felt.

22 The sector, you know, wasn't, certainly, anywhere
23 near the top of the priority list when it came to PPE,
24 and that was felt as well, and made workers even more
25 vulnerable.

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1 And particularly in warehouse distribution and
2 elements of transport, we found that there was no
3 provisions. We had to be involved on hundreds and
4 hundreds of occasions to make sure that the relevant
5 social distancing was put in place. It wasn't always
6 forthcoming from employers. Sometimes we had to have
7 political intervention. And it really did feel that
8 workers during that time felt that they were invisible
9 because of the lack of the support.

10 **Q.** Unless there's any other comments on that, thank you
11 very much for your insights on that important topic.

12 I'm going to move on just to start the second
13 section because we will have a break at 11.30, you will
14 probably be relieved to hear.

15 So, the key workers have described the impact of
16 workplace safety issues in evidence. The Inquiry has
17 already heard about particularly the roundtable report
18 and the Every Story Matters report. The point I think
19 I will cover before the break is this issue about
20 implementing guidance, and I'll cover it with you,
21 Mr Shears.

22 The point is that there's a lot of evidence that key
23 workers, amongst others, found government guidance
24 extremely confusing. Is that the case? And the TUC
25 statement essentially sets out in quite a lot of detail

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1 expectations simply weren't being met at all. And that
2 was, in our experience, pretty clear across the whole of
3 the piece. Almost every sector we organised in, we were
4 having huge challenges with getting even basic measures
5 put into place, because the guidance simply wasn't good
6 enough.

7 **Q.** Mr Leach, I think you had a point?

8 **MR LEACH:** Yeah. To complement that, I mean, what we find
9 right across transport is you've got, like, a two-tier
10 workforce pretty much everywhere, where you have the
11 directly employed staff and then you have the contracted
12 staff, and then a lot of the emphasis in the contracted
13 sector, which is, of course, inherently zero-hours based
14 and suchlike, would be that they would almost be playing
15 cat and mouse with the client about these new health and
16 safety rules, which kept evolving. And it was a real
17 challenge for us.

18 And we had, on top of the "make it up as you go
19 along" -- because that's what our direct experience
20 was -- we had to have the conversation twice with, for
21 example, London Underground and then with about five or
22 six different contractors, who would then be being
23 managed in all of this.

24 It just fell between the cracks, and with inevitable
25 consequences.

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1 many unions' efforts to ensure more tailored and
2 comprehensive guidance was in place across sectors as
3 the pandemic went on. And there are particular concerns
4 about PPE, ventilation and social distancing over time.

5 Mr Shears, is that a fair, though of course brief,
6 summary of the twists and turns of those interactions?

7 **MR SHEARS:** Yes, absolutely.

8 I think it's worth making the point that, for almost
9 all of our collective organised workplaces, we will have
10 workplace health and safety representatives. They're
11 used to dealing with regulations, laws, and government
12 guidance that's quite detailed, quite prescriptive.

13 In the first part of the pandemic, there is no
14 guidance. Full stop. The guidance that comes in is
15 quite weak, it's principle based, it's not binding.

16 So, we are getting thousands of complaints per day
17 from members saying: why is this current approach not
18 being used? You know, we don't understand why these
19 things are not being implemented. We thought this was
20 very straightforward. The protections that we thought
21 would be in place are not happening. When they are
22 happening, it's not clear who's decided them and why.

23 So there was mass confusion. And that really
24 reinforced that sense of fear and anxiety, because
25 workers knew what protections they expected, and those

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1 **Q.** Thank you.

2 Back to Mr Shears for the sort of general points
3 that are made about this. At paragraph 25, TUC reports
4 mention protecting workers' safety, April 2020, and that
5 identified areas of poor, as well as good, measures,
6 safety measures, in workplaces across a range of
7 sectors; is that correct?

8 **MR SHEARS:** Yes, that is correct, yeah.

9 **Q.** Thank you.

10 And the report explained what you've been
11 describing, how the TUC had received many, I think at
12 that stage over a thousand, contacts from workers
13 regarding concerns about unsafe working in the pandemic;
14 is that right?

15 **MR SHEARS:** Yes, that's correct.

16 **Q.** And you state in summary that the concerns included not
17 being supplied with appropriate PPE, not having adequate
18 hygiene or social distancing measures in place, and
19 finally, employers not putting in place specific support
20 for vulnerable colleagues?

21 **MR SHEARS:** (Witness nodded).

22 **Q.** So was that sort of typical of the types of concerns
23 being raised in those early contacts?

24 **MR SHEARS:** Yes, absolutely. In some cases the questions
25 were as basically straightforward as: what protective

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1 equipment should we be receiving? Because at the moment
2 there is none. What measures should our employers be
3 implementing? Where can we find more information? Why
4 is there nothing being produced by governments or the
5 Health and Safety Executive, or the sectoral bodies in
6 these areas?

7 So part of what we had to do collectively with the
8 TUC and as individual unions was to try and develop and
9 source good practice guidance from existing sources to
10 fill that vacuum. That was really quite pronounced.
11 I can recall one member ringing up, I think the
12 President of the United States had mentioned about the
13 benefits of bleach and was getting concerns from his
14 colleagues that maybe they should be drinking diluted
15 bleach, which obviously is not a good idea under any
16 circumstances, but people were panicking because they
17 were scared, and for the first few months we didn't have
18 anything to fill that gap, so we had to try and develop
19 it ourselves. But these were absolutely the issues at
20 the time.

21 **MS RAHMAN:** Thank you very much.

22 I think that's, my Lady, an appropriate time to
23 break.

24 **LADY HALLETT:** Certainly, and I shall return at 11.45.

25 Don't worry, we will finish you before lunch, I promise.

45

1 difficulties they reported to you with regards to
2 workplace safety.

3 So earlier on, Mr Short, we touched upon the
4 difficulty, impossibility perhaps, in controlling
5 infection for young children who may be coughing and
6 sneezing. Is it right that that caused particular
7 concern at some special schools where children found it
8 particularly difficult to prevent spitting or dribbling?

9 **MR SHORT:** That's right, and I wouldn't want to
10 overgeneralise but there will naturally be a more
11 extreme concern, if you like, in some special schools
12 where some children are perhaps more likely to have
13 a problem or have difficulty with controlling those
14 sorts of physical behaviours. But even without those
15 more extreme things like spitting and so on, it's just
16 that the older a child is, the more likely they are to
17 respect things like social distancing, to understand the
18 concept of social distancing and respect it.

19 Younger children, those with some special
20 educational needs, perhaps would not really grasp it in
21 the same way. So absolutely, in those kind of settings
22 there would be a heightened risk and the workplace would
23 be less safe.

24 **Q.** That's a particular risk in the education sector. That
25 is highlighted in the evidence. Another issue that

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1 (11.30 am)

2 (A short break)

3 (11.45 am)

4 **LADY HALLETT:** Ms Rahman.

5 **MS RAHMAN:** My Lady, I'll continue on what we were talking
6 about before the break. We were covering issues of
7 workplace safety and I'm going to ask about particular
8 impacts in particular sectors. Now, clearly, there's
9 been a bit of coverage of this in your earlier comments
10 but we will explore whether or not there's more to add
11 from a particular sector.

12 So Mr Short, I'll ask you again about the education
13 sector. I think this is also something that GMB may
14 have a perspective on so I'll turn to you at the end,
15 Mr Shears, in case there's anything to add.

16 There's a lot of detail, Mr Short, about this at
17 section D of the statement, at paragraph 93 it's noted
18 that, and I think this is a point you made earlier on,
19 reference is often made to school closure but they never
20 actually closed, and that, Mr Short, that's because they
21 needed to remain open for certain children to attend
22 throughout the pandemic; is that correct?

23 **MR SHORT:** That's right, yes.

24 **Q.** So some teachers, support staff, catering staff were
25 required to attend. And you then set out the particular

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1 seems to have been a real concern is inadequate
2 ventilation; is that correct?

3 **MR SHORT:** That's right, yes.

4 **Q.** Now, there was also, however, an issue that the Inquiry
5 has heard already about classes being too cold if
6 windows were kept open; is that something you recognise?

7 **MR SHORT:** Yes, and a lot of our members reported there
8 being -- well, it's an obvious trade-off, isn't it? I
9 mean, I recall in the early weeks of the pandemic, the
10 weather was okay, but the second lockdown in particular
11 was very difficult. It was very cold, it was winter, it
12 was very cold. You could open a window. I'm not
13 a scientist so I'm not even sure just opening a window
14 does provide the ventilation you need to protect against
15 Covid but it can't hurt, but obviously that makes the
16 classroom extremely cold and for both staff and for
17 children and young people, that's not really good
18 enough. And the government were extremely slow to even
19 recognise the issue of needing proper ventilation and to
20 begin to fund it to be provided.

21 **Q.** You've provided firsthand accounts of the impact of
22 that, and they are consistent with those which we've
23 seen in the ESM report and roundtable report. In terms
24 of the guidance that was coming through, is it right to
25 sum up the impact as being of increasing frustration

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1 with timing and clarity of guidance in this sector?
 2 **MR SHORT:** Yes, that's right. The guidance changed
 3 frequently, it came at the last minutes, and it was
 4 produced without any consultation with workers or their
 5 representatives.

6 **Q.** And you mention at paragraph 94 it was challenging to
 7 interpret it, such that you would sometimes have
 8 a situation where schools in the same locality could
 9 have different interpretations of guidance?

10 **MR SHORT:** Yes, absolutely. As I said, there was very
 11 little engagement, so schools naturally would interpret
 12 guidance in different ways, especially if it's changing
 13 frequently.

14 **Q.** So, that would be very challenging for staff to deal
 15 with, challenging questions about why certain measures
 16 were being enforced --

17 **MR SHORT:** Yes, absolutely.

18 **Q.** -- in some areas and some not?

19 You mentioned later, in paragraph 98, particular
 20 problems with parents, and the Inquiry has heard that,
 21 you know, there were quite significant disputes that
 22 were going on in this sector between parents, not
 23 understanding, and staff. Can you expand a little on
 24 those incidents?

25 **MR SHORT:** I mean, I think it was a constant battle for
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1 being raised about critical workers lists. And again,
 2 in broad terms, the impact on staff is that -- the
 3 timing, as you've discussed already, but also sometimes
 4 they were dealing with very broad categories that they
 5 had to then apply. Interpretation was the issue that
 6 was causing them a lot of stress, in summary?

7 **MR SHORT:** Yes, and there's evidence from the NAHT, the head
 8 teachers and leaders union here, we found this in
 9 education, in local government as well, where guidance
 10 would refer to "critically vulnerable", "critically
 11 extremely vulnerable", and there would be a lot of
 12 question marks about what counted as what.

13 **Q.** And you also explained that the guidance was often too
 14 high level to cover specific issues around hygiene, PPE,
 15 safeguarding, and those living with underlying health
 16 concerns. I think you've mentioned that the last thing,
 17 safeguarding, would be an issue of particular concern in
 18 the education sector, presumably?

19 **MR SHORT:** Yes, absolutely.

20 **Q.** There are also particular concerns about guidance on
 21 face coverings, and you say at paragraph 108 that most
 22 education staff felt safer with face coverings,
 23 particularly given the concerns you've already mentioned
 24 about ventilation; is that correct?

25 **MR SHORT:** That's absolutely right, yeah.
 51

1 schools and school staff, our members working in
 2 schools, to explain the guidance. And it was changing
 3 frequently, so that made it more difficult to explain
 4 it.

5 And I could understand how some parents, perhaps, in
 6 the face of that, they were hearing one thing in the
 7 media, another thing from the school, because of
 8 inconsistent reporting, no one in the media
 9 understanding the guidance, you can see why there would
 10 be issues there between parents and school staff,
 11 potentially.

12 **Q.** And then, at paragraph 97, you describe a particular
 13 challenge, and that was the challenge of reopening in
 14 January 2021. And I think the reason why that was so
 15 challenging is particularly because of the need to set
 16 up testing centres. Did that create greater pressure?

17 **MR SHORT:** Yes. It's probably stating the obvious, but
 18 schools had no experience of running test centres. It's
 19 not something schools would be doing.

20 They were told to do it at very short notice. They
 21 were told that schools would be reopening in January.
 22 There was a lot of criticism of that, but that was going
 23 ahead, guidance was put out very late. And then, after
 24 one day, the schools were closed again.

25 **Q.** At paragraphs 100 to 102, you describe particular issues
 50

1 **Q.** Thank you.

2 Finally in this sector, you stress that there were
 3 ongoing issues being reported to unions about testing,
 4 and at paragraph 117 you say that UNISON conducted
 5 a survey as late as January 2022, and that found that
 6 only 32% of school support and nursery staff at that
 7 stage had access to sufficient tests, the recommendation
 8 being to test twice weekly at that point; is that
 9 correct?

10 **MR SHORT:** That's correct. We had a situation where the
 11 government were saying test twice weekly but staff
 12 weren't able to do that.

13 **Q.** Thank you.

14 Mr Shears, do you have anything to add from the GMB
 15 perspective on that?

16 **MR SHEARS:** I think a couple of quick points that are worth
 17 mentioning. One is that classically in other sectors
 18 members were able to talk to staff from the union, take
 19 advice directly during the work day from the union, and
 20 in some cases, if they were able to, send us photos or
 21 videos of the work activity. Obviously, schools
 22 couldn't do this under any circumstances. So they
 23 were -- (overspeaking) --

24 **Q.** That's because of the safeguarding -- (overspeaking) --

25 **MR SHEARS:** The safeguarding issue in terms of the potential
 52

1 to expose children.

2 **Q.** Yes.

3 **MR SHEARS:** But more generally it wasn't custom and
4 practice. So we were often having to take meetings with
5 those members late at night. They've worked a full day,
6 they were extremely tired, they're very worried and
7 anxious, then having, you know, an hour, two-hour long
8 meetings with union staff to go through these concerns,
9 because they were very common.

10 The other point that it's probably worth reflecting
11 on is that the nature of the work that they were doing,
12 in lots of other areas we would have said: you need to
13 withdraw yourself from this circumstance. If you're
14 covered in bodily fluids, you need to go and get cleaned
15 up, you need to get fresh protective equipment.

16 Often, especially the first part of the pandemic,
17 that protective equipment wouldn't have been available.
18 So you've now got a choice between working unprotected
19 or working for the rest of the day covered in blood,
20 vomit, whatever it may be. And members found that very
21 difficult. They didn't want to frighten the pupils,
22 especially the younger children -- they wanted to ensure
23 that they were safe.

24 That was paramount for them. This was very much
25 a calling, a vocation. They were very concerned -- that

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1 installation of things like perspex screens in
2 supermarkets, at paragraph 163. Could you expand
3 a little on that, and the particular issues in
4 supermarkets?

5 **MS THOMAS:** Yes, like I say, it was very difficult for
6 retail workers to even get access to PPE, because at the
7 time it was so scarce. So a lot of the time there
8 wasn't any PPE. And then there was the additional
9 burden of trying to implement things like social
10 distancing when actually you had -- the best way I could
11 describe it is imagine how you see things like Black
12 Friday sales where you have hordes of people trying to
13 get in one area because there was, like, little stock,
14 the stock was very low. So people were going into this
15 sort of, like, frenzy mode to try to get access to food,
16 and obviously their barrier was the shop worker who was
17 trying to implement provisions with very little support,
18 so the impact that had on their, like I said earlier,
19 their mental wellbeing and their general safety was
20 absolutely shocking.

21 And that caused issues when they were advising to
22 maintain social distancing, there was also people that
23 when PPE did come into -- a bit more into effect, they
24 were saying that they were exempt from wearing it, and
25 obviously that shop worker was then tasked with the

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1 point about moral guilt, very strong for our members,
2 especially in the first part of lockdown, because they
3 didn't want to do anything that might upset the pupils
4 they were caring for, given that those pupils were
5 already pupils of parents who were going into the front
6 line in work. And the mental burden of that was
7 extremely strong, and it all stemmed from that failure
8 to provide adequate health and safety provision.

9 **Q.** Thank you very much for that insight.

10 I'm going to turn now back to retail, Ms Thomas,
11 turning to you on that sector.

12 Early in the statement at paragraph 26, there is an
13 account of a retail worker and an example of the issues
14 that key workers reported with workplace safety, and
15 I'll read it out rather than getting it up on screen.

16 It says:

17 "There's no extra cleaning measures being put in
18 place. Our tills are closer than 2 metres apart and we
19 aren't being given hand sanitiser or gloves. We don't
20 have social distancing in the queues at the checkout and
21 customers are standing too close to each other and to
22 staff."

23 Again, in this sector, Ms Thomas, there were
24 challenging problems with implementing guidance at pace
25 that you mention. In particular, you note delays in the

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1 responsibility of asking questions when really that
2 burden shouldn't have been placed on them.

3 Later on down the line, they came with the sunflower
4 lanyards but then you'd still often get some customers
5 saying, "Actually, I am exempt, I just haven't got the
6 lanyard" and the workers felt frightened of having to
7 sort of put them challenges in place.

8 I remember one particular scenario where a shop
9 worker had said they'd had to intervene in a fight in
10 a shop because two customers were arguing over stock and
11 one of them wasn't social distancing, and then it ended
12 up being the shop worker that had to break up the fight
13 and had -- came into very close contact with two other
14 people, and it was absolutely harrowing situations like
15 that, and the worst is that it was every single day
16 multiple times a day, hundreds of times a week, these
17 scenarios were happening.

18 And even though when customers started to accept
19 social distancing was more the norm, they often would
20 not respect that when it came to the member of staff.
21 And quite often, I'd hear this all the time, when
22 customers asked a question, they would pull their mask
23 down to ask the question in the shop worker's face
24 invading that social distancing guideline, which put
25 shop workers directly at risk.

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1 And again, this happened every single day. So it
2 was a really awful set of circumstances, and you've seen
3 some of the statistics that's been produced by the TUC
4 and by our own surveys within USDAW, and it was just
5 really startling and very, very sad and tragic, you
6 know, the shop workers who were being recognised at the
7 time later, albeit later down the line, as being, you
8 know, key workers, and unsung heroes, that actually they
9 had to put up with that on a regular basis.

10 In fact, we've actually seen those statistics
11 continue after the pandemic, but it was initiated during
12 that period when they were just trying to help the
13 public.

14 **Q.** Thank you very much indeed.

15 In line with the general theme, there were felt to
16 be gaps in high-level guidance but it's right that USDAW
17 worked within the sector to develop that, and that was
18 through the British Retail Consortium; is that correct?

19 **MS THOMAS:** That's correct.

20 **Q.** And some of the concerns raised were, again, around what
21 you've just mentioned, face coverings, and workers in
22 your sector as well did not feel safe without them and
23 therefore resisted that requirement being withdrawn in
24 2021; is that correct?

25 **MS THOMAS:** That's correct.

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1 **MS THOMAS:** Yeah, and so many other examples to make
2 reference to, as well.

3 If you recall in 2020, there were the curfews that
4 were introduced across the pubs but they weren't
5 introduced within supermarkets so what you would often
6 find was that people would leave the pubs intoxicated
7 and then head straight to the supermarkets. So you'd
8 often find that our members, the shop assistants, would
9 have to deal with anti-social behaviour aspects because
10 there wasn't the structure put in place to protect the
11 shop workers.

12 **Q.** Thank you very much.

13 One other factor that's come up in the evidence --
14 I won't bring it up on screen, but it was raised by
15 USDAW at the Key Workers Roundtable and that was that
16 the size and type of retail space played a part in some
17 of the impact. Is it right that, for instance, some of
18 the smaller convenience stores would lack the space for
19 social distancing as well as having poor ventilation?

20 **MS THOMAS:** Yes, quite often.

21 **Q.** And that would impact on those working in those
22 environments?

23 **MS THOMAS:** Yes, very much so.

24 **Q.** Thank you. As I say, we'll come back to the issue of
25 abuse of retail key workers separately.

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1 **Q.** And there were particular concerns which you've again
2 just described, that customers did not comply with those
3 requirements even when required to.

4 Can I get out the ESM report again, INQ000659763 at
5 page 21. Really these comments illustrate what you've
6 just described to us, you were hearing.

7 A retail worker said this in the key workers ESM:

8 "Working in a supermarket during Covid was a unique
9 time. People were forced to queue 2 metres apart
10 outside but as soon as they got inside they all acted
11 like everything was normal and would walk straight up
12 into you without a second thought. Often coughing right
13 behind you. No one followed the rules and if
14 I complained because it wasn't safe, I was the problem."

15 Another worker said:

16 "I worked in a large supermarket and I found that
17 customers were split into two camps, those that were
18 petrified and those who thought it was just a version of
19 [the] flu. These people didn't always wear masks, they
20 would literally push us out of the way to get what they
21 wanted (toilet rolls etc) and our managers just stood
22 back because they didn't know what to do."

23 So those accounts do seem, Ms Thomas, to reflect the
24 sorts of challenges that your members were reporting to
25 you?

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1 Mr Leach, can I come back to you now on the
2 transport sector and some specific issues raised there
3 in the statement from paragraph 170.

4 Now, again, and unsurprisingly, ventilation is
5 raised as a particular concern, and there was
6 a particular issue, as I understand it, around
7 air-conditioning on older trains; is that correct?

8 **MR LEACH:** That is right, yeah.

9 **Q.** A survey, again, revealed that there were delays
10 reported in the installation of screens, issuing PPE,
11 similar concerns about mandatory face masks which
12 members wished were in place, unions pressed for that to
13 be a requirement following concerns about deaths of
14 transport workers; is that correct?

15 **MR LEACH:** Very much so, and it was a major concern at the
16 time, the recycling of air, but -- essentially in the
17 confined space of a train, and so that was a big
18 problem, yeah, at the time.

19 **Q.** And at paragraph 175 of the statement you refer to an
20 RMT survey of bus drivers -- of course, we've heard
21 about the real impact on bus drivers --

22 **MR LEACH:** Mm-hm.

23 **Q.** -- and it revealed what you called a "wild west"
24 approach to safety with overwhelming numbers reporting
25 that their employers were simply not implementing safety

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1 measures adequately?

2 **MR LEACH:** That's right, and I think I referenced it

3 earlier. They kind of -- it's a fragmented industry.

4 It's a consequence of privatisation, in our opinion,

5 that you have these standalone little bus companies that

6 do their own thing on a normal day and they were doing

7 the very same then, and playing fast and loose with our

8 members' health and safety. And the stats proved it.

9 We saw a higher proportion of death in that sector.

10 **Q.** The Inquiry has also heard an account from the Key

11 Workers Roundtable of the impact of some operators only

12 providing a sheet to separate a bus driver. We've also

13 heard within Every Story Matters reports of members of

14 the public being unhelpful in terms of ventilation

15 because they would close windows. Were you aware of

16 concerns of that sort?

17 **MR LEACH:** Absolutely. And more so people -- you know, the

18 use of hazard tape to cordon off where the driver was on

19 a bus. Obviously you could, you know, breathe straight

20 through it, but it was -- it would have been laughable

21 if it wasn't so serious.

22 **Q.** Understood.

23 Finally, we focused quite a lot on bus drivers, and

24 we've touched on rail workers as well, at paragraph 176

25 you note that similar issues were experienced in

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1 **Q.** Finally, on refuse collectors, there seems to be

2 significant impacts on those workers being reported.

3 Paragraph 156 says that there were very poor health and

4 safety practices being reported, in particular around

5 social distancing in vehicles, and hygiene; is that

6 correct?

7 **MR SHORT:** That's right. I mean, obviously when the refuse

8 collectors are collecting the rubbish, they're outside,

9 but when they're in the cabs of vehicles, it's very

10 tight -- you know, it's a very tight environment. There

11 was lots of -- there was a lot of concerns from a lot of

12 our members, as a lot of employers insisted on having

13 three in a cab, which immediately made it impossible to

14 social distance. We worked with an industry body to

15 improve the guidance on that.

16 **Q.** Thank you so much.

17 Mr Shears, back to you. I believe that all the

18 remaining key worker occupations covered in the

19 statement do fall within GMB's remit, and those are

20 prisons, construction, manufacturing and food

21 production.

22 It's fair to say that very similar concerns arose,

23 particularly in the manufacturing and the food

24 production sector. And at paragraph 199, the statement

25 talks about reports of cramped, overcrowded conditions

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1 relation to infection prevention and control in the

2 aviation sector; is that correct?

3 **MR LEACH:** Yeah.

4 **Q.** Thank you.

5 If I can turn now back to you again, Mr Short, I'm

6 going to ask you about some sections of the statement

7 that concern police, probation and refuse collectors.

8 So, for the police first, at paragraph 143, again

9 you note the mixed messages around guidance, and

10 implementing that, and dealing with the public would

11 have had a particular impact on workers in this sector,

12 presumably?

13 **MR SHORT:** Yes.

14 **Q.** You also referred to a lack of PPE initially, but you

15 say that this position improved as the pandemic

16 progressed?

17 **MR SHORT:** Yes, it did, due to the intervention of unions.

18 **Q.** And in relation to probation workers, you've also

19 flagged very similar concerns about a lack of PPE. You

20 say that continued to be reported, although, again,

21 there were -- there was some engagement with unions and

22 a series of revised safety practices?

23 **MR SHORT:** Yes, and that engagement stemmed out of existing

24 partnership fora that were in place which enabled us to

25 make those representations.

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1 and lack of appropriate PPE being a real concern?

2 **MR SHEARS:** Yes, absolutely. One of the biggest challenges

3 we had in the food production sector was the enforcement

4 of social distancing. So, social distancing legislation

5 is made under coronavirus regulations, it's not health

6 and safety law. We immediately get reports from very

7 large employers to say that social distancing is

8 impossible, but no attempt is being made, actually, to

9 try and implement anything. And at that point there is

10 no office body that you can turn to, to try to get an

11 intervention.

12 So we spoke to police and crime ministers, we spoke

13 to police forces, the Health and Safety Executive, local

14 authority, environmental health; no one can tell us

15 actually where this stands from a legal point of view.

16 The input on that was very, very difficult for members

17 because they had no recourse but to work very tightly

18 together to get the food produced, knowing that if

19 someone developed Covid symptoms, the chances were the

20 whole workplace would. And we saw those outbreaks very

21 quickly.

22 **Q.** Thank you.

23 Yes, the concern was close quarters also in the

24 context of prisons. Close contact including searches

25 and an enclosed environment; that was a particular

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1 concern in that sector. Can you expand on that?
 2 **MR SHEARS:** Again, you come into close intimate physical
 3 contact with someone. Even if someone has symptoms,
 4 you're still required to do this. There is protective
 5 equipment that can be worn, but in some circumstances
 6 that may become a threat in itself, because it gives
 7 something to grab or claw onto. So there were real
 8 issues about standards here, and about the guidance that
 9 was being provided, in terms of what was appropriate,
 10 what should be worn, what the safe method to do this
 11 work was.

12 Again, it was essential work needed to be done.
 13 There was an urgent need to do these kind of very
 14 intimate physical personal checks. And unfortunately,
 15 as a result, we saw members that were doing that work
 16 getting infected very quickly, going off of work very
 17 quickly, and then workers and members who weren't
 18 trained to do that work having to be deployed to cover
 19 it, because it was essential it was done.

20 So it was seen as very much as a job that was
 21 extremely high risk, that no one had any availability to
 22 get out of, if that makes sense.

23 **Q.** Yes, I understand.

24 The final two sectors are construction and fire and
 25 rescue. Are there any particular concerns in those

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1 representatives on sites was very difficult because they
 2 were very easy to say that we are not having this, we
 3 expect this provision, it's standard, we would have it
 4 normally, we absolutely demand it during these
 5 circumstances.

6 **Q.** Thank you very much.

7 I've run through there most of the sectors that are
 8 covered. Unless there are any points that people feel
 9 haven't been covered, I will move on to the third topic
 10 area.

11 **MR LEACH:** Yes, I would at some stage very much like to talk
 12 about assaults and abuse.

13 **Q.** Ah, yes, this is the next topic.

14 **MR LEACH:** The next topic.

15 **Q.** The very next topic, so it's a timely reminder.

16 Topic three was other impacts on key workers that we
 17 have seen covered in the statement and have already
 18 heard evidence both before today and today, and firstly
 19 the topic, Mr Leach, is abuse of key workers.

20 Can I get this page 45 of the roundtable report
 21 INQ000659704:

22 "Some frontline workers experienced anger, abuse and
 23 sometimes physical violence from the public when they
 24 enforced restrictions such as mask wearing, social
 25 distancing, or rules about the maximum number of people

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1 sectors that we haven't already highlighted elsewhere?

2 **MR SHEARS:** The one point to make with construction in
 3 particular was there was very good social partnership
 4 work in terms of the standards that were developed,
 5 there were very, very good operating procedural
 6 standards. Construction is a very different type of
 7 work activity, large numbers are nominally self-employed
 8 workers, often large numbers of migrant workers,
 9 non-English as a first language. So having overarching
 10 principles to control the risks was really very
 11 important, and that work that was done in the first
 12 instance, the first two versions of that guidance were
 13 extremely good and we used that as a template quite
 14 widely. The challenge then was when the requirements
 15 for protective equipment were stepped down in the third
 16 version, these are workers who often are already wearing
 17 FFP2 and FFP3 masks because of the dust and the asbestos
 18 exposure risk. They knew very clearly that they should
 19 not be stepping that level of protection down and it was
 20 very difficult to understand why that decision was
 21 taking. Speaking frankly, my view at the time was a
 22 lack of available PPE was the problem, but the workers
 23 were intelligent enough to know that that was
 24 compromising their health, so we were very clear that
 25 that was not acceptable, but just trying to talk to our

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1 permitted in a space. This was more common in
 2 public-facing roles such as the retail, transport,
 3 distribution, funerals burials and cremation sectors.
 4 They said this made some workers fearful to do their job
 5 and more reluctant to engage with customers and enforce
 6 the rules."

7 Ms Thomas, we've heard evidence that this was
 8 a particular problem in retail, and paragraph 158 of the
 9 statement refers to a survey in April 2020 and that
 10 found that abuse against workers had doubled since the
 11 start of the pandemic with 196 of the 5,000 shop workers
 12 also having reported being physically assaulted; is that
 13 correct?

14 **MS THOMAS:** That's correct.

15 **Q.** And the high level of abuse and violence, that continued
 16 throughout the pandemic?

17 **MS THOMAS:** That's correct.

18 **Q.** There are many examples of this reported within Every
 19 Story Matters report, but in particular, it's emphasised
 20 that quite a lot of this abuse was targeted against
 21 younger people, women in particular, and also racial
 22 minorities?

23 **MS THOMAS:** (Witness nodded).

24 **Q.** Is that consistent with what has been reported to USDAW?

25 **MS THOMAS:** Yes, very consistent, in fact.

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1 **Q.** It's a consistent theme of evidence across sectors and
 2 Mr Leach, in terms of the travel sector, at
 3 paragraph 178, it's noted that the increased tension
 4 associated with travelling, the confusion over changing
 5 guidance, and so-called police function being placed on
 6 transport workers, combined to raise levels of
 7 aggression encountered by transport workers. And it was
 8 further aggravated by the concern amongst transport
 9 authorities to resume revenue collection duties at gate
 10 lines and on trains.

11 Mr Leach, do you want to add to that?

12 **MR LEACH:** I very much do, yeah. I mean, this was
 13 a consistent -- it's a problem on a normal day. Our
 14 members in all sectors, right across transport, verbal
 15 abuse, physical abuse, intimidation, I could spend days
 16 talking about it.

17 That was exacerbated and made so much worse by all
 18 the pressure that came about as a consequence of Covid.
 19 And also the employer wanting to get revenue back up and
 20 running as you've just expressed. This was seen in the
 21 appalling incident of a member being spat at, who lost
 22 her life. I will say no more about that, because that's
 23 a matter of process, but that -- where she went, others
 24 went too.

25 It normalised itself. People were threatened with
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1 point again, and our members had to enforce that
 2 guidance, enforce the rules, and that, at times, was
 3 unpopular.

4 **Q.** Mr Shears, I'm asked if you could speak slightly more
 5 slowly for our stenographer, in your answers, but
 6 there's a lot of really interesting points you're making
 7 so we're really keen that we get it all noted down, as
 8 you say it.

9 Is there anything you'd like to add on the impacts
 10 of abuse on key workers?

11 **MR SHEARS:** I think the only other point I would add is that
 12 in many cases the workers were unable to get immediate
 13 support from colleagues because there were so few staff
 14 working, and those colleagues weren't available. Very
 15 often they will have reported to managers, those
 16 managers were either working from home or in some cases
 17 furloughed, so normally before Covid, and to a degree
 18 post-Covid, there would be some internal support
 19 systems, peer support, that would have been available
 20 when an incident occurred. That largely collapsed
 21 during the acute pandemic period which meant the workers
 22 felt very isolated, very much alone, very vulnerable
 23 after an incident, and that certainly had huge impacts
 24 on their mental health going forward.

25 **Q.** Thank you.

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1 being spat at on a very regular basis. Bus staff,
 2 station staff, train drivers, cleaners, maintenance
 3 workers. They became fair game. And it continues to
 4 this day, I'm afraid, but at that time it seemed to
 5 bring the worst out in people, and, you know, we lost
 6 members to death, and it's a very serious matter still
 7 and it was then. And made so much worse by the fact
 8 that we were all under so much pressure.

9 **Q.** Thank you, Mr Leach.

10 I will move on to some of the other sectors, which
 11 again, sadly, these reports of abuse recur. We've heard
 12 about this being experienced by local government workers
 13 and that's covered at paragraph 151. Mr Short or
 14 Mr Shears, do you have anything to add on this from
 15 that, or any other sector?

16 **MR SHORT:** Yeah, just to draw out that -- I mean, the
 17 specific example given in that paragraph is a library
 18 worker and libraries were seen by many as an open
 19 community space and that's the way they're supposed to
 20 work, and that's the way our members -- going back to
 21 the pride point before the break, that's the way our
 22 members wanted to work, wanted to deliver library
 23 services but it was made very difficult for them, often
 24 because, I think, people, sometimes vulnerable people
 25 didn't understand the guidance, going back to another
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1 **MS THOMAS:** May I add before we move on to a different
 2 subject?

3 **Q.** Yes.

4 **MS THOMAS:** I just wanted to say that, you know, going back
 5 to some of the statistics, you know, when you're looking
 6 at 88% of retail workers that have been abused every
 7 single day, and then 60% threatened by a customer, and
 8 9% actually being assaulted, I think the key message for
 9 all of us to remember is that this could have been
 10 avoided, and one of the reasons that could have been
 11 avoided was simply by the government talking to the
 12 trade unions and the people like us that represented our
 13 workers, and it didn't happen.

14 **Q.** Well, Ms Thomas, as I know you are aware, we aren't
 15 looking at the actual decision making or critique of
 16 decisions that were made, but we understand the point
 17 that you're making.

18 **MS THOMAS:** Thank you.

19 **Q.** What you've very helpfully done, all of you, is explain
 20 the impact of decisions, whether they were right or
 21 wrong, and in particular you've talked about the impact
 22 on the retail sector of abuse.

23 In terms of how that abuse could have been
 24 mitigated, I think Mr Shears what you were saying is
 25 that the lack of presence of other members of staff
 72

1 during the pandemic had a particular effect?

2 **MR SHEARS:** Yeah.

3 **Q.** Thank you.

4 In that section, there's a lot of detail about other
5 impacts on key workers. I'm not going to take you to
6 those other impacts other than the ones that we've
7 discussed about mortality, infection, mental health,
8 wellbeing, and abuse, in much detail, but there is
9 reference to the financial impact on key workers.

10 There's a lot of detail about the operation of sick
11 pay, which I know the Inquiry has already heard quite
12 a lot about, and a legacy of redundancy in a number of
13 sectors. It's right that some of the points go wider
14 than issues affecting key workers, but in summary, if
15 I could get a point up -- in fact, I'll just read it
16 out -- from the key workers' summary report at
17 paragraph 51, it says this:

18 "Several examples were given of the significant
19 financial impact of the pandemic on key workers,
20 particularly those on 'zero hours', temporary contracts,
21 and subcontracted/outsourced key workers. There was
22 a consensus amongst representatives that sick pay, for
23 those who were unwell with Covid-19 was not sufficient
24 or accessible for those who needed it."

25 That's a summary, Mr Shears. Is it consistent with
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1 being exploited again. And it was a kick in the teeth
2 for every single person that had kept this country
3 moving, in my case, along with all the other workers in
4 society, to have that denied.

5 And then, you know, we ended up with a national
6 dispute to defend our pensions, our jobs, our
7 agreements, afterwards. So, you know, when we come to
8 write the story of Covid, we need that to be seen:
9 heroes one moment and then villains the next. And that
10 wasn't right either.

11 **Q.** Thank you, Mr Leach.

12 Mr Short?

13 **MR SHORT:** Just to add to all of those points, the points --
14 all the points made about sick pay and the
15 inconsistencies between those who work, if you like, for
16 the core service and those who were contracted also
17 apply, perhaps even more in a sense, for workers who
18 perhaps weren't sick but were supposed to self-isolate.
19 Based on government guidance: don't go to work.

20 There was no clarity on whether they would get paid,
21 should they get paid. And so, you know, contractors
22 employers were aching exploiting that, to be honest, and
23 not paying them, which basically meant that people just
24 went to work and spread the disease.

25 **MS THOMAS:** Can I just echo that point as well. And again,
75

1 what the unions were hearing from their members?

2 **MR SHEARS:** Absolutely consistent.

3 We heard earlier on about a two-tier workforce; that
4 was never more the case than during this key part of the
5 Covid Inquiry.

6 And one of the big impacts of that was that it
7 undermined work that was done to mitigate risk
8 elsewhere. So, often, employers would have, by the end
9 of the pandemic, fairly sophisticated systems --
10 ventilation screens, protective equipment -- for their
11 own workforce, but then the cleaners, the security
12 guards, the maintenance workers also in those workplaces
13 were completed unprotected, often unable to isolate,
14 because they couldn't afford the reduction to sick pay,
15 which meant all of those other measures had been
16 defeated.

17 So this really was critical, not just for those
18 individual members, but actually for everyone in their
19 workplaces.

20 **Q.** Thank you.

21 **MR LEACH:** Yeah, I'd echo that point very much. And there
22 was a feeling afterwards that everyone's sick pay was
23 switched off, because that was what happened. It wasn't
24 a feeling; it happened.

25 And it was like we are all going back to normal,
74

1 just to bring to life some of the statistics around the
2 inconsistencies in USDAW, only 24% of our members
3 actually received full sick pay, 22% only received
4 payment for the contractual hours, and 12% were reliant
5 on Statutory Sick Pay. So, of course, that did create
6 a scenario where thousands of workers went to work when
7 actually they were symptomatic, and were, in fact,
8 infected.

9 We would get calls, hundreds of calls actually,
10 every single week about colleagues saying that they were
11 aware that other colleagues were affected and they
12 couldn't afford to stay away, which absolutely,
13 undoubtedly, contributed to the spreading of the virus,
14 and directly caused deaths because of that.

15 **Q.** Thank you.

16 Mr Shears?

17 **MR SHEARS:** A very brief extra point, which is we also had
18 members that were knowingly going into workplaces with
19 symptoms because they couldn't afford to isolate. And
20 the guilt that those workers felt after the fact was
21 absolutely incredible. They are very often suffering
22 the very long-term impacts of that to this day, because
23 they felt they put their colleagues and their friends
24 and in serious harm's way, and some of them know that
25 they did infect people that died. And that should not
76

1 be underestimated in terms of the mental health toll.

2 **Q.** Thank you.

3 I think that at that point we will be able to move
4 to the next topic, and that is inequality of impact
5 among key workers.

6 Now, the Inquiry has already heard evidence from
7 experts and other witnesses on unequal impact, including
8 pre-existing inequalities. And for that reason, I will
9 limit questions on this topic.

10 Firstly, Mr Shears, I'll cover the broad points in
11 the statement and then I'll move again to particular
12 groups that might be relevant to the issue of inequality
13 amongst key workers, key workers covered by this module
14 as opposed to earlier modules, such as health and
15 careworkers.

16 So, firstly, in relation to black and minority
17 ethnic workers, key workers, at paragraph 3 of the
18 statement, Mr Shears, it says that both black, minority
19 ethnic men and women were likely to be working in jobs
20 with a higher mortality rate; that's right?

21 **MR SHEARS:** Yes, that's correct, yeah.

22 **Q.** At paragraph 39 it is noted that black workers, as well
23 as women and disabled workers, are all overrepresented
24 in insecure work, and you include there descriptions of
25 workers that appeared to be key workers, such as those

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1 adjustments.

2 **Q.** Thank you. And you mention, and indeed exhibit,
3 a report, 'Dying on the Job - Racism, and risk at work',
4 and that's from July 2020, and that describes, amongst
5 other things, black and minority ethnic workers
6 reporting that, in some cases, they were deliberately
7 denied PPE which white colleagues were getting. And
8 that was in circumstances where it had become known that
9 they were at likely greater risk of contracting the
10 virus.

11 Are you aware of or can you explain to us the impact
12 of that?

13 **MR SHEARS:** Yes. So some of that was a visibility issue.
14 Our members reported to us very strongly that because
15 they were doing work that was supportive rather than
16 primary -- so cleaning work being a big one, security
17 work -- they were not to be perceived as part of the
18 core workforce who needed the protective equipment. And
19 as a result, they were very much at the back of the
20 queue. That meant that they could see themselves as
21 being in harm's way. And often, with these roles, they
22 were either dealing with the public directly or they
23 were cleaning up, again, things like bodily fluids, in
24 close contact with people that might be contaminated.

25 So, that was very much a failure to adequately both

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1 working in supermarkets and cleaners. Is that correct?

2 **MR SHEARS:** Yes, that's correct, yeah.

3 **Q.** And at paragraph 40 to 41, the statement notes
4 pre-existing inequalities, which, as I say, we've heard
5 expert evidence about.

6 Research by the TUC found that 56% of black and
7 ethnic women and 46% of black and minority ethnic men
8 reported discriminatory treatment at work during the
9 pandemic?

10 **MR SHEARS:** Yes, yeah, that was absolutely typical.

11 **Q.** And at paragraph 42, the statement goes on to describe
12 reports from black workers experiencing problems
13 accessing PPE, and the issue noted there is that they
14 were overrepresented amongst outsourced workers, who
15 were said to be at the back of the queue for PPE. So
16 was that a factor that you would identify that would be
17 likely to affect black and ethnic workers more?

18 **MR SHEARS:** Absolutely. The combination of that being at
19 the back of the queue plus, in some cases, the need for
20 adapted or specific protective equipment for those that
21 wear, for instance, turbans, or face coverings for
22 people with beards, these are not new issues. These
23 issues have been resonant for a very long time. But it
24 was very clear during the pandemic that employers had no
25 idea of how to make those provisions and those

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1 assess the risk but almost to really conceive the risk
2 being equal across the workplace in the first place. It
3 was very much seen as something that white workers were
4 experiencing, with other workers from other minority
5 groups participating in the background elsewhere.

6 **Q.** Thank you.

7 There are other comments on other groups, and there
8 are particular areas that other core participants would
9 like me to explore with you, so if I can move to that
10 now.

11 First, disabled workers. They are referred to in
12 the statement at paragraphs 50 to 51. They're not
13 specifically referred to as disabled key workers, but
14 I'm asked to clarify some points about that group.

15 So, in the question, it said that disabled people
16 worked in frontline and insecure jobs with often lower
17 incomes, whilst facing higher costs, and they worked in
18 occupations that were more exposed to risk, such as in
19 the retail and wholesale sector.

20 So the question is, are any of the witnesses aware
21 of any evidence about heightened risk of infections,
22 mortality, or impacts on mental wellbeing amongst
23 disabled key workers during the pandemic?

24 Mr Short?

25 **MR SHORT:** On the last of your points, about mental

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1 wellbeing, I think a lot of our -- UNISON's members who
2 are disabled, we talked them a lot, and they gave us
3 a sense of the pre-existing issues they often had, of
4 discrimination and prejudice at work, were heightened by
5 the pandemic. So, for example, you would have -- in
6 a lot of services, it might be more difficult for
7 a disabled person, depending on the disability, to
8 socially distance properly, to wear the right kind of
9 mask or covering, those sorts of things. It depends on
10 the disability, it depends on the type of job. And one
11 disabled worker told us that the pandemic highlighted
12 this sense of being a second-tier worker as a disabled
13 person.

14 **Q.** Thank you.

15 Ms Thomas?

16 **MS THOMAS:** Yeah, also there was a really poor understanding
17 and implementation of the disability provisions by the
18 Equalities Act, and we found that many employers and
19 most managers that were talking about ordinary,
20 reasonable adjustments, just put that to one side,
21 because they were fully focused on social distancing
22 measures, which again caused issues, major issues, in
23 the workplace, particularly for disabled people.

24 **Q.** Thank you.

25 That in fact, it's the next question. Are the

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1 about that impact on women, Mr Short?

2 **MR SHORT:** I don't want to repeat comments I made earlier
3 but school support staff were a particular risk group in
4 Covid because of the nature of the work. The vast, vast
5 majority of teaching assistants were women. The vast,
6 vast majority of school cleaners are women.

7 **Q.** Yes, that's paragraph 93 of your statement:
8 disproportionate impact on women due to the composition
9 of support staff such as catering, and cleaning staff;
10 is that the point?

11 **MR SHORT:** Yes.

12 **Q.** Mr Shears?

13 **MR SHEARS:** Just to add that the particular reference to
14 pregnant workers there is very important. In many cases
15 the work that these pregnant workers were doing was
16 genuine and very high-level key work, it was not easy to
17 take them out of the workplace, and it was not easy to
18 replace them, necessarily. Employers in many cases
19 simply didn't try. It was a case of: you can have
20 a face mask, some hand sanitiser, you can carry on as
21 usual, not realising those additional risks that would
22 normally be managed still needed to be managed. So one
23 of our biggest challenges was getting good practice
24 across ever sector in terms of dealing with pregnant
25 workers very early. Again, in those sectors where we

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1 witnesses aware of reports of failures to make
2 reasonable adjustments for disabled key workers during
3 the pandemic?

4 **MS THOMAS:** Yes.

5 **MR SHEARS:** (Witness nodded)

6 **Q.** Are there any other examples?

7 **MS THOMAS:** (Inaudible)

8 **Q.** Then, the third question is: are the witnesses aware of
9 how any intersections with other protected
10 characteristics such as, but not limited to, gender,
11 affected disabled key workers?

12 No answers to that particular question. Okay.

13 At paragraph 52, there is reference to the vast
14 majority of frontline workers during the pandemic being
15 women, those it's right to say that when you look at the
16 percentages there, a number of them worked in health and
17 social care which is outside the scope of this module.

18 There's a lot of detail on the impact of women
19 workers and, again, it goes beyond key workers, but at
20 paragraph 53 it's noted that many were in jobs that
21 heightened their risk of getting the virus, and they
22 were in jobs that could not be done at home, and again,
23 there's a point about them being more likely to be in
24 insecure and zero-hours contracts.

25 Do any of you have any further comments to make

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1 had good pre-existing social partnership arrangements,
2 that was done quite well. For those where that didn't
3 happen, it was much more difficult, it took a lot
4 longer, and unfortunately a lot of those workers, a lot
5 of those members were in those insecure type hidden
6 roles.

7 **Q.** Thank you.

8 **MS THOMAS:** I'm just going to, again, bring some statistics
9 to it, 77% of women are healthcare workers, 83% of the
10 social care workforce are women, and 70% of those
11 working in education and also, statistically, mothers
12 are more likely to be key workers as well.

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

14 Turning to migrant workers, at paragraphs 58 to 60,
15 they are noted to be disproportionately represented in
16 key worker jobs. Again, some of which do fall outside
17 this module, but some that may be in this module, for
18 instance, cleaning and food distribution.

19 And I'm asked to clarify one question with you about
20 this group. And that is, would you agree with the MRC's
21 evidence, which I think you've been provided with, that
22 in fact many more migrant workers were not eligible at
23 all? I'm sorry, I should have read this
24 paragraph first, sorry, I'll read it.

25 At paragraph 59 of your statement, you discuss

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1 concerns expressed by the TUC that many migrant workers
2 who were eligible to receive job-related benefits such
3 as unemployment benefits, had low awareness of their
4 entitlements. And the question is: would you agree with
5 the MRC's evidence that in fact many more migrant
6 workers were not eligible at all due to their exclusion
7 from mainstream welfare benefits, including Jobseeker's
8 Allowance and Universal Credit, as a result of having no
9 recourse to public funds?

10 Mr Shears, I could ask you about that.

11 **MR SHEARS:** Yes, certainly, again, in our members'
12 experience that would absolutely be the case. For many
13 of our migrant worker members they work in workplaces,
14 textiles, food production, where the vast majority of
15 the workforce are migrant workers from the same
16 communities. They are heavily reliant on their
17 employers for information about benefits. Frankly, the
18 information that was received from government agencies
19 was often not translated, was not very well
20 communicated. So they were very much in the dark about
21 this. And again, would not have seen themselves as
22 having been eligible in many cases, unless the union had
23 explained to them very clearly what they were able to
24 claim and how they were able to do that.

25 So yes, their eligibility was very questionable,

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1 which is conversations that wouldn't take place
2 ordinarily, you know. So this was a brand new, you
3 know, situation that had appeared that was just very
4 complicated, and nine times out of ten, that's not
5 a legit statistic that I'm saying from my experience,
6 a high proportion of times, should I say, actually,
7 people didn't bother because it was just too
8 complicated.

9 **MR LEACH:** Yeah, that's it.

10 **Q.** Thank you very much indeed for those insights.

11 I want to move finally to some reference in the
12 statement to shielding workers, but also those who did
13 not fall within those required to shield but were still
14 clinically vulnerable. So paragraph 124 describes
15 essentially an education or -- education workers in that
16 precise position, and the way they're described is
17 essentially being forced into work.

18 You have had some sections of a statement from Lara
19 Wong on behalf of Clinically Vulnerable Families
20 provided to you, and that also covers this ground, as
21 well as other disadvantages such as stigma and
22 discrimination. And it also notes that some clinically
23 vulnerable workers were obliged to leave their jobs
24 during the pandemic.

25 So taking you to your statement, and I'll ask

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1 information was very poor, not well communicated. They
2 did not, for the most part, have trusted sources outside
3 of the trade unions to go to try to educate themselves
4 about what was available.

5 **Q.** Thank you.

6 Mr Leach?

7 **MR LEACH:** Yes, just another example of the two-tier
8 workforce, as well, in real terms where you have this
9 kind of shadow workforce who were all at work in the
10 pandemic doing all this critical work, who don't really
11 feel valued and even like a bona fide workforce. Their
12 employer isn't really interested in them, their
13 colleagues probably work for somebody else, and they may
14 be being looked after, in their eyes, and they were just
15 another group that fell between the cracks. And, you
16 know, it's still a problem today, but it was made so
17 much worse then when we all needed so much more support.

18 **Q.** Thank you, Mr Leach.

19 Ms Thomas?

20 **MS THOMAS:** We had reports from our representatives quite
21 regularly, particularly where agency workers were,
22 around the complications of just supporting their
23 colleagues around benefits as such, because it's
24 a complex, you know, issue if you speak English, let
25 alone to try and translate that into other languages,

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1 Mr Short about this. A firsthand account appears at
2 paragraph 247, and it gives the account of a clinically
3 vulnerable teacher who gets very unwell, is
4 hospitalised, is -- then attempted to go back to work to
5 return, only then to get another infection, and
6 ultimately decides to take ill health retirement.

7 So I'm asked to explore with you or ask you, are
8 there any specific ways in which employers could
9 approach keeping clinically vulnerable key workers like
10 this both in work and safe at work?

11 **MR SHORT:** I mean, for teachers, I think one key way of
12 keeping teachers more safe at work is to have more
13 online provision which is something, there are pros and
14 cons to that, but that is something which developed, you
15 know, during the Covid and one of the issues with online
16 service delivery is it works for some services and not
17 others, and it works for some workers and not others.

18 I think this goes back to the sick pay provisions
19 and the sort of isolation provisions, as well. If we've
20 got properly negotiated sick pay, properly negotiated
21 time-off revisions, agreed between the employer and the
22 union, the government, depending on which sector it is,
23 and what the government's role is, then that's the main
24 thing really, to protect workers and give them that
25 leeway to get better before they are forced back into

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1 work.

2 **Q.** Thank you.

3 I want to move finally to lessons learned, and there

4 are a number of very sector-specific lessons learned,

5 not across all sectors, in the statement, and the

6 paragraphs where they appear are in relation to

7 financial lessons which we've explored at paragraphs 213

8 to 220 but of course you've explored that in your

9 evidence today. Specific lessons learned from the

10 experience of the education sector at paragraphs 221 to

11 225. The police and justice sector at paragraph 150,

12 and finally the transport sector at paragraphs 226 to

13 231.

14 You were also all provided with the report from the

15 Key Workers Roundtable, which was attended by TUC, and a

16 number of the unions. Now, that sets out a number of

17 lessons learned, and if I can just end by putting those

18 to you for your comments.

19 In summary, some of the key lessons were the need

20 for pandemic planning embedding the voice of key

21 workers, the need for clear and timely guidance, the

22 need for improved safety measures, and the need for

23 policies to combat abuse and support the mental health

24 of key workers. Those are just some of them.

25 Could I turn to each of you in turn to ask whether

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1 **Q.** Thank you.

2 I think you will want to add something. I'm quite

3 conscious of the time -- there are some more questions

4 for you -- if I could ask you to be very brief in any

5 additional points, Ms Thomas?

6 **MS THOMAS:** Trade unions undoubtedly saved lives throughout

7 the pandemic, our intervention. And just to, sort of,

8 echo what my colleagues just said, I think we absolutely

9 need to be reflected in government structures, through

10 that tripartite structure and method, particularly with

11 worker representation, and I would say that would be my

12 key reflection on that.

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

14 Mr Leach?

15 **MR LEACH:** Two points. One, that we were caught unawares

16 and not ready for this. And I don't think we are

17 particularly now, as a transport industry. There's been

18 no huge debrief, there's been no stand-up plan prepared

19 that I'm aware of -- and I'm the head of self-safety in

20 my own union -- and in -- across the union industry

21 level. And the other thing is, the two-tier workforce

22 is inherently unjust and unsafe.

23 **Q.** Thank you, Mr Leach.

24 Finally, Mr Short?

25 **MR SHORT:** Yeah, the point about trade union involvement

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1 or not they reflect the main concerns or lessons that

2 you think can be drawn from the experience of key

3 workers during the pandemic.

4 Firstly, Mr Shears.

5 **MR SHEARS:** Yes, I think they do. I think they can.

6 One very important point I think that underpins all

7 of this is having a body for collective decision making

8 in terms of that preparation and planning.

9 To give a very concrete and specific point, it was

10 very apparent very early in the pandemic in -- by late

11 February/early March 2020 that there were not enough

12 FFP3 masks and there would have to be some kind of

13 system of prioritisation.

14 Now, for our members as a general union, that meant

15 that some members would get protective equipment and

16 some wouldn't. We were not able to have mature

17 discussions with either government or our members about

18 what the prioritisation was and why it was necessary.

19 In future, having a tripartite body that was able to

20 plan, to say, "Right, these are our sectors that we have

21 to ensure have first provision, we can then use the

22 hierarchy of control to step down where we need to go,

23 and plan the response accordingly", would have been

24 extremely valuable.

25 For us, that was a very clear, key lesson.

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1 Ms Thomas made was one I was going to make as well. The

2 recommendations around worker voice and having forums,

3 trade unions underpin all of that. Without a trade

4 union, it would be very difficult to do worker voice

5 effectively.

6 The other point I was going to make, I know this

7 module isn't about preparedness or preparation, but

8 a lot of the impacts on key workers, they resulted --

9 they were the results of things which it was too late to

10 solve by the time the pandemic kicked off. So, for

11 example, you know, proper ventilation in schools

12 requirements investment now for the next pandemic, and

13 it would have been helpful before the previous pandemic.

14 **MS RAHMAN:** Thank you very much. There may be some more

15 questions for you.

16 My Lady.

17 **LADY HALLETT:** There are indeed.

18 The first person is Ms Davies, who is that way.

19 **Questions from MS DAVIES KC**

20 **MS DAVIES:** Can you see and hear me?

21 **MR SHEARS:** Yes.

22 **Q.** My name is Liz Davies and I represent the Domestic Abuse

23 Group, which comprises three organisations who provide

24 domestic abuse services in the violence against women

25 and girls sector.

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1 My question, I think, is best directed to Mr Shears,
2 so I hope you can see me.
3 **MR SHEARS:** Yes.
4 **Q.** My clients' experience is that there was considerable
5 confusion throughout the pandemic as to whether
6 frontline workers supporting survivors of domestic abuse
7 were key workers, even though they were working in roles
8 where in-person contact with vulnerable individuals was
9 essential. And this confusion deprived those workers of
10 key worker benefits, such as schools, early access to
11 the vaccine, and so on.

12 So, my question is, do you agree that in a future
13 pandemic scenario, it would be essential that frontline
14 workers in the violence against women and girls sector
15 be formally recognised as key workers, so that the
16 essential work they do can continue, and they're able to
17 consistently access key worker priority schemes?

18 **MR SHEARS:** Yes, I would absolutely agree with everything
19 you just said there. It was very striking during the
20 pandemic, especially in the earlier parts of the
21 lockdowns, that some of those really key supportive
22 roles were not perceived to be key worker roles.

23 For many our members who had children, they were not
24 able to get their children to school. That meant they
25 had to work from home and, as a result, couldn't give

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1 clinically extremely vulnerable workers were recognised
2 as being high risk and advised to shield, but during the
3 period that we've been discussing, the protection in the
4 workplace for those workers still generally, in --
5 certainly in clinically vulnerable families' experience,
6 depended on individual risk assessments of the
7 particular worker and discretion by the employer, as
8 opposed to policies which imposed measures like better
9 ventilation or masking or whatever it would be to keep
10 them safe.

11 Do you agree that that individualised approach left
12 many clinically extremely vulnerable workers without
13 clear and enforceable rights?

14 Yes, hand up.

15 **MR SHORT:** Yes, is the short answer. The slightly longer
16 answer is we had a lot of experience of this in local
17 government and education, where workers -- our members
18 were concerned, perhaps members who are not clinically
19 vulnerable or clinically extremely vulnerable but had
20 family members who were, and were relying on exactly
21 that -- as you characterised, that sort of discretion of
22 an employer or the intervention of a trade union to help
23 them. And sometimes that worked, sometimes that was
24 effective, and they were treated sympathetically, and
25 other times not.

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1 the kind of primary face-to-face support they would
2 normally give.

3 Now, I must be frank, I don't speak with any great
4 firsthand experience of this, but I know from some
5 colleagues that that was extremely different, because
6 those were very essential and sometimes life-saving
7 services that effectively were stopped dead at that
8 point.

9 So, I think there are a number of key worker roles
10 that needed to have that degree of consideration in that
11 initial list. They were not there. And again, the
12 point around vaccination is absolutely critical there,
13 because, again, those workers will have been at higher
14 risk later, and were not prioritised when vaccines were
15 available. But yes, I would conclude absolutely with
16 everything that you said.

17 **LADY HALLETT:** Thank you, Ms Davies.

18 **MS DAVIES:** Thank you, my Lady.

19 **LADY HALLETT:** Next is Mr Wagner, who is that way.

20 Questions from MR WAGNER KC

21 **MR WAGNER:** Good afternoon. I ask questions on behalf of
22 Clinically Vulnerable Families. This is a question for
23 anyone who wants to answer it, maybe someone could just
24 pick it out.

25 Under Health and Safety Executive guidance,

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1 So, yes, more high-level guidance for those
2 situations would have been extremely helpful, yes.

3 **Q.** So, it was really a bit of a lottery, because it
4 wasn't -- there wasn't that high-level guidance?

5 **MR SHORT:** Yes, absolutely, yes.

6 **Q.** Yes?

7 **MS THOMAS:** I would say that it was incredibly inconsistent,
8 in my experience. For all of the representatives and
9 full-time officers I spoke to, this would constantly
10 raise its head, particularly for disabled workers and
11 workers that were vulnerable, because -- and I'm going
12 to repeat myself here, but just for the purpose of the
13 question -- because the focus was just so directly on
14 the mass implementation of the legal guidance.

15 I think, from my experience, that there was quite
16 a lot of disabled workers and vulnerable workers that
17 were left more vulnerable than they should have been
18 because there just wasn't the resources put in place to
19 support them with their ordinary list of reasonable
20 adjustments that sat outside of the pandemic scenario.

21 **Q.** So it wasn't just policy; it was about resources as
22 well?

23 **MS THOMAS:** I think it was resources and the fact that,
24 quite frankly, a lot of employers, you know, were
25 panicking. A lot of them did have the resources but

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1 chose to focus on the pandemic.
 2 And then there were obviously good practices as
 3 well, and I would say that is where you have got strong
 4 trade unions in place, because, statistically, any
 5 workplace that has a trade union present actually has
 6 better health and safety standards. And I think that
 7 was the key for us: it was making sure we supported our
 8 members, via our network of representatives, where we
 9 had, even -- policies or without them, we managed to
 10 intervene. But I did, you know, and still do, worry
 11 about all of those workplaces that go underrepresented
 12 by trade unions.

13 **Q.** Yes.

14 **MR LEACH:** Just one point would be that every single one of
 15 our members has some form of -- or would probably have
 16 some form of family life outside of work, and that would
 17 include vulnerable, clinically vulnerable family
 18 members.

19 That was always an issue when they had to come to
 20 work. And anything that we can respond to that
 21 collectively, rather than individually, would always be
 22 able to do better, is the way we would describe it, so
 23 yes, to your question.

24 **Q.** Thank you.

25 And just one other question. In relation to
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1 competent to determine what the appropriate measures
 2 were. So we had a lot of experience of members who were
 3 clinically vulnerable receiving face coverings when face
 4 masks were required, being deployed into areas that were
 5 screened but not screened adequately, and a full sense
 6 of security from the employer thinking they'd put
 7 measures in place that were protective but actually,
 8 frankly, were more performative. They made the employer
 9 feel better about the fact that they had taken some
 10 action but the action was not really adequate or
 11 appropriate.

12 **LADY HALLETT:** Thank you very much, Mr Wagner.

13 Ms Beattie, who is that way.

14 **Questions from MS BEATTIE**

15 **MS BEATTIE:** Thank you, my Lady.

16 I ask questions on behalf of national Disabled
 17 People's Organisations, and I have questions on two
 18 short topics, please. The first is about who is or
 19 might be a key worker in a civil emergency or a future
 20 pandemic from the perspective of disabled people, for
 21 whom a range of workers may be key to maintaining
 22 independent living, and so keeping life going, if I can
 23 put it that way, but who may not be key or essential for
 24 non-disabled people.

25 And just to give some examples for context, I mean
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1 clinically vulnerable workers who were not classed as
 2 clinically extremely vulnerable, so were in the
 3 non-shielding or the group that wasn't told to shield,
 4 the HSE guidance focused on general workplace risk
 5 assessments rather than clear enforceable actions to
 6 reduce exposure.

7 Do you agree that that left those higher-risk
 8 workers who weren't being told to shield even more
 9 exposed to severe outcomes in the workplace as a result?
 10 **MS THOMAS:** I think if they didn't have the right practices
 11 put in place, then yes, but again, to use your own
 12 words, it was such a lottery, it's hard to give, in my
 13 opinion, a generic answer to that because there were so
 14 many different practices that were going on in the
 15 public sector and the private sector, but of course,
 16 where that was the case, it would automatically leave
 17 individuals more vulnerable if effort wasn't put into
 18 the protections of them.

19 **Q.** And on top of that, you would have Mr Leach's two-tier
 20 issue as well --

21 **MS THOMAS:** Yeah.

22 **Q.** -- that the contracted versus non-contracted workers
 23 would be in a different situation?

24 **MR SHEARS:** Can I just add on those points, often the
 25 managers performing those assessments were not really
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1 that might be personal assistants, that might be workers
 2 who provide communication support, might be teaching
 3 assistants, that might be cleaners or other people
 4 working in disabled people's homes.

5 So do you agree that identifying who is a key worker
 6 in a civil emergency or future pandemic needs to reflect
 7 the needs of disabled people and the risks facing
 8 disabled people, as well as any unequal impacts and
 9 intersectional impacts?

10 Maybe I'll just start from left to right, or if
 11 anyone wants to jump in.

12 **MR SHEARS:** Certainly from my perspective, I'd absolutely
 13 agree with that. Again, we had significant experience
 14 during the pandemic of members requiring additional
 15 support through schemes like Access to Work that frankly
 16 wasn't available, because the workers were not present
 17 to be able to give that support -- for exactly the kind
 18 of roles you've just described.

19 One of the concerns, as we understood it, was there
 20 was a risk that some of these workers would become
 21 superspreaders because they may have been visiting
 22 multiple different dwellings in one day to service
 23 different clients. However, with proper resourcing, you
 24 can individualise that support and that care in the same
 25 way you can have one member of staff per bubble in
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1 a school.

2 So this was as much about, again, a failure to
3 adequately resource and manage the risks as it was
4 a general policy, we think, of not making things happen.
5 It was both a failure of understanding but also of
6 imagination in terms of what people actually needed.

7 **Q.** Thank you. And I'll just check if anyone else wanted to
8 add to that. Thank you.

9 **MS THOMAS:** I was just going to add to that, in short yes,
10 but I think it would always be with the right PPE and
11 the right provisions because what we've all seen,
12 I think, throughout the pandemic in workplaces, actually
13 things did get better as time went by with lots of
14 different interventions. So I think absolutely, that
15 should be the case, in ensuring as much as normal life
16 can go on as possible, as long as the right provisions
17 is put in place and I think we started to get to that
18 point.

19 **MR LEACH:** Just very quickly, yes, 100%, but of course that
20 sector of the workforce, it's not traditionally my area,
21 my union's experience, but we have members who have
22 families that have disabled family members or friends,
23 and of course that is an outsourced industry as well.
24 So those workers quite often work for some of the most
25 exploitative multinational companies, these care

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1 **Q.** And that report also covers barriers to disabled workers
2 reporting and providing data, so in terms of collecting
3 data and disabled workers having the trust to provide
4 that data and that covering, the kind of pre-existing
5 inequalities that Ms Rahman took you to, do you agree
6 that, given those issues, there needs to be both
7 collection of disaggregated data on disability and
8 intersectional data, and that systems to collect and
9 then use that data need to be developed in partnership
10 with disabled people, intersectional disabled people,
11 and intersectional disabled people's organisations?

12 **MS THOMAS:** Yes, I would agree with that.

13 **MR SHORT:** Yes, I think it's important that disabled workers
14 feel comfortable and confident giving that data, and
15 a big part of that is working with disabled people's
16 organisations. That would help give them that
17 confidence.

18 **LADY HALLETT:** Thank you very much, Ms Beattie.

19 **MS BEATTIE:** Thank you.

20 **LADY HALLETT:** That completes the questions we have for you.

21 I'm sorry if you've been uncomfortable, in a line, four
22 of you -- we've done all four before together -- so
23 you've been an experiment which I don't think I would
24 repeat, but as I'm not having any more hearings --
25 sorry, it's not the quality of your evidence, just

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1 workers, and that's going to be made worse by the fact
2 that they're not even recognised as being key workers
3 when they should be.

4 **Q.** Thank you.

5 And just the second area is about data gaps about
6 disabled workers and disabled key workers. At
7 paragraph 51 of the joint statement you refer to the TUC
8 report on disabled workers' experiences during the
9 pandemic, which set out -- sets out workplace barriers
10 including, as Ms Thomas, you've already mentioned,
11 difficulties in getting and keeping reasonable
12 adjustments necessary to work effectively and safely,
13 and problems of the disability pay gap and the
14 disability employment gap.

15 Do you agree that the disproportionate impact of the
16 pandemic on disabled key workers highlights the need for
17 further monitoring data to expose those barriers during
18 a pandemic, including problems of timely provision of
19 reasonable adjustments and disability and pay employment
20 gaps?

21 **MS THOMAS:** Yes, I do think, without a doubt, that should be
22 monitored and that should continue for a very long time
23 and possibly indefinitely because ultimately that is the
24 only way you could make the best provisions and get good
25 outcomes for disabled people.

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1 having the four of you together.

2 Anyway, thank you so much for your help. I very
3 much take on board the point about lack of recognition
4 during the course of this inquiry. As you've a probably
5 noted, I've heard about -- many thousands, if not
6 millions, of unsung heroes, so I very much take on board
7 the point about your members being amongst those unsung
8 heroes. So, thank you for making that point, and thank
9 you -- could I also, through you, thank the TUC, who
10 have been with me, I think, throughout this Inquiry, and
11 they've been of great assistance, expertly represented
12 by Mr Jacobs and Ms Peacock.

13 So, thank you for all the help that the TUC has
14 given to this.

15 **MS THOMAS:** Thank you.

16 **LADY HALLETT:** Very well, I shall return at 2 o'clock.
17 (12.58 pm)

18 (The Short Adjournment)

19 (2.00 pm)

20 **LADY HALLETT:** Ms Blackwell.

21 **MS BLACKWELL:** My Lady, this afternoon we begin the final
22 element of our public hearings, which will focus on
23 bereavement and the bereaved, and our first witness is
24 Dr Samuel Royston who will give evidence on behalf of
25 the UK Commission on Bereavement.

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1 May he be sworn, please.

2 **DR SAMUEL ROYSTON (affirmed)**

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

4 **LADY HALLETT:** Thank you for coming to join us, Dr Royston.

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

6 **A.** Yes, my name is Dr Samuel Peter Royston.

7 **Q.** Thank you. You should have before you a copy of your
8 witness statement which bears our reference
9 INQ000657845. Please can you confirm that that is the
10 statement which you have provided on behalf of the
11 UK Commission on Bereavement?

12 **A.** It is.

13 **Q.** And that the contents are true to the best of your
14 knowledge and belief.

15 **A.** They are.

16 **Q.** Thank you very much.

17 You are currently the Executive Director for
18 Research and Policy at Marie Curie and you previously
19 have held the position of Director of Research and
20 Policy at Marie Curie.

21 Prior to that you served as Director of Policy and
22 Research at The Children's Society. You hold
23 a Directorate [sic] of Philosophy and a master's degree
24 in social policy from the University of York and
25 a bachelor's degree in philosophy from the University

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1 commissioners including at least one from each of the UK
2 nations; is that right?

3 **A.** Yes.

4 **Q.** They included leaders, experts, with a professional
5 understanding of bereavement, journalists with an
6 interest in bereavement issues, political influencers
7 with experience of securing policy change, and
8 individuals who had experienced bereavement during the
9 course of Covid; is that right?

10 **A.** That's correct.

11 **Q.** And the steering group which supported its work was
12 chaired by you, and who else was on the steering group,
13 please, Dr Royston?

14 **A.** The other charities which established the UK Commission
15 on Bereavement. So that was Marie Curie, ourselves,
16 National Bereavement Alliance and Childhood Bereavement
17 Network, Independent Age and Cruse Bereavement Support.

18 **Q.** Thank you. Between its launch in 2021 and the
19 publication of its report, Bereavement Is Everyone's
20 Business, which we will look at throughout the course of
21 your evidence this afternoon, the commissioners met
22 online or in person about every six weeks; is that
23 right?

24 **A.** Yes, about that.

25 **Q.** And the role of the commissioners was varied but it

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1 Cambridge; is that right?

2 **A.** A doctorate of philosophy rather than a directorate --

3 **LADY HALLETT:** Ah, I was about to correct that.

4 **MS BLACKWELL:** So sorry, a doctorate of philosophy, yes.

5 You're giving evidence in your capacity as chair of
6 the steering group on the UK Commission on Bereavement;
7 is that right?

8 **A.** That's right.

9 **Q.** And you held that position from June 2021 until
10 October 2022. In preparing the statement you have given
11 to Module 10 you have consulted with colleagues and you
12 have relied on your own knowledge and recollections and
13 the input from the other members of the UKCB steering
14 group and you've set out the history of the organisation
15 and also the work that it has done during the course of
16 Covid and beyond.

17 So the UK Commission on Bereavement didn't have
18 a legal status but it was established to investigate
19 recent experiences in the United Kingdom and to make
20 recommendations for improving bereavement support; is
21 that right?

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

23 **Q.** It comprised 16 commissioners including a chair, Dame
24 Sarah Mullally, who was then Bishop of London now
25 Archbishop of Canterbury, and then a series of

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1 included attending the meetings, leading oral evidence
2 sessions, reviewing reports and making decisions about
3 the recommendations; is that right?

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

5 **Q.** And it was guided at every stage by what you describe as
6 a Lived Experience Advisory Forum known by the acronym
7 LEAF. Tell us what LEAF did, please, Dr Royston?

8 **A.** The Lived Experience Advisory Forum, it was advisory, so
9 they weren't members of the commission, although we had
10 one member who provided a contact between the LEAF and
11 the commission so was also a commissioner --

12 **Q.** Yes.

13 **A.** -- and it was made up of 14 people who had been bereaved
14 within the previous three years, and they helped to
15 guide the scope, priorities and recommendations of the
16 commission.

17 **Q.** Thank you.

18 You tell us at paragraph 14 what the aims and
19 objectives of the commission was. You say that it was
20 to review the experiences of and support available for
21 people affect by bereavement through and beyond the
22 Covid-19 pandemic, and to make recommendations to key
23 decision makers, including the UK Government and each
24 devolved government, in order to improve support for
25 bereaved people in each nation in the UK.

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1 And its three objectives were these: one, to collect
2 evidence, including by hosting an open public call for
3 written evidence on bereavement experience and support
4 through Covid-19, and holding oral evidence sessions for
5 people with lived experience of bereavement through the
6 pandemic, and also key experts.

7 Two, to produce and publish findings on experiences
8 of bereavement through the pandemic, including
9 recommendations for change.

10 And, three, to make the case for change, meeting
11 with key decision makers to bring about improvements to
12 support and for bereaved people through and beyond the
13 pandemic.

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

15 **Q.** You say at paragraph 16:

16 "Bereavement is a universal human experience which
17 will affect all of us in the course of their lives.

18 However, many of the challenges facing bereaved people
19 were brought into sharp focus during the course of
20 the ... pandemic."

21 What sort of figures did your commission receive and
22 discover in terms of the increase in bereavement during
23 the course of the pandemic?

24 **A.** We estimated that there were an estimated 6.8 million
25 bereavements in the United Kingdom over the course
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1 from all strands of evidence were then synthesised in
2 the report narrative, and the structure and chapters for
3 the report were decided on collectively by researchers,
4 members of the steering group and commissioners, after
5 careful consideration of the key themes that emerged
6 through the analysis?

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

8 **Q.** You also mention in your statement something called the
9 BeCovid survey. Does that stand for Bereavement during
10 Covid study?

11 **A.** Yes.

12 **Q.** And was that led by Dr Emily Harrop, who is a research
13 fellow at the University of Cardiff, and who has also
14 provided a witness statement to this Inquiry?

15 **A. (Witness nodded)**

16 **Q.** And also Professor Lucy Selman, Professor of Palliative
17 and End-of-life Care at the University of Bristol?

18 **A.** That's correct. And Lucy and Emily were also
19 represented on the steering group for the UKCB.

20 **Q.** Thank you very much.

21 Let's take a look at the report, please.

22 It's at INQ000349021.

23 We can see the UK Commission on Bereavement 2022
24 report: Bereavement Is Everyone's Business.

25 And if we go to page 5, please -- thank you -- we
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1 of 2020 and 2021 alone, and that was an estimated
2 additional 750,000 compared with the average between
3 2015 and 2019.

4 **Q.** Thank you.

5 At paragraphs 22 to 31 you set out the demographic
6 distribution of respondents to the written consultation.
7 I won't ask you to set that out here, save and except to
8 say that you recorded distribution in terms of
9 characterisations such as age, gender, ethnicity,
10 nationality, respondent's first language, religion, and
11 sexual orientation; is that right?

12 **A.** That's correct.

13 **Q.** And was the data available in relation to some of those
14 characterisations better than others?

15 **A.** Um ...

16 **Q.** I think we'll come to look at the data in a moment, and
17 to see what the gaps were in terms of --

18 **A.** Yeah.

19 **Q.** -- what was capable of being recorded.

20 In terms of oral evidence, the commission held eight
21 sessions on different topics and a series of roundtable
22 events bringing together key stakeholders; is that
23 right?

24 **A.** Yes, that's right.

25 **Q.** And you say at paragraph 33 that themes and findings
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1 can see that:

2 "The Covid-19 pandemic has not only exacerbated
3 challenges around bereavement, it has also spotlighted
4 this universal human experience, and presented a rare
5 opportunity to reflect as a society how well-equipped we
6 are to support people through a bereavement, and how we
7 can work together to improve that support both now and
8 in the future."

9 And you say here:

10 "Working in partnership with a number of UK
11 voluntary sector organisations, and with researchers
12 Drs Emily Harrop and Lucy Selman who led an academic
13 study on bereavement during the pandemic, an independent
14 UK Commission on Bereavement through and beyond COVID-19
15 was established in June 2021 to investigate this key
16 question in all four nations of the UK."

17 Then may we go to page 15, please.

18 We can see that one of the sections was "Findings
19 and recommendations". The impact of bereavement is
20 described there as being "A very lonely place to be".

21 And if we can just -- thank you very much --
22 highlight those bubbles and the paragraph following, we
23 can see that somebody aged 13-15 told the commission:

24 "It is quite hard at times it's really like a roller
25 coaster, you could be feeling good one minute then you
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1 have a big moment where all of your emotions come out."
 2 Then this:
 3 "Almost all of us will experience bereavement in our
 4 lives and each of us will experience it differently.
 5 A bereavement can be one of the most profound upheavals
 6 any one of us faces. As well as the direct emotional
 7 impact, a bereavement can create a wide range of
 8 practical challenges, which a bereaved person has to
 9 face, while trying to cope with their grief".
 10 And then if we can highlight from the following
 11 page, please -- thank you very much.
 12 "Many respondents talked about feeling overwhelmed
 13 by sadness and devastation. Respondents described this
 14 in a variety of ways, including feeling lost or numb,
 15 feeling like their world had fallen apart, and some
 16 likened it to a bad dream, saying they didn't want to
 17 carry on."
 18 Then these quotes:
 19 "It's awful, draining and it takes control of your
 20 life."
 21 That from a teenage person.
 22 Then:
 23 "Respondents of all ages described the strength and
 24 changeability of their feelings, which could be
 25 overwhelming and feel out of control. The feeling of
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1 a reason. The key question for the commission was to
 2 set out what needs to be done to improve support for the
 3 future, and we wanted to set it out as the things which
 4 the commission wanted all bereaved people to be able to
 5 say. So each of the statements is an "I" statement in
 6 order to respond to that challenge.
 7 And the first thing that we heard when we analysed
 8 the evidence, and one of the most central, was about the
 9 importance of support by family, by friends, by wider
 10 community settings, in order to support people through
 11 bereavement. And some of the statements you
 12 illustrated, so that really struck home so powerfully,
 13 were about the sense of isolation through bereavement
 14 and really, this was about the need of treating
 15 bereavement as something which is a shared experience
 16 across the community and something which requires
 17 support from not just one or two people but by the whole
 18 community surrounding the person whose being -- faced
 19 bereavement.
 20 **Q.** Thank you for explaining that to us because, of course,
 21 not everybody is lucky enough to have a family and
 22 a large group of friends. So it's important to
 23 understand that community support is also something
 24 that's important in this regard.
 25 **A.** Absolutely.

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1 being on a rollercoaster, with emotions emerging
 2 unexpectedly, could make grief hard to manage over the
 3 course of the day. Specific triggers could be
 4 a problem, but these weren't always predictable."
 5 Then, finally, from a woman aged 51-60 whose son
 6 died of Covid-19, she said:
 7 "I felt like I was drowning -- the waves of grief
 8 hit me so hard."
 9 These quotes are chosen, are they not, to represent
 10 the wealth of evidence that was collected by the
 11 commission during the course of its work?
 12 **A.** They are.
 13 **Q.** Yes, thank you. We can take that down, please.
 14 I'd like to now ask you, Dr Royston, about the
 15 commission's eight principles established for change,
 16 and could we put up, please, INQ000349021 and have
 17 a look at page 13, going back to the report.
 18 Thank you very much.
 19 So eight principles for change. And I'd like you to
 20 talk us through each of these, please. Principle 1:
 21 "I am supported by my family, my friends, and the
 22 communities around me."
 23 What lies behind principle 1?
 24 **A.** Well, first, just to say about all of the statements,
 25 they're a set of "I" statements and that was chosen for
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1 **Q.** Yes, all right. Thank you very much.
 2 Moving on to principle 2:
 3 "I am sensitively supported by my school, college,
 4 or workplace during my bereavement."
 5 What lies behind that principle, please?
 6 **A.** This was in some ways, really, building on the first but
 7 recognising there were some settings which were
 8 particularly important and came out through the course
 9 of the commission as particularly important, and often
 10 neglected places of -- for provision of bereavement
 11 support. So for young people, the importance of their
 12 school or their college setting, in terms of the way in
 13 which bereavement support is provided, and that related
 14 incidentally not just to the point at which
 15 a bereavement had happened but making sure that that
 16 early education about grief and bereavement was embedded
 17 for all children and young people in the school or
 18 college setting.
 19 And similarly, we heard too often from people in the
 20 workplace that issues around bereavement or grief
 21 weren't discussed, weren't engaged with, and the
 22 importance of having a supportive workplace in terms of
 23 responding to those issues to someone's bereavement
 24 experience.
 25 **Q.** Thank you.

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1 Principle number 3:

2 "I feel well supported before and during the death
3 and feel confident that my relative received appropriate
4 and compassionate care."

5 **A.** Yes, so this just relates specifically to the time of
6 death and the importance of support through the time of
7 death, including prior to the point at which the person
8 died. So effective palliative care and support for
9 people living with terminal illness, including support
10 for their family members, being crucial to people's
11 bereavement experiences was one of the things that we
12 heard. But really relating in closely to the support
13 that's received around that point of mortality and its
14 really profound impact on the longer course of
15 bereavement for somebody who's faced it.

16 **Q.** Thank you.

17 Principle 4:

18 "The things I must do after death are simple and
19 straightforward."

20 **A.** Yeah, "I'm at an already difficult time." Any newly
21 bereaved people are faced with huge volumes of practical
22 tasks, with paperwork, which the commission found to be
23 complex, sometimes duplicative, often very difficult and
24 poorly supported. We asked that -- one of the things
25 the commission found was that there were changes that

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1 the commission was the importance of an affordable and
2 meaningful funeral for people's bereavement experiences
3 and that too often, in particular, challenges of
4 affording a decent funeral service were -- created
5 particular challenges through the course of the
6 pandemic, and that that was exacerbating a challenge
7 that had already existed in society, in truth.

8 **Q.** Thank you.

9 And in addition to funerals, respondents mentioned
10 other form of memorialisation, and let's look at
11 page 104, please, in this report .

12 Thank you.

13 This is the section that deals with principle
14 number 6, "I have access to an affordable and meaningful
15 funeral", but if we turn to page 106 and could we
16 highlight, please, "Other forms of memorialisation",
17 towards the bottom of the page. Thank you.

18 "In addition to funerals, respondents mentioned the
19 value of other forms of memorialisation. They described
20 how sharing stories, tributes, music, artwork and shared
21 interests allowed a powerful, alternative form of
22 expression and remembrance and provided a lasting bond
23 with the person who died. Examples shared in the
24 evidence included the National Day of Reflection, to
25 remember all who died during the Covid-19 pandemic, and

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1 were needed in that space in order to ensure that
2 processes were kept as simple and as supportive as
3 possible for people who had been bereaved.

4 **Q.** Thank you.

5 Principle 5:

6 "The professionals I am in contact with at all
7 stages through my bereavement are compassionate and
8 helpful."

9 **A.** Yeah, there was a recognition here that too often the
10 responsibility for providing bereavement support would
11 be felt to be on just a very small number of
12 professionals with a specialism in that space, and
13 recognising that there are numerous points of
14 interaction with various different organisations and
15 businesses that people experience after a bereavement,
16 from registering a death to sorting out financial
17 affairs through to organising a funeral. And this was
18 to recognise those wide -- that wide set of points of
19 contact, and ensuring the need to ensure that support is
20 provided for all of them.

21 **Q.** Thank you.

22 Principle 6:

23 "I have access to an affordable and meaningful
24 funeral."

25 **A.** Something that came out very clearly through the work of

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1 walls of remembrance."

2 And there we can see some quotes.

3 "Common music and interests I shared with my father
4 helped."

5 Then from a participant in Northern Ireland at your
6 roundtable there:

7 "People express themselves in many other ways --
8 some of the other initiatives that exist currently and
9 memory stones and walls of remembrance."

10 Then finally:

11 "Other organisations have provided spaces where
12 people can come together to share stories, do tributes,
13 art work, music, et cetera."

14 "Beyond having a funeral, respondents identified a
15 number of key factors which supported them to have
16 meaningful funerals and last rites, including: advanced
17 planning, financial support, and using culturally
18 specific providers."

19 And do we see there, Dr Royston, that how somebody
20 chooses to memorialise their loved one is, or can be,
21 very personal to them, and it's important to remember
22 that -- whilst there are some very formal ways for that
23 to take place, it's important to remember that there
24 might be other more informal and more personal ways to
25 do that?

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1 A. It absolutely can and that came out very clearly through
2 the work of the commission.

3 Q. Thank you.

4 If we could go back to the principles, please, back
5 to page 13 and look at principle number 7:

6 "I feel insecure in my home and have the right" --
7 sorry:

8 "I feel secure in my home and have the right
9 financial support."

10 What lies behind that, please?

11 A. Yes, so that was a recognition that for many people who
12 faced bereavement, one thing that came out of the
13 commission was that too many people were facing eviction
14 or insecurity in their home as a result of that
15 bereavement, and a lot of that relating back to their
16 financial security, and their ability to pay their
17 bills. So making sure that people had that financial
18 security in place and that security of tenure really,
19 really important for people's bereavement experiences.

20 Q. Thank you.

21 And finally, principle 8:

22 "I can easily find and access the right emotional
23 bereavement support that recognises my needs and
24 circumstances."

25 A. Yeah, and the important part of this is "for my
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1 please, Dr Royston, to talk us through series of tables
2 that appear here in your report.

3 This table, table 1, shows reported bereavement
4 difficulties related to the pandemic. What do we see
5 here?

6 A. This is about the bereavement difficulties that people
7 reported related to the pandemic, and shows a range of
8 the different challenges that people faced at that time.

9 As you can see, the most frequent, and it relates
10 back to a previous question, most frequent challenge was
11 around the difficulties of not being able to have the
12 funeral that people desired, shortly followed by issues
13 around social isolation and, related to that, of course,
14 limited contact with their loved ones before they died.

15 Q. Yes.

16 A. But you can see that we also saw a range of other
17 challenges emerging as well, including specific fears
18 around Covid-19 and the experiences of the pandemic,
19 problems being unable to escape some of the media
20 coverage and the constant reflection back to the
21 pandemic, and also that, kind of, issue around lack of
22 support from professionals as well, where it was needed.

23 Q. Thank you.

24 Now, in terms of any regional differences, did your
25 research in relation to Scotland, Wales,
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1 circumstances" because while good support from friends
2 and relatives is sufficient for most people who are
3 bereaved -- and we didn't -- one of the key things
4 that -- the conclusions that the commission came to was
5 about the need to avoid over-medicalising bereavement
6 experiences. Nonetheless, some people will need more
7 formal emotional support, and it raised -- the
8 commission highlight a range of issues with the current
9 levels of support that were available where people
10 needed it.

11 Q. Thank you.

12 I know that you then go on to set out a number of
13 initiatives that are under way in the UK, and you list
14 progress and improvements. So I'm going to come back to
15 that at the end of your evidence, if I may. But before
16 we look at that, you tell us about disparities in
17 bereavement experiences, and this is something about
18 which the Inquiry has already heard some evidence and is
19 going to hear more evidence over the course of this
20 week. You helpfully split these disparities into nine
21 headings in your report, and we're going to look at
22 those individually if we may now.

23 The first is national or regional differences.

24 Let's have a look in your witness statement, please,
25 which is at INQ000657845, and I'm going to ask you,
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1 Northern Ireland and the nine English regions which you
2 looked at, in fact show you that there was no
3 significant difference to be found around the UK, that
4 the picture was very much similar?

5 A. Yes, I think it did, yes.

6 Q. Thank you.

7 Could we look now, please, at table 2, which I think
8 is on the next page. Thank you very much.

9 This shows the incidents of administrative
10 difficulties experienced through bereavement. What do
11 we see here?

12 A. So, as well as some of the emotional challenges that
13 people experience through the course of the
14 bereavement -- through the pandemic, people also talked
15 about some of the challenges that people faced with
16 what's sometimes called death administration, some of
17 the challenges around kind of processes and paperwork
18 associated with a death. So, a big issue coming out
19 from that was the challenges of sorting out about
20 people's financial affairs. So, closing bank accounts,
21 dealing with mortgages or things like that, came out
22 very, very strongly.

23 And many people talked about receiving often
24 multiple letters addressed to the wrong person and that
25 kind of issue following someone's death.
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1 But it wasn't limited to that. Many people also
2 talked about specific challenges related to registering
3 a death and making sure that that happened, difficulties
4 with funeral arrangements, and of course other
5 practically responsibilities.

6 And one of the big challenges that came out was that
7 often a lot of this -- a lot of these issues were things
8 that occurred at the same time.

9 **Q.** Right.

10 **A.** So, rather than being able to, you know, have the time
11 to pace themselves through a very emotionally turbulent
12 time, people were finding that actually they had to sort
13 out all of these things all at once.

14 **LADY HALLETT:** Whilst you're thinking about pacing, could
15 you slow down a bit?

16 **THE WITNESS:** Sorry, my Lady.

17 **MS BLACKWELL:** Thank you, my Lady.

18 So, really, that was compounding the situation?

19 **A.** Yes.

20 **Q.** Because they were having to deal with more than one
21 issue at the same time?

22 **A.** Yes, and through a very emotionally turbulent time. So,
23 often these things having to be sorted out within, you
24 know, a matter of days or weeks following the death.

25 **Q.** Thank you.

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1 from this table is that many people felt -- how many
2 people felt that the support they needed wasn't
3 available. So a third people saying that the support
4 that they needed wasn't available.

5 **Q.** Thank you. Is it right that in the oral evidence
6 sessions that you held, there were some regional
7 disparities highlighted? For example, within hospice
8 services there were differences in terms of whether or
9 not local bereaved families could access their
10 bereavement support services regardless of care
11 settings?

12 **A.** There were. And there were particular kind of -- I'm
13 not sure whether to call it a place-based difference,
14 but things like the level of rurality of an area
15 affecting the kinds of support that would be available.

16 **Q.** Yes, thank you.

17 So, that deals with national and regional
18 differences. The second area that I want to look at
19 now, please, in relation to disparities is
20 qualifications or education level.

21 And at paragraph 185 you talk about the BeCovid
22 analysis, and you say that:

23 "In the BeCovid analysis relating to end of life and
24 pandemic bereavement experiences participants with
25 higher levels of qualification were significantly more

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1 You also collected evidence on the support that
2 bereaved participants received from employers and
3 education providers, and this is set out at table 3,
4 which shows the ratings of support received from
5 employers. So that was quite varied, was it not?
6 **A.** It was. It was. And we heard from many people through
7 the course of the commission who said that actually
8 their employer supported them really well. One of the
9 things that really stuck out about this area of evidence
10 was how variable it was, and some people saying they got
11 really good support, and other people saying that
12 actually the support was awful.

13 **Q.** Yeah, thank you.

14 And table 4, at page 30, shows ratings of support
15 from educational settings. That looks as if it's fairly
16 standard across the board, doesn't it?

17 **A.** Yeah, again, very variable. Just to note, that's
18 a survey of adults, there was also findings related to
19 children and young people, but this is related to
20 adults -- (overspeaking) --

21 **Q.** Adults. Thank you for pointing that out.

22 And then, finally, table 5, respondents who wanted
23 to access some sort of formal support.

24 And this shows barriers to accessing that support?

25 **A.** Yeah, I think the thing that sticks out most, perhaps,

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1 likely to report being well supported by healthcare
2 professionals immediately after the death and contacted
3 by the hospital or care provider following the death."

4 Are you able to help us with what might lie behind
5 that difference?

6 **A.** Well, on one of the previous tables you'll see that one
7 of the reasons people reported barriers in accessing
8 bereavement support was not knowing what support was
9 available or how to access it.

10 So, abilities of people to be able to self-advocate
11 and to challenge, in some circumstances, a lack of
12 bereavement support might be one factor which
13 contributed.

14 **Q.** Thank you.

15 Thirdly, gender. You say at paragraph 188, again,
16 looking to the BeCovid analysis, that, in relation to
17 the end-of-life and pandemic bereavement experiences:

18 "... the effects of gender identity were generally
19 weak, although the likelihood of reported limited
20 contact with other close relatives/friends after the
21 death was found to be significantly higher for women
22 compared with men ..."

23 And again, is there any thought lying behind why
24 that difference might be?

25 **A.** Well, one part of the analysis, I understand, showed

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1 that men, in some circumstances, lean towards
2 a preference for more informal and practical support,
3 but could also find it difficult to talk about grief and
4 feelings. Obviously, that's a generalisation, but in
5 some circumstances. So, it might be that actually the
6 lack of some of those appropriate forms of support to
7 respond to the ways in which men wanted to talk about
8 issues of grief and bereavement were particularly
9 lacking.

10 **Q.** Thank you. Next, age. You say at paragraph 191 that:
11 "Regarding sources of informal support, those in the
12 31-40 age group received significantly more informal
13 support than those in [other age groups]."

14 Again, any thoughts on why that might be?

15 **A.** No, I think it's quite difficult to say exactly why it
16 was that there were variations, though possibly again,
17 something about knowledge and understanding of
18 bereavement support services available.

19 **Q.** Yes. Number 5, sexual orientation. At paragraph 195
20 you say that:

21 "In [the commission's] analysis, sexual orientation
22 had a small effect on one support outcome. Those who
23 had an [LGBTQ+] identity were more likely to believe
24 that support wouldn't provide the help that they needed
25 ... [and that] Sexual orientation was not included in

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1 relationships, which could all be contributing factors
2 which may well have existed prior to the pandemic.

3 **Q.** Thank you.

4 Now, in terms of missing data, does the missing data
5 on LGBTQ+ in the BeCovid analysis that we've just read
6 of end-of-life outcomes reflect, in your view, the need
7 for additional research in respect of the impact on
8 LGBTQ+ communities?

9 **A.** Yeah, I think that's fair to say.

10 **Q.** And are you able to tell us whether or not there's been
11 any progress since the pandemic in respect of the
12 provision of specialist support for LGBTQ+ people or an
13 additional gathering of data?

14 **A.** It's not an area I'm particularly conscious of, though
15 I may be unaware of something.

16 **Q.** All right. Six, ethnicity.

17 Now, you tell us at paragraph 198 that there was no
18 statistically significant differences relating to
19 ethnicity found on any of the outcomes either by the
20 commission's research or by the BeCovid analysis.
21 However, the BeCovid survey of bereavement support
22 providers found that around half of services, that's
23 49%, identified minority ethnic communities as groups
24 with unmet needs who were not accessing services before
25 the pandemic; is that right?

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1 the BeCovid analyses of end-of-life or grief outcomes
2 due to missing data."

3 You go on to say that:

4 "Pre-pandemic research-evidence presented to the
5 Commission identified high levels of complicated grief
6 amongst both bereaved partners of same and different
7 gender couples, but significantly higher levels of
8 psychological distress amongst same-gender bereaved
9 partners."

10 Is that right?

11 **A.** That's right, yes.

12 **Q.** Was there a known lack of appropriate bereavement
13 support for LGBTQ+ people before the pandemic?

14 **A.** There is some evidence of that. So a survey of
15 bereavement services identified sexual minority
16 groups -- sorry, 27% of bereavement services identified
17 sexual minority groups as having unmet needs before the
18 pandemic. So it might be that it does relate to an
19 exacerbation of paucity of services prior to that point.

20 **Q.** And in your view, does that reflect existing health and
21 social inequalities going into the pandemic?

22 **A.** In my view, yes. I think that a lot of that distress,
23 that absence of support, was linked to isolation, fear
24 of discrimination. Lack of recognition of relationships
25 was a big issue, or fear of lack of recognition of

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1 **A.** Yes, that's right.

2 **Q.** Thank you.

3 Let's just look, please, on this point at the
4 Bereavement Roundtable, it's at INQ000588201. We can
5 see there the report -- thank you -- and go to page 6,
6 and highlight the paragraphs in the middle of the page,
7 thank you very much.

8 So the respondents at the roundtable said that:

9 "Some bereaved people, in particular in households
10 where English was not widely understood, did not know
11 about some or all of the pandemic restrictions and
12 guidance. Mind, who provided mental health support to
13 bereaved people during the pandemic, highlighted
14 examples from Haredi Jewish communities and some Asian
15 communities with whom they work, where people did not
16 understand why they could not conduct funerals in line
17 with their usual cultural or religious practices."

18 And Mind said:

19 "Some communities struggled to understand why they
20 couldn't run funerals as per their cultural norms.
21 There was a lack of thought and understanding about how
22 the impact on different cultural ways of bereavement was
23 happening. It led to a White, Western understanding of
24 Covid-19 restrictions."

25 And is that evidence also reflected in what the

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1 commission found?
 2 **A.** I think the commission found that -- certainly that
 3 there were issues of disruptive cultural and faith-based
 4 mourning rituals, such as rapid burials, Muslim body
 5 washing, Jewish sitting Shiva, and the Caribbean
 6 Nine-Nights, due to pandemic restrictions, but also
 7 additional challenges, including deaths of relatives
 8 overseas and restrictions on the ability to -- inability
 9 to travel and delayed opportunities to grieve
 10 collectively all came up very clearly within the UKCB's
 11 work.

12 **Q.** Thank you.

13 You also say, at paragraph 200, that participants
 14 also described the emotional and psychological impacts
 15 of the disproportionately high Covid death rates within
 16 minority ethnic communities, and you say:

17 "Multiple close bereavements within families and
 18 communities was not only highly distressing but also
 19 contributed to an enhanced sense of vulnerability and
 20 anxiety relating to the health risks of the disease, as
 21 well as feelings of anger and injustice at the health
 22 and social inequalities were exposed by the
 23 pandemic ..."

24 Do you agree that impacts described by you at
 25 paragraph 202, where you talk about difficulties in

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1 support, I would hesitate to say.

2 **Q.** Thank you.

3 Number 7, people with learning disabilities.

4 You tell us at paragraph 206 that the commission
 5 respondents highlighted specific challenges facing
 6 people with learning disabilities, including that they
 7 are not always told that friends or relatives have died,
 8 or may not be allowed to attend their funerals.

9 And on this topic, may we go back to the roundtable,
 10 please, and to have look at the top of page 8 and on to
 11 page 9. Thank you.

12 "Some groups added [to the roundtable] that it was
 13 particularly difficult for people with a learning
 14 difficulty to understand the death of loved ones and
 15 associated restrictions on end-of-life rituals, during
 16 the pandemic, given the changes to end-of-life rituals."

17 Thank you.

18 And then if we look to the bottom of the page --
 19 thank you:

20 "Some representatives spoke about people with
 21 a learning disability or neurological condition not
 22 being prioritised when families were deciding who could
 23 attend funerals, as they were less likely to understand
 24 the restrictions in place or how to follow them."

25 And Cruse Bereavement Support Scotland, who are

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1 minority ethnic communities accessing formal bereavement
 2 support, highlight the need for greater levels of
 3 tailored bereavement support for communities?

4 **A.** Absolutely. And again, something which there is some
 5 evidence was in existence pre-pandemic, so 49% of
 6 bereavement services identified minority ethnic
 7 communities as having unmet needs before the pandemic as
 8 well. So, particular challenges there.

9 **Q.** Thank you.

10 Do you agree that the impacts described highlight
 11 the need -- sorry, do you agree that the lack of
 12 appropriate bereavement support reflects the existing
 13 health inequalities which ethnic minority people were
 14 feeling going into the pandemic, and were those
 15 exacerbated during the pandemic?

16 **A.** Absolutely agree.

17 **Q.** And has there been any progress since the pandemic in
 18 respect of the provision of specialist support for
 19 minority ethnic communities?

20 **A.** It's hard to say about provision of support. In terms
 21 of understanding of support, there has been an
 22 NIHR-funded research study on equitable bereavement
 23 support across ethnic groups, which I think will provide
 24 some further really important evidence into this space,
 25 but in terms of progress in terms of the provision of

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1 going to be giving evidence just after you this
 2 afternoon, told the roundtable:

3 "[If they] have a learning disability they didn't
 4 understand what was happening in the wider world with
 5 the complexity of a bereavement. Those people were
 6 pushed out of the restricted numbers for funerals."

7 Thank you.

8 In your view, Dr Royston, did disabled people
 9 experience disenfranchised grief, including that people
 10 with learning disabilities, as we have seen, had
 11 particular difficulties in understanding the changes
 12 that were happening?

13 **A.** Certainly in the case of people with learning
 14 disabilities. And I think that that was in some ways
 15 exacerbated -- some of the challenges that some people
 16 with learning disabilities may have faced with
 17 understanding processes of bereavement were also
 18 exacerbated by not being told.

19 **Q.** Yes.

20 **A.** And not having the efforts made to communicate
 21 experiences of bereavement to them, as a result of fears
 22 that they wouldn't understand or a, kind of, won't be
 23 able to engage. So, a kind of a double pressure, as it
 24 were.

25 **Q.** And did you find that disabled people with additional

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1 support needs, such as hearing or sight loss, were left
 2 particularly unsupported?
 3 **A.** Well, I don't think we specifically covered -- found
 4 that through the UK Commission on Bereavement work,
 5 though I am conscious that other pieces of work --
 6 evidence did find that -- apologies if I'm wrong about
 7 this -- but other pieces of work did find that, such as,
 8 for example that use of PPE creating restrictions for or
 9 making it more difficult to communicate for people -- to
 10 people with hearing difficulties, for example.
 11 **Q.** Thank you.
 12 Did disabled people who were clinically extremely
 13 vulnerable experience a disproportionate impact on the
 14 grieving and bereavement process from being unable to
 15 attend funerals and other mourning rituals even once
 16 restrictions were lifted?
 17 **A.** I think that that would be fair to say.
 18 **Q.** Thank you.
 19 And finally on this topic, you refer at
 20 paragraphs 87 and 88 to death certification and death
 21 certification reforms, and the link to complex or
 22 complicated grief, and also reflect upon the coronial
 23 procedures.
 24 Do you agree that post-death processes, including
 25 the investigation and accountability of aspects of

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1 **MS BLACKWELL:** Just taking that one step further, if those
 2 sorts of pressures are left unresolved and unaddressed,
 3 can that also link to more complicated and complex grief
 4 being suffered?
 5 **A.** Absolutely, if those -- yes. And both in the short and
 6 in the long term, as you say.
 7 **Q.** Thank you. Number 8, the experiences and needs of
 8 people experiencing homelessness. You tell us at
 9 paragraph 208 that the oral evidence received by the
 10 commission revealed that homeless people commonly
 11 experience bereavement intersected with other trauma and
 12 health problems making it especially hard for them to
 13 cope; is that right?
 14 **A.** Yes, absolutely.
 15 **Q.** And then finally, number 9, the experiences and needs of
 16 people in prisons. The Inquiry heard a significant
 17 amount of evidence about this last week. And you tell
 18 us at paragraph 209:
 19 "Respondents highlighted that many bereaved
 20 prisoners (including those bereaved following the death
 21 of another inmate) faced an environment in which it was
 22 difficult for them to express their grief and display
 23 vulnerability."
 24 Is that right?
 25 **A.** Yes, that's right.

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1 a death, are aspects of bereavement that themselves
 2 require support?
 3 **A.** Absolutely. And not just coronial processes -- and it's
 4 one of the principles as we talked about, about being --
 5 keeping the things that -- principle 4, the things that
 6 someone must do after a death being simple and
 7 straightforward. That yes, it is concerning that there
 8 are delays to death certification and support through
 9 death certification and other processes being really
 10 important. But it's also important that people are
 11 supported through issues like closing bank accounts,
 12 addressing kind of legacy social media accounts, all of
 13 those things that can contribute to that sense of
 14 enormous amounts of pressure with dealing with process
 15 following a bereavement, all of that requires some
 16 support.
 17 **LADY HALLETT:** You can't even get to that stage without the
 18 death certificate?
 19 **A.** No. Fair point.
 20 **LADY HALLETT:** Do I understand it, and sorry, I haven't
 21 really followed this sufficiently closely, but do
 22 I understand that a lot of the new rules about death
 23 certification have come in as a result of the
 24 Shipman Inquiry?
 25 **A.** I don't know, I'm afraid.

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1 **Q.** Thank you. Now that we have looked at the disparities
 2 in terms of how people experience grief and bereavement,
 3 let's look, please, at what would lead to a more
 4 positive experience of bereavement, and you set out in
 5 your report four areas that need to be considered.
 6 Number 1, access to holistic end-of-life care. This is
 7 at paragraph 223.
 8 Can you talk us through what you mean by this,
 9 please?
 10 **A.** Well, having access -- again, this isn't about just one
 11 form of support; this is about a holistic recognition of
 12 the needs of people following a bereavement and engaging
 13 with all aspects of that in an appropriate way to
 14 respond to their individual needs. So for some people,
 15 that might be around financial support. For some people
 16 that might be around emotional support. For other
 17 people it might be about process-related support through
 18 death administration. But providing that holistic care
 19 is what's most important.
 20 **Q.** Thank you.
 21 Number 2, this is at paragraph 224, good
 22 communication with professionals.
 23 **A.** Yes, and again, going back to the principles from the
 24 commission, this wasn't just about professionals whose
 25 specialism is specifically around provision of

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1 bereavement support but making sure that all
2 professionals encountering somebody with bereavement
3 experience might -- are well supported. So that
4 includes making sure that professionals working in HR in
5 a workplace and, actually, all people working in
6 a workplace are appropriately supported to support
7 a colleague, making sure that bank staff are
8 appropriately -- have the knowledge and training that
9 they need to communicate effectively with people who
10 have faced bereavement.

11 Thinking holistically, again, about the different
12 professionals that encounter bereaved people and
13 ensuring appropriate support is provided.

14 **Q.** Thank you.

15 Number 3, contact with the dying person. Did you
16 find that both individual and organisational respondents
17 emphasised the value and importance of contact with the
18 person around the time of death, and the role of this --
19 and the role that that played in a good death and good
20 grieving?

21 **A.** Absolutely. And again, embodied in principle 3, about
22 being well supported through the death, thinking --
23 I think one of the hesitations of the commission was
24 about thinking about bereavement support and bereavement
25 experience as something that only starts after the point

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1 **A.** Absolutely. And that's, as you rightly noted, not just
2 about funerals, but memorialisation more generally, and
3 also perhaps -- how best to put it? -- not just
4 recognition of the individual death but a recognition of
5 dying and death more generally, and a memorialisation of
6 loss, and a recognition and engagement with loss as
7 a common shared experience.

8 **Q.** At paragraph 228 you say this:

9 "While the pandemic in many ways impacted on
10 funerals negatively, some respondents felt that
11 adaptations and innovations introduced in this period
12 should be maintained as an option going forward, as they
13 were more accessible for some people."

14 What did you hear about that?

15 **A.** Yeah, so -- and you mentioned that for some people
16 facing visiting restrictions prior to a death could also
17 be a challenge, and this similarly applies to that
18 period as well. But that there were more -- or
19 different options for how people could communicate,
20 contact, engage with somebody either before the point of
21 death or afterwards, were -- for people who would
22 otherwise have found it difficult to engage with
23 traditional options, opened a up some more ways of
24 engaging.

25 So, for somebody living at a great distance,

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1 of mortality, after the point at which somebody has
2 died. We need to think, what sometimes can be referred
3 to as kind of perimortality, through the point of death
4 and beyond, about providing appropriate support both
5 before the bereavement, through effective palliative
6 care and engagement with the household members through
7 their pre-grief experiences, through the point of --
8 sorry -- through the point of death and on into the
9 longer term as well.

10 **Q.** Thank you.

11 We will hear, over the next couple of days, from
12 impact witnesses, many of whom have made reference in
13 their witness statements to communicating virtually with
14 their loved ones whilst they were in hospital and before
15 they died. And of course we know that during the
16 pandemic there were severe restrictions on contact. And
17 the Inquiry will hear about the differing experiences
18 that were taking place, depending on what level of
19 contact was being permitted and how that was taking
20 place.

21 And finally, collective grieving and funerals. Did
22 the commission hear that funerals and memorialisation
23 can play a critical role in bereavement as a chance to
24 publicly acknowledge a death, collectively express
25 grief, and celebrate someone's life?

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1 obviously through the course of the pandemic, travel
2 just wasn't possible, but actually, in some
3 circumstances, they may not have been able to travel
4 anyway, whether the pandemic was there or not. And for
5 those people, actually being able to, for example, to be
6 involved in a funeral by video link could actually have
7 been a good thing that opened up an opportunity for
8 engagement that wouldn't otherwise have been available.

9 **Q.** Thank you.

10 I'm going to look now at the work that the
11 commission has done in securing what are described as
12 six key national changes that took place in the
13 two years following the report being published, so
14 between 2022 and 2024. And this is set out at
15 paragraph 80 of your report.

16 But before I do that, can you just give the Inquiry
17 an idea as to how many people or organisations took part
18 in the commission's work between the time that it was
19 set up, in June of 2021, through the time that the
20 report was published, in 2022, and then up until the
21 present day, because we are also going to come and talk
22 for a moment about the update report from 2024.

23 **A.** Of course.

24 So we held a survey, took oral evidence, held
25 roundtables across all four UK nations. We had

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1 1,119 adult respondents from our call for written
2 evidence, had 99 respondents from children and young --
3 responses from children and young people for the
4 children's consultation. We had 130 responses from
5 professionals, through an organisational survey
6 conducted as part of the Inquiry. And we also had
7 engagement from 31,000 students from a discrete piece of
8 work that was done by an organisation called
9 VotesforSchools as part of the commission's work.
10 We also -- no, sorry, I'll leave it there.

11 **Q.** All right. Thank you.

12 So the key national changes that took place between
13 2022 and 2024, you note that the first of those was in
14 relation to the eligibility criteria for social security
15 benefits for parents of bereaved children, which had
16 been extended. The second is that the UK Government has
17 reviewed the gov.uk web pages on bereavement and
18 bereavement support to facilitate access to key
19 information.

20 Number 3, that the National Institute for Health
21 Research has commissioned a major study into equitable
22 bereavement support for people of all ethnicities.
23 I think you've made reference to that already.

24 Has that report yet been published, do you know?

25 **A.** No, I don't think the report's been published just yet.

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1 bereavement.

2 **Q.** Yes.

3 **A.** The work mustn't stop with the publication of a report
4 that would then just sit on a shelf and go dusty, but
5 actually make sure that change was delivered as a result
6 of that. Not just through the work of the steering
7 group members and kind of follow-up with key decision
8 makers through them, but actually the work of all,
9 charities, individuals, who wanted to engage with the
10 work of the commission and continue to drive the work
11 forwards.

12 So, as part of that, we thought it was really
13 important -- we produced a follow-up report about the
14 progress that was being -- that had been made, engage
15 with the former commissioners around that, bring them up
16 to date, and reflect again on what further areas -- both
17 on what had changed and what had been done, but also on
18 what further progress was needed and what new things
19 needed to be particularly prioritised from the report.

20 **Q.** Right. And you list at paragraph 81 a further nine
21 changes that have taken place since that follow-up
22 report was published. Do you want to take us through
23 those, please?

24 **A.** So, yes. So, the UK Government introduced, I think it
25 is now, as a result of the Employment Rights Bill, a new

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1 **Q.** So that's still ongoing.

2 Number 4, the UK Government contributed half
3 a million pounds of funding towards a UK-wide Day of
4 Reflection in 2024 to remember those who died or were
5 bereaved during the pandemic.

6 Number 5, that the Northern Ireland Government
7 introduced a new dedicated bereavement support website.

8 And number 6, the new National Bereavement Support
9 Services Standards have been published.

10 What are those?

11 **A.** They were a set of standards that was ... sorry, I've
12 just lost track a second.

13 **Q.** I think it's at paragraph 80.

14 I really wanted to know who the National Bereavement
15 Support Service Standards were published by.

16 **A.** I'm going to have to reflect back on that, sorry.

17 **Q.** All right, perhaps you can let us know.

18 Then you go on to talk about the additional
19 improvements and changes that have been made since the
20 follow-up progress report was published in 2024. Why
21 was there a progress report published, and how did that
22 come about?

23 **A.** Well, we felt that it was incredibly important that the
24 work of the commission -- the purpose of the commission
25 was about securing change for people affected by

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1 right to bereavement leave for employees bereaved of
2 a close relative.

3 We saw the Northern Ireland Bereavement Network
4 supported the Department of Health on a new bereavement
5 charter.

6 We had the Northern Ireland Health Minister
7 committed to start planning process for development of
8 a new bereavement strategy for Northern Ireland.

9 The Welsh Government is now developing a bereavement
10 care pathway for children and young people, in -- that's
11 due in 2025.

12 The UK Government's introducing the facility to --
13 for people to register a death online.

14 We had a change in the Renters' Rights -- now Act,
15 I think, which protects private renters from eviction
16 because of their bereavement.

17 And similarly, in Scotland, we had a legislation
18 introduced protecting bereaved social tenants from
19 eviction within the first six months of bereavement.

20 And the Department for Education has published new
21 statutory guidance which includes reference to death and
22 grief as part of life, though ensures that there is some
23 reflection on death, dying and bereavement as part of
24 the curriculum.

25 **Q.** Thank you.

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1 The National Bereavement Support Service Standards,
2 I can tell you, were produced by the National
3 Bereavement Alliance.

4 **A.** Correct.

5 **Q.** And they have been developed with a wide range of
6 stakeholders, including managers and practitioners of
7 bereavement services, those with lived experience of
8 bereavement, and those from underserved communities.

9 And, my Lady, we will provide you with a copy of
10 those standards. Thank you.

11 So, finally, Dr Royston, you go on at the conclusion
12 of your witness statement to talk about further work
13 that can be done and should be considered, and lessons
14 that we can learn from this pandemic.

15 The overarching point that you make is that
16 a whole-systems approach to bereavement is vital. And
17 you say that there must be leadership within government
18 departments, and those leaders should sit across all
19 national government, and there should be an
20 understanding within each government department that
21 bereavement is something which affects everybody, and
22 it's an important issue that must not be lost sight of?

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

24 **Q.** You also say that there is a need for further grief
25 education across all of government, and across all of

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1 clear guidance provided, guidance provided on how
2 services should be supporting people affected by
3 bereavement. It was good that they explored it, but we
4 still don't have that guidance produced, and we'll want
5 to continue to push for that.

6 And the other key thing, and it goes back to the
7 issue of death administration, is one of the things the
8 commission heard very positively from many respondents
9 was about the Tell Us Once service, which coordinates
10 across government, so that following a bereavement you
11 only need to tell one government department rather than
12 tell every government department about your bereavement
13 experiences. And actually, we heard from a number of
14 respondents very good things about that service.
15 However, it's limited because it only applies to the
16 public sector and doesn't include private companies, and
17 one of the commission's recommendations was that that
18 should be extended to private companies, as well, so
19 people don't have to tell, as well as telling
20 government, don't have to tell their bank, don't have to
21 tell their housing provider, don't have to tell their
22 insurer, all of those different agencies they'd
23 otherwise need to be in contact with. If they could all
24 be brought within Tell Us Once, they'd only have to tell
25 their story once, significantly reducing the complexity

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1 society. And that bereavement training requirements for
2 education, for employment, and for third sector
3 organisations, is also something that should be
4 encouraged and thereafter, once it's in place, reviewed
5 regularly?

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

7 **Q.** Anything else that you'd like to add?

8 **A.** There are a couple of specific things. I mean, you draw
9 attention to the need for that holistic support.

10 **Q.** Yes.

11 **A.** But actually, if there was one core recommendation from
12 the commission it was that there should be
13 a cross-government bereavement strategy. And we still
14 don't have a cross-government bereavement support
15 strategy.

16 We do now have a cross-government in England. We've
17 got a cross-government working group around bereavement
18 support that brings together different departments
19 across government to consider bereavement support, but
20 I would say we still don't have a clear bereavement
21 support strategy in this country, and that feels like it
22 is a notable omission at the moment.

23 At the same time, there are a couple of other areas
24 where progress is needed. So NICE have not produced
25 guidance on bereavement support and we would like to see

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1 of those processes. So that would be a key step forward
2 that could be taken to improve death administration.

3 **LADY HALLETT:** Can I just ask how that would work,
4 Dr Royston? So, Tell Us Once, you can understand how
5 you can link up public sector departments, because
6 sometimes -- they occasionally have IT that talks each
7 other, but not always, but how do you then have a system
8 whereby a bank, utility companies -- how do you get them
9 all linked? Does it need development of a more
10 sophisticated app? How do you do it?

11 **A.** It would require some kind of data-sharing approach, so
12 that at the point at which the person told government,
13 they were also able to have their private company
14 providers notified as well. So, it would require some
15 data sharing; it would require some systems in order to
16 support that, but I don't see a reason, a technical
17 reason, why it couldn't be done in principle.

18 We do have circumstances such as I know -- for
19 example, where people apply now, I think, for certain
20 forms of fuel energy support, government will liaise
21 with their energy provider in order to ensure that that
22 support is provided. So there isn't a fundamental
23 distinction which makes it impossible for government to
24 communicate with the private sector; it's just getting
25 those processes to work better, I think.

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1 **LADY HALLETT:** I was just thinking -- funnily enough, I've
 2 recently been making a list of my utility account
 3 numbers for my sons -- wouldn't you need to have
 4 a system whereby you had the account number for the
 5 utility company, or the bank account number, because
 6 otherwise a private sector organisation is going to be
 7 saying, "Well, wait a minute, I've got two
 8 Heather Halletts" -- poor things. Anyway, wouldn't you
 9 need more to be able to link all these things up?
 10 **A.** Yeah, you might -- you wouldn't necessarily need an
 11 account number, although you could ask people to provide
 12 that, I suppose. A postcode might work, for example.
 13 I think -- I've got a feeling they're doing -- so,
 14 there is a thing in the -- amongst utility companies,
 15 energy companies specifically, called the Priority
 16 Services Register, so that vulnerable consumers can be
 17 added to the Priority Services Register to be
 18 prioritised. For example, if somebody's severely
 19 disabled and there's a power outage, they're prioritised
 20 for support.
 21 That Priority Services Register, I think there's now
 22 work being done to share that between utility companies,
 23 so it's not just the energy company but also the water
 24 company and so on, are aware that somebody is on the
 25 Priority Services Register.

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1 (3.08 pm)

(A short break)

3 (3.25 pm)

4 **LADY HALLETT:** Ms Kassamali?

5 **MS KASSAMALI:** My Lady, we are now going to hear from the
 6 next two witnesses for today, Mr Langford and
 7 Ms Arnott-Barron. Mr Langford is the representative for
 8 Cruse and Ms Arnott-Barron is the representative for
 9 Cruse Scotland.

10 Mr Langford is here in person with us here today and
 11 Ms Arnott-Barron attends remotely.

12 Please can the witnesses be sworn.

13 **MR ANDREW LANGFORD (sworn)**14 **MS FIONA ARNOTT-BARRON (affirmed)**15 **LADY HALLETT:** Thank you very much.16 **Questions from COUNSEL TO THE INQUIRY**

17 **MS KASSAMALI:** Mr Langford first. Thank you for attending
 18 to give evidence today.

19 You've provided a witness statement to Module 10 of
 20 the Inquiry and that is dated 18 December 2025. That
 21 should be in front of you?

22 **MR LANGFORD:** Yes.

23 **Q.** The reference number for the record is INQ000659963, and
 24 Mr Langford, are you able to please confirm that that
 25 statement is true to the best of your knowledge and

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1 So, I think that that can be addressed, recognise
 2 that there are some challenges of doing so, but I don't
 3 see a fundamental reason why it couldn't be. And
 4 certainly, we'd like to see it explored.

5 **MS BLACKWELL:** My Lady, where there is a will, I'm sure
 6 there is a way.

7 Dr Royston, thank you very much.

8 That completes my questioning, and I don't think
 9 there are any further questions.

10 **LADY HALLETT:** There aren't any.

11 Dr Royston, thank you very much indeed for your help
 12 to the Inquiry. I see you're a co-founder of the
 13 commission. I'm not going to embarrass you by asking
 14 whose primary idea it was to come up with the
 15 commission, but it sounds as if it's been a very
 16 worthwhile project, so thank you to you and your
 17 colleagues, all of whom set it up and then carried out
 18 all of the research. It has been extremely helpful and
 19 a very interesting afternoon. Dreadful subject,
 20 obviously, but very interesting.

21 Thank you very much indeed.

22 **THE WITNESS:** Thank you.

23 **LADY HALLETT:** Very well, break now and I shall return
 24 at 3.25.

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

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1 belief?

2 **MR LANGFORD:** Yes, I can confirm.3 **Q.** I'm grateful.

4 And Ms Arnott-Barron, can you see and hear me?
 5 Apologies, I should have checked that before.

6 **MS ARNOTT-BARRON:** Yes, I can hear you, thank you.

7 **Q.** Thank you for also attending to provide evidence today.
 8 You've similarly provided a witness statement to this
 9 module of the Inquiry and your statement is dated
 10 8 January 2026. Do you have that in front of you?

11 **MS ARNOTT-BARRON:** Yes.

12 **Q.** I'm grateful. And the reference is INQ000660033, and
 13 again, the same question to you. Are you please able to
 14 confirm that the statement is true to the best of your
 15 knowledge and belief?

16 **MS ARNOTT-BARRON:** Yes, I confirm.17 **Q.** Thank you.

18 Mr Langford, I'll turn first to you, and if I may,
 19 run through your professional background and your time
 20 at Cruse quite quickly.

21 Mr Langford, you produced this statement in your
 22 capacity as the Clinical Director of Cruse Bereavement
 23 Support, is that right?

24 **MR LANGFORD:** Yes.25 **Q.** That's a role you've held since 2020?

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1 **MR LANGFORD:** That's correct.
 2 **Q.** And before this you held two roles at Cruse; are you
 3 able to tell me what those roles were, please?
 4 **MR LANGFORD:** Yes, firstly the Director of Operations
 5 nationally with Cruse and then as Chief Operating
 6 Officer.
 7 **Q.** And how many years have you been at Cruse in total?
 8 **MR LANGFORD:** So I started at Cruse in 2015 in late August.
 9 **Q.** And as for Cruse itself, you say in your statement at
 10 paragraph 18 that its mission is that you support people
 11 through one of the most painful times in life. So
 12 that's with bereavement support, information, and
 13 campaigning. And we can see from the history that you
 14 set out of Cruse that that's always been at the core of
 15 Cruse's work, so just very briefly on the history of
 16 your organisation, I won't take us through the various
 17 name changes over the decades, but you explain that the
 18 organisation was incorporated in 1959 and then
 19 registered as a charity in 1962?
 20 **MR LANGFORD:** That is correct.
 21 **Q.** And it was in fact initially established from the front
 22 room of your founder, Margaret Torrie?
 23 **MR LANGFORD:** (Witness nodded).
 24 **Q.** You explain in your statement that she set up what was
 25 called Cruse Clubs, so those were safe spaces for widows

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1 mission of Cruse exactly.
 2 Ms Arnott-Barron, can I just ask for the
 3 stenographer, that instead of nodding, perhaps you say
 4 "yes" or "no" or "I entirely disagree with you,
 5 Ms Kassamali" but a statement, nonetheless, just so
 6 stenographer can get that down.
 7 **MS ARNOTT-BARRON:** No problem.
 8 **Q.** I'm grateful, thank you.
 9 I understand that Cruse Scotland has five key
 10 strategic aims; you set those out in your statement?
 11 **MS ARNOTT-BARRON:** Yes, that's correct.
 12 **Q.** Are you able to, very briefly, tell the Inquiry what
 13 those strategic aims are -- at a very high level?
 14 **MS ARNOTT-BARRON:** So sustainability, that's financial and
 15 environmental, positive bereavement health, obviously
 16 bereavement services, equalities, diversity, and
 17 inclusion, and it's -- like Mastermind, it just went
 18 right out of my head, the last one there, I'm so sorry,
 19 um ...
 20 **Q.** I believe it's at paragraph 5 of your statement.
 21 **MS ARNOTT-BARRON:** Yeah, sorry, and influencing. Sorry.
 22 **Q.** I'm grateful.
 23 Today I'd like us to focus on the bereavement
 24 services that you mention, a core component of Cruse's
 25 mission. And let's start from the very beginning of the

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1 to talk about their grief and to seek support from one
 2 another?
 3 **MR LANGFORD:** That's correct.
 4 **Q.** And then later on in the eighties, we see that Cruse
 5 begins to support widowed men as well as widowed women?
 6 And then by the end of the 1980s Cruse is extending
 7 its support to all bereaved people?
 8 **MR LANGFORD:** (No audible answer).
 9 **Q.** Then in April 2001, we have the Scottish branches of
 10 Cruse and they formally separate from Cruse, so up until
 11 this point it's all four nations and then we have
 12 Scotland as a separate ...
 13 **MR LANGFORD:** Mm.
 14 **Q.** That takes me quite nicely on to you, Ms Arnott-Barron.
 15 You're here today in your capacity as the CEO of Cruse
 16 Scotland; is that right?
 17 **MS ARNOTT-BARRON:** Yes.
 18 **Q.** And you have held that role since 2022; correct?
 19 **MS ARNOTT-BARRON:** Yes.
 20 **Q.** And prior to that you were the Chief Operating Officer?
 21 **MS ARNOTT-BARRON:** (Witness nodded).
 22 **Q.** But you've in fact been at Cruse for a number of years,
 23 since 2002, as you've told me earlier today?
 24 **MS ARNOTT-BARRON:** Yes, that's correct.
 25 **Q.** And the mission of Cruse Scotland is very similar to the

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1 pandemic, if we may, and I'll stay with you for the time
 2 being Ms Arnott-Barron.
 3 You speak about the outset of the pandemic, and you
 4 address that at paragraph 13 of your witness statement.
 5 And you say, quite interestingly, that waiting lists
 6 were not an issue for Cruse Scotland at the outset of
 7 the pandemic. At face value, that is actually perhaps
 8 quite a surprising comment. Are you able to tell the
 9 Inquiry why you consider that to be the case?
 10 **MS ARNOTT-BARRON:** Absolutely, so it was very unusual for
 11 us, absolutely. So I think the assumption was that
 12 people just assumed that the services were closed,
 13 because, let's face it, so many others were closed. Our
 14 helpline did remain open. And so we just used that
 15 opportunity to connect with clients who were already on
 16 our waiting list and used our resources that way.
 17 However, it was fairly short lived, I would say for
 18 about three months, until people realised that we were
 19 still there, and we didn't look back.
 20 **Q.** Yes, and we'll come on to the various sort of additional
 21 needs that were placed on services like yours during the
 22 course of the pandemic, but what you say in fact accords
 23 with what we have heard or what the Inquiry has heard
 24 over the course of this module from other services as
 25 well.

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1 So, you say others, other people, assumed that other
2 services were closed, and we've heard that from some of
3 those speaking to mental health operations as well.
4 What you say also accords with what the Inquiry has
5 heard through its own roundtable exercise, and I know
6 that the both of you were in fact sent a copy of the
7 roundtable summary report on bereavement. There were --
8 I don't need to, sort of, explain what it is to you,
9 there were representatives from both organisations
10 there. And the views of Cruse and Cruse Scotland are
11 both reflected in the reports. But nonetheless I'd like
12 to turn up a particular paragraph from that report, if
13 I may.

14 You're ahead of me.

15 For the record, INQ000588201, and that's at page 19.
16 And it is in fact already ahead of me.

17 So there we have a quotation from the National
18 Bereavement Alliance, but before that we see that the
19 findings of the report were as follows:

20 "Bereavement support organisations saw a drop off in
21 referrals in the early stages of the pandemic. They
22 suggested several reasons for this, including [and as
23 you say, Ms Arnott-Barron] people assuming that services
24 would not be available, people not having privacy in
25 their homes and some people not having the skills or

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1 and difficulties in an effort to try to support those
2 that they love, whilst clearly having the burden of
3 grief as well, and then contacting us afterwards, when
4 there was an opportunity to do so.

5 **Q.** So they were dealing with the immediate urgency of the
6 situation before them?

7 **MR LANGFORD:** Absolutely.

8 **Q.** The next topic that I'd like to turn to, which relates
9 in fact entirely with what you've just told us, are the
10 adaptive measures that both of your organisations had to
11 take in order to provide those bereavement services
12 during the pandemic. And I'd like to say at the very
13 beginning of the pandemic, so we're still at the outset.

14 And again turning to you, Ms Arnott-Barron, this is
15 something that you discuss at paragraph 10 of your
16 statement. So you say that:

17 "During the Covid-19 pandemic Cruse Scotland
18 continued to provide bereavement support services, with
19 only a small break of 10 days in March 2020, to attend
20 to logistics."

21 Ten days is a very impressive time for that shift.

22 But can I ask what you mean by logistics, please?

23 **MS ARNOTT-BARRON:** Sure. Um, so the logistics were Attend
24 Anywhere software, and that's used by the NHS in
25 Scotland, and we were fortunate enough to have had that

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1 confidence with technology to access support. Other
2 people did not have access to the Internet or devices
3 such as laptops or tablets."

4 Then we see a quotation from the National
5 Bereavement Alliance and that in fact entirely accords
6 with what you've just told us, both in terms of
7 timescale, the three-month period, and more generally in
8 terms of the drop off in waiting lists:

9 "A number of support services saw a drop off in
10 referrals in April, May and June [2020], partly because
11 people were reluctant to access support or didn't think
12 there would be access to the support."

13 So that chimes with what you've told us today.

14 Mr Langford, this isn't a point that you've
15 addressed in your statements. Would you say that that
16 accords with the experiences of Cruse in England, Wales
17 and Northern Ireland?

18 **MR LANGFORD:** It absolutely accords with the experiences
19 that bereaved people have told us. In addition to this,
20 several people told us that what they'd found is that
21 they were trying to address their own immediate needs,
22 the immediate needs of their family, the people they
23 were caring for, their children that they were caring
24 for as well, and so those very immediate needs often
25 meant that people put aside their own emotional needs

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1 in place for people that couldn't access services in
2 person before the pandemic. So, that was a huge
3 positive for us, because really, it was already there.
4 We just had to -- we trained people up in how to use it,
5 because it was just a now and again, rather than
6 standard use.

7 I would say we had more logistical challenges around
8 the online support, because that needed quite a bit of
9 training, which wasn't already in place. And I would
10 also a bit of confidence from our volunteers as well.
11 So that took a bit longer to get in place.

12 **Q.** And, in fact, that's very helpful that you mention that.
13 I'll just jump ahead and turn to the roundtable where we
14 speak about the upskilling of volunteers or rather Cruse
15 spoke about the upskilling of volunteers.

16 So that is INQ000588201, at page 19 again.

17 And there we have the quotation from Cruse
18 Bereavement Support, I believe that was another member
19 of your organisation, Mr Langford, where it said:

20 "There [were] some real challenges, the rapid
21 shift."

22 So that's talking, as you say, Ms Arnott-Barron,
23 about that shift from occasional online services to,
24 sort of, essentially it being the *modus operandi*, as it
25 were.

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1 "Cruse is primarily volunteer delivered and was very
2 local and face to face, and moving to virtual using
3 technology that was new to us. Upskilling thousands of
4 volunteers ... that can be tricky at the best of times
5 [that again chimes with what you said], so at speed,
6 that's harder."

7 Mr Langford, can you elaborate on what was tricky?
8 What was difficult?

9 **MR LANGFORD:** Absolutely, so we have and at the time had
10 approximately 3,500 volunteers across England,
11 Northern Ireland and Wales, with a staff team that is
12 comparatively small, so probably around 120 people but
13 not full-time equivalent. So, moving everyone over to
14 consistent, good quality practice that bereaved people
15 need in terms of excellent support, is hard, that's --
16 it's hard to get, sort of, quality, but also, we have to
17 bear in mind that many of those volunteers were also
18 themselves facing difficulty, many faced bereavement
19 themselves, many were also caring for elderly relatives
20 and also their own children, and trying to adapt their
21 own lives as well. So, each volunteer was juggling
22 their own unique experiences, whilst also trying to
23 serve bereaved people in the very best way possible.

24 **Q.** And did you find, for example, that the number of
25 volunteers increased, decreased? You had a shift in the
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1 to paragraph 30 of your statement you say -- you've set
2 out a high-level overview of the specific roles that
3 Cruse played during the pandemic. And then you say:

4 "We provided bereavement support throughout the
5 period from 1 January 2020 to 28 June 2022."

6 That is, of course, because that is the relevant
7 period for this module of the Inquiry.

8 And then some lines further down you speak of what
9 we've just been discussing. So you say:

10 "To meet increased needs for bereavement support,
11 due to the nature of the Covid-19 pandemic and
12 associated rising mortality rates, we expanded our
13 volunteer recruitment activities [as we've just
14 discussed], increased provision on the national helpline
15 [as we've just discussed], and sourced additional
16 funding to open new services."

17 Then you say:

18 "The largest initiatives were an online video
19 support service covering all geographical areas where we
20 did not have a local branch, a synchronous written chat
21 service provided by qualified counsellors, and online
22 psychoeducational groups, to help people gather, learn
23 more about grief and [learn] how to cope."

24 Then later on, a few paragraphs later at
25 paragraph 40, you add that you diversified your training
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1 composition of your volunteers, perhaps? Did it --
2 essentially, did the difficulties that you're talking
3 about impact your volunteer resources?

4 **MR LANGFORD:** It did, indeed. So, we found that volunteers
5 that clearly had their own personal priorities to deal
6 with, needed to take a break, or needed to focus and
7 thus leave Cruse, which is entirely understandable.
8 Others, what we found was that other people wanted to
9 solely support people on a face-to-face in-person basis.
10 Clearly that wasn't possible at the time. But however,
11 what we did find is that many volunteers, new volunteers
12 joined us, who wanted to give, wanted to support people
13 at the time of national crisis, but also wanted to
14 provide support on the phone, and felt they were able to
15 do so and with the right training were able to.

16 So some parts of our service increased, so, like the
17 helpline increased from around 30 to 40 volunteers, to
18 over 100.

19 **Q.** Ms Arnott-Barron, is there anything that you would like
20 to add from that from the perspective of Cruse Scotland?

21 **MS ARNOTT-BARRON:** No, there's lots of similarities.

22 **Q.** Grateful.

23 And that in fact leads us very nicely on to my next
24 set of questions, as it were, which is what bereavement
25 support looked like during the pandemic. If I take us
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1 offer to companies, organisations and other services.

2 And I'd like to delve into that in a little bit more
3 detail, if I may.

4 So we've already discussed the helpline. We've
5 discussed that the provision of the helpline expanded,
6 essentially.

7 Are you able to tell me a little bit more about the
8 extent to which it expanded? So you've said that the
9 number of volunteers you had over the phone increased.
10 Any other expansions?

11 **MR LANGFORD:** So, in terms of the helpline?

12 **Q.** Yes.

13 **MR LANGFORD:** Yeah, absolutely. So, we expanded with our
14 volunteer numbers, as previously indicated, and what we
15 were -- what of course became apparent very, very
16 quickly is people needed support there and then, as soon
17 as they contacted us. Any wait is too long.

18 So, with increasing our volunteer cohort, it meant
19 that we could provide more people with telephone
20 support, which is the core of the helpline activity. It
21 was and still is to this day. And also, we increased
22 our email response, which is part of the helpline too.

23 So, what that meant is we could field more queries
24 and often requests where people wanted some bereavement
25 support but also some advice about accessing other
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1 organisations too, for other needs. And that was more
2 possible through email.

3 **Q.** And was that something that Cruse did before in terms of
4 acting as that signpost to other services?

5 **MR LANGFORD:** Yeah, absolutely, throughout our services,
6 particularly what we find was and is the case with email
7 too.

8 **Q.** And you also discussed one-to-one support that Cruse
9 provided to bereaved individuals, again a service that
10 existed prior to the pandemic but took on, is it fair to
11 say, a new shape, form and quantity during the pandemic?

12 **MR LANGFORD:** Very much. So, leading up to the pandemic, it
13 was -- or, rather, leading up to the first lockdown,
14 should I say, it became very clear that that in-person
15 support which Cruse has traditionally delivered through
16 decades was not going to be possible. We didn't know
17 how long that would not be possible for. So we already
18 started making some preparations to shift over to more
19 remote options.

20 We started training our volunteers, predominantly in
21 telephone support, providing one-to-one over the phone,
22 but then also looked at opportunities for video support.
23 Clearly, in those early days, what we had to take into
24 account of was that not many people were confident in
25 using video support. So we stuck to mainly telephone

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1 in more rural communities, what they feed back to us and
2 say is that access to wi-fi, a decent internet
3 connection, is difficult. And so a phone is also more
4 accessible.

5 **Q.** And that ties in to some of the points we'll come on to
6 in relation to digital exclusion as well, and different
7 groups' accessibility to different forms of digital
8 means.

9 You speak also about a synchronous written chat
10 service. Are you able to tell me more about that?

11 **A.** Yeah, absolutely. So, we provided the synchronous chat
12 service, Cruse Chat, through additional funding, in the
13 interim, which was really helpful. And we were able to
14 support thousands of people through that. So that would
15 be a qualified counsellor who would be supporting any
16 number between one and three people, optimally, over the
17 synchronous chat at any one time.

18 And sometimes chats could last for, I believe,
19 around 20 minutes.

20 **Q.** And just on that, and I appreciate that this isn't
21 something that's touched on in your statement, did you
22 find that the demographics of those you were able to
23 reach through those virtual means were different to
24 those you'd previously been able to reach in person?

25 **MR LANGFORD:** It's a really important question, I have to

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1 and increasing the capacity around telephone support,
2 and then experimented with video, as people continued to
3 grow in confidence, and also accessibility.

4 **Q.** And focusing for a second on the confidence point,
5 that's something that actually comes up later in your
6 statement. It's a point that I find personally very
7 fascinating. It sounds like we think about it in terms
8 of in-person shifts to virtual shifts; but it's more
9 nuanced than that, it's in-person to phone, to increased
10 confidence with video, as you've just said.

11 Do you have any reflections on why that might be the
12 case? Where did that increased confidence come from?

13 **MR LANGFORD:** Absolutely. The basis of this -- we find this
14 all the time at Cruse, really, and it's entirely
15 understandable -- is that when we are very, very
16 vulnerable, as is often the case with a bereavement,
17 which is why people contact us, then we tend to need to
18 be supported in a way that we trust, in a way that we
19 feel is acceptable, and that is as familiar as it can be
20 for us. Unfamiliarity at that point can feel very
21 destabilising for many people. And so that confidence
22 in having a means of talking to someone is vital. And
23 most of us still use the phone in order to do so.

24 And also, most of us have access to the phone.
25 Video, bit more difficult for many people. Particularly

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1 rely on memory. There was more variety, more diversity,
2 in those. Absolutely. Absolutely. Both in age, also
3 ethnicity.

4 **Q.** Additionally, you talk about "online psychoeducational
5 groups". Tell me more about those.

6 **MR LANGFORD:** Yes, so we call them Understanding Your
7 Bereavement online, and that's where bereaved people
8 would meet, usually in a group of between 12 up to 20
9 people, and some trained volunteers, often a staff
10 member, will oversee, and will meet for an hour, will
11 talk through what it's like to be bereaved, some common
12 experiences. Essentially, then, options for coping for
13 yourself, how you can support others, and then how to
14 seek more support from ourselves and also other
15 organisations if need be.

16 And then what we developed also alongside that is an
17 opportunity for a short peer support experience online
18 afterwards.

19 **Q.** Tell me more about that peer support experience.

20 **MR LANGFORD:** Yes, so that's where we would tend to then
21 have participants in breakout rooms, and you can opt in
22 or opt out, if you like, and then they can have some
23 support from a -- through each other, but also from
24 a trained volunteer who'd be facilitating that small
25 group. So those small groups were generally split off

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1 to between three to six people from the larger group.
 2 **Q.** And you're speaking of training volunteers within your
 3 organisation, but another limb of the support that Cruse
 4 provided, as I understand from your statement, is
 5 providing training and advice to other non-bereavement
 6 specialist organisations. Are you able to tell me more
 7 about that?

8 **MR LANGFORD:** Yeah, absolutely. A lot of the research
 9 points towards, many of us, the best support we can get
 10 and the most accessible support we can get is actually
 11 from our immediate communities, our families, friends,
 12 workplaces. Other places with whom we have contact
 13 with -- education establishments, often non-bereavement
 14 support organisations.

15 And so we have, for many years prior to Covid,
 16 provided training to organisations around bereavement
 17 awareness. So what -- within their role, they can
 18 provide around having a compassionate conversation with
 19 people who are bereaved whether they be their clients,
 20 customers, employees, or volunteers.

21 **Q.** And you say, leading on from that, in your statement at
 22 paragraph 45, that those organisations or delivery
 23 partners are predominantly local authorities, private
 24 sector finance companies, educational providers, health
 25 trusts, faith-based organisations, and other voluntary

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1 would I have thought, I would have thought in-person is,
 2 you know, far superior, but actually, the research shows
 3 no, it is as effective by phone or online. And, yeah,
 4 that's not just within Cruse and Cruse Scotland, but
 5 yeah, wider, that has been evidenced. And yeah, we are
 6 seeing the benefits of that.

7 **Q.** And in fact now you tend to operate on hybrid models,
 8 don't you?

9 **MS ARNOTT-BARRON:** Absolutely, yeah.

10 **Q.** Mr Langford, would you agree with that?

11 **MR LANGFORD:** Absolutely. Absolutely, we'd agree. We find
 12 that evidence to be the same.

13 One of the important aspects, though, for bereaved
 14 people, and people tell us this throughout their
 15 evaluations, is the importance of having the right
 16 information upfront, but also having the right choice.

17 So, many people come to us, and certainly did even
 18 during the pandemic, asking if it was possible to meet
 19 with someone in person. And understandably so. Many
 20 people lacked companionship or wanted to be close to
 21 people. But actually being informed about how telephone
 22 support and sometimes video support can be useful, often
 23 that conversation helped in advance to help people feel
 24 like they could trust the service.

25 **Q.** And in fact that goes exactly to one of the points you

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1 sector organisations. That's quite a broad remit.

2 **MR LANGFORD:** Lots of people need help, and it's
 3 a conversation we believe everyone can have, and we can
 4 be prepared for.

5 **Q.** Ms Arnott-Barron, turning to you on that note, and this
 6 is a very wide question, we've heard a lot from
 7 Mr Langford about what Cruse was doing in terms of the
 8 provision of specific services. Was Cruse Scotland
 9 carrying out similar activities during the pandemic?

10 **MS ARNOTT-BARRON:** Yeah, we didn't do it all at the same
 11 time. That wasn't all synchronised, but yes, we've done
 12 similar with the training and a lot of what Mr Langford
 13 has said, yeah, we absolutely resonate with. So yeah,
 14 it's another really great way of reaching more people.

15 **Q.** I'd like to turn now to the efficacy of digital support
 16 vis à vis in-person support and that's something you
 17 both touch on and is hugely important in a context where
 18 the type of support that you are practically able to
 19 provide is changing?

20 I'll turn to you first, Ms Arnott-Barron. Was your
 21 experience that remote bereavement support was equally
 22 effective, less effective, more effective, than
 23 in-person support that you had provided prior to the
 24 pandemic?

25 **MS ARNOTT-BARRON:** I think if you'd asked me beforehand what

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1 make later on in your statement, so that falls with --
 2 so, taking a step back to the bucket of digital
 3 exclusion, as it were, you say that you were acutely
 4 aware of the prospect and actuality of digital
 5 exclusion, which is what you've just been saying, and
 6 then you say -- and this is at paragraph 49 of your
 7 statement -- that Cruse made the strategic decision to
 8 continue providing both remote telephone support and
 9 online video support to bereaved people requiring
 10 ongoing sessions on a weekly basis.

11 And to my mind, it sounds like that chimes with what
 12 you've just said, which is giving people the agency to
 13 choose?

14 **MR LANGFORD:** Yeah, absolutely. It's so important. A lot
 15 felt out of control for people, and so it was important
 16 to have some control over the support they could
 17 receive.

18 **Q.** Was that -- did you find that that impacted how you
 19 trained your volunteers, for example? Did you train
 20 them in both mediums or -- how did that work,
 21 practically?

22 **MR LANGFORD:** We started off training everyone in telephone
 23 support, because it was the most accessible and
 24 available at the time, and then rolled out video support
 25 in a gradual basis. Logistics allowing, really.

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1 But also, the other element I would add is the
2 training of people who were undertaking initial
3 conversations with bereaved people coming to us,
4 predominantly on the helpline, but also locally, because
5 then they were having the conversations with people to
6 talk with them about what choices are available, and
7 that conversation needs to be handled really delicately,
8 compassionately, really well, to help people understand
9 what choices are on the table for them.

10 **Q.** Ms Arnott-Barron, does that reflect the experiences of
11 Cruse Scotland?

12 **MS ARNOTT-BARRON:** Yeah. And I would say just one thing
13 that really helped, because we had several clients who
14 were mid-session, if you like, when first lockdown
15 happened, the volunteers were really worried about
16 leaving people partly supported, if you like. And it
17 was them who were saying, "Could I connect with them by
18 phone instead?"

19 And so that happened quite organically, and then
20 that was encouraging other people that actually this
21 would work as well. So we used to have meetings of the
22 different volunteer groups kind of throughout the
23 pandemic, and they could share some of their learning
24 and things, and that really helped quite a lot too.

25 **Q.** And that, in fact, chimes with what we've been saying

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1 could learn how to particularly engage on video support,
2 so that they wouldn't feel alone and isolated. And what
3 we commonly find is a large room where people were
4 socially distanced, on individual devices, or learning
5 with each other with one or two of our volunteers or
6 staff online, whilst also then they'd have some
7 care home or nursing home staff available too.

8 **Q.** And in fact, Ms Arnott-Barron, that links to one of the
9 initiatives that you talk about in your statement as
10 well.

11 So, you talk about the different groups who were
12 impacted more or less to an extent by digital exclusion,
13 and I'll read it out. You say at paragraph 17 that:
14 "Despite Cruse Scotland being able to implement
15 telephone and online support quickly, it was not without
16 its challenges and unfortunately did not meet the needs
17 of when who needed their support. The communities most
18 affect were those who did not have access to, or an
19 independent understanding of, technology, those without
20 private space within the home, and those who needed the
21 support of a third party to refer or accompany them to
22 support. These tended to be those whose first language
23 was not English, children and young people, [which the
24 Inquiry has considered within a previous module], those
25 with a learning disability, those with additional

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1 about upskilling volunteers, so it's a volunteer-driven
2 upskilling as well as a, sort of, organisation-driven
3 upskilling, as it were?

4 **MS ARNOTT-BARRON:** Absolutely.

5 **Q.** Mr Langford, you also talk about your work with other
6 organisations to mitigate some of the impact of digital
7 exclusion. And you mention your partnership with
8 ExtraCare. Are you able to tell the Inquiry a little
9 bit more about that, please?

10 **MR LANGFORD:** Yeah, absolutely.

11 So we had 3-year, and then it was expanded to 5-year
12 funding to provide support to bereaved people in
13 retirement villages and care and nursing homes that were
14 run by ExtraCare. So, predominantly in the Midlands but
15 also stretching through into Buckinghamshire.

16 And at the time, at the start, it was face to face.
17 We were also training staff and volunteers in our
18 facilities. Of course, then, when the pandemic
19 lockdowns hit, we moved everything to be as remote as
20 possible -- well, entirely remote, particularly
21 considering those facilities needed to be completely
22 locked down, because of the vulnerability of the people
23 who were residing in them.

24 So, what we did then was organise, as much as
25 possible, remote group activities, where people together

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1 support needs such as hearing or sight loss."

2 Then, a few paragraphs down, you talk about the
3 difficulties that older clients faced, so including
4 those in nursing homes and care homes. And you say at
5 paragraph 21 of your statement that you weren't actually
6 initially sure how to address that issue, and you became
7 creative in your approach to this group.

8 I quite liked that turn of phrase, actually. Are
9 you able to tell me how you were creative?

10 **MS ARNOTT-BARRON:** So, we were funded to provide -- it was
11 groups for people who'd become socially isolated because
12 of their bereavement, and that tended to be older people
13 that had perhaps been in a caring role for a long time,
14 and, you know, people lose their connections with
15 friends and, to an extent family, and maybe even
16 workplaces, where that applied. So these were people
17 that had kind of lost their confidence in connecting
18 with others again. And before the pandemic, they met in
19 person. You know, we'd have kind of chats, we'd go out,
20 have walking groups, things like that. And then of
21 course the pandemic hit.

22 Now, part of this we could offer individual support
23 but the whole part of the group was to get people
24 connecting and sharing. And it was actually myself that
25 came up with the idea of a conference call and

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1 I appreciate that some people may not know what that is
2 because it's an older thing, but back certainly in the
3 1990s it used to be if there was a group of people,
4 before we had Teams and Zoom, we all used to dial into
5 the same number and you would have an access code and
6 then you could all speak on the same call. And that's
7 actually what we ended up doing with that group.

8 They did receive individual contact, particularly
9 those that were living alone, but it meant they could
10 still keep up the connection with each other. And that
11 was a really lovely, lovely thing to have been able to
12 have done.

13 **Q.** And you say in fact that it was so popular that although
14 it was initially a fortnightly call, you subsequently
15 extended it to a weekly call.

16 **MS ARNOTT-BARRON:** Yes, absolutely.

17 **Q.** Another group who were particularly impacted by the move
18 to digital were those living in busy households, as you
19 say. As you say, the key issue, is they were unable to
20 access private space in order to actually receive the
21 bereavement support, be it by way of telephone call or
22 a video --

23 **MS ARNOTT-BARRON:** (Witness nodded).

24 **Q.** -- even if they had access to the technology.

25 In your experience, what tended to happen in those
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1 INQ000659894 at page 0062, just for the record.

2 And here we see that:

3 "There was also a mistrust of formal bereavement
4 support services among people from some ethnic minority
5 communities. They were concerned about the privacy of
6 their information and preferred to seek support from
7 within their local communities, where they felt
8 a greater sense of security and better understanding of
9 their culture."

10 Now, I know that we've primarily been focusing on
11 the practicalities of support provision but is this
12 something that you came across in Cruse Scotland's work?

13 **MS ARNOTT-BARRON:** Yes, I guess that for ourselves it was
14 more where there was a language, a barrier, if you like.
15 Because sometimes it would be support for referring in,
16 but actually to have those sessions was quite complex to
17 try and get somebody that was maybe in a busy household
18 having sort of private time, if you like, for a call
19 that matched alongside when the interpreter or
20 translation service was available, alongside when, you
21 know, the bereavement counsellor was free. So that was
22 quite a challenge.

23 I'm not sure I've answered your question.

24 **Q.** I think in fact perhaps I'm answering my own question
25 now, but to some extent you have. This is perhaps the
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1 sorts of cases? What was the work around?

2 **MS ARNOTT-BARRON:** Well, it is part of the contractual
3 agreement that people do have private space, and of
4 course, most people want to have that in any case.

5 So people could be creative. They would join calls
6 from a car. We had one client that would have regular
7 sessions from the caravan that was in their driveway.
8 So there was lots of different ways that people could
9 come up with things.

10 And I think that was easier where you actually had
11 a specified date and time for a session, but much more
12 challenging for people just looking to hook in with
13 helpline or something like that.

14 **Q.** So it perhaps worked better for the one-to-one support
15 series over six weeks than the helpline, for example?

16 **MS ARNOTT-BARRON:** I would say.

17 **Q.** Ms Arnott-Barron, you speak about another group, as
18 well, who was particularly affected, those from ethnic
19 minorities particularly where language barriers were an
20 issue. Both of you have been provided with the
21 Inquiry's listening exercise, Every Story Matters.

22 I'd like to ask you some questions about this group
23 but before I do so, if I could just turn up an extract
24 from that listening exercise.

25 Again, you're ahead of me. Many thanks.
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1 preliminary step because once somebody is accessing your
2 services, perhaps this step has been overcome. I don't
3 mean to speculate, though.

4 **MS ARNOTT-BARRON:** Yes, certainly people referring in
5 because they can do that through email or through
6 GriefChat and things, that has been less of a barrier
7 for ourselves in Scotland. And of course, Scotland is
8 not as diverse as other parts of the UK, as well, so
9 I think that's been less problematic across the
10 pandemic.

11 **Q.** And as you say it was perhaps more about ensuring that
12 everybody could be available at the same time?

13 **MS ARNOTT-BARRON:** Yeah.

14 **Q.** You also talk about individuals with additional support
15 needs, such as hearing or sight loss, those with
16 a learning difficulty and other disabilities. And you
17 say that they also needed the support of a third party
18 to refer or accompany them. Are you able to provide
19 further detail about that, please?

20 **MS ARNOTT-BARRON:** Yes, so very different groups. So,
21 people with -- obviously with sight loss or, you know,
22 needs around sight, the phone support was certainly
23 accessible for them. Hearing was a real challenge,
24 because whether that's online or whether that's by
25 phone, that poses a huge barrier. So, really, the only
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1 option we had was the GriefChat support, kind of the
2 web-based.

3 And where that can offer an immediate response, it
4 doesn't offer a counselling relationship. So that was
5 definitely a group that we had to prioritise once we
6 could meet in person, but until we could, they did, they
7 did miss out.

8 For people with learning disabilities, very similar
9 to the barriers with children and young people as well.
10 It's having somebody there to support. You know, to
11 have the IT equipment and things all set up. And of
12 course, there's regulations around that as well.

13 So, that was a lot more trickier to navigate, and
14 I would say we didn't get the same number of referrals
15 for that client group of over that time; it wasn't until
16 face-to-face was available again. So definitely
17 impacted.

18 **Q.** Mr Langford, did that reflect your experiences as well,
19 with Cruse?

20 **MR LANGFORD:** It absolutely did. And if I may add, our
21 deepest concern is so often not who contacts us, but who
22 doesn't.

23 **Q.** Yes.

24 **MR LANGFORD:** And so much data would say that there are many
25 groups that don't. But actually we also, as a sector,

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1 her, because they haven't had something like this. They
2 later did workshops to find out what it [a sudden
3 Covid-19 bereavement experience] was like."

4 And I think that chimes with what you're saying,
5 learning, sort of, how to provide that support?

6 **MR LANGFORD:** Well, absolutely. Of course, we were all
7 learning at the time, and also all contending with our
8 own difficulties too. But nevertheless, bereaved people
9 need the support they need.

10 And what was becoming apparent every day for us is
11 that Covid-19 and the resulting lockdowns, partly they
12 unearthed issues of intersectionality and multiple
13 vulnerabilities, where they were more prevalent with
14 some groups than others. It unearthed those that were
15 there anyway. And also, the nature of lockdowns and
16 often the suddenness of a bereavement through Covid-19
17 meant that those vulnerabilities were compounded.

18 And so, often, there was more complex, more
19 prolonged experience of grief, and also trauma as well.

20 **Q.** And just on that exact point that you mention, it's
21 a point that you both mention in your statements,
22 actually, so you talk about the complexity of -- the
23 increased complexity of the needs with which you were
24 being presented during the pandemic, and indeed continue
25 to do so.

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1 have a responsibility to be accessible. And what we've
2 managed to do partway through, when lockdowns were --
3 there was a bit more flexibility, and a little bit
4 afterwards, we've been able to sell(?) some funding to
5 experiment more about actually growing up support from
6 within communities and having a more co-produced
7 approach, where it's more equitable. And what we've
8 seen is that that works well.

9 And we trust familiarity, don't we? And there's
10 a lot more to explore there, but that seems to break
11 down some of those barriers that clearly have been there
12 for people.

13 **Q.** And in fact that links quite well with the next question
14 I'm going to ask you, which is about the additional need
15 for bereavement support during a pandemic. It sounds
16 pretty self-evident when I put it like that, but if we
17 could turn to the roundtable, please.

18 I'm sure it will be ahead of me, but INQ000588201.
19 And that's page 15.

20 And this section deals with bereavement support and
21 whether it was suitable for those suffering from
22 a Covid-19 bereavement. And we have a quotation here
23 which says:

24 "My sister got through [to] an organisation for
25 bereavement. They said they would probably learn from

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1 The Inquiry has also received written evidence from
2 Dr Harrop, and we've just heard from UKCB, she was
3 involved with that project, and you've been provided
4 with a copy of her statement today -- in advance of
5 today, apologies. She's conducted significant research
6 on the exact points that you've mentioned.

7 And one of the findings that she references in her
8 statement is that there was a relatively high finding of
9 prolonged grief disorder during the pandemic. So she
10 says that was 29% at 25 months indicated
11 post-bereavement versus an expected level of 10% in
12 non-pandemic times.

13 I appreciate that you are both, sort of, working at
14 the front line, as it were, but does that chime with
15 your experiences and what you were seeing?

16 **MR LANGFORD:** Absolutely does.

17 **Q.** Ms Arnott-Barron?

18 **MS ARNOTT-BARRON:** Yes, absolutely.

19 **Q.** And just to follow up on that line of questioning --
20 I'll turn to you first, Ms Arnott-Barron, and I'll give
21 Mr Langford a small break -- do you consider that there
22 was sufficient training and expertise within the sector
23 to address the specificity and complexity of grief in
24 and by Covid-19?

25 **MS ARNOTT-BARRON:** Yes, I would say it's there. It's

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1 perhaps just not the volume. And I think that that
2 volume of people with such complexity of grief usually
3 isn't needed, because most people will respond well to
4 a lower level response, more, sort of, listening support
5 and things, rather than counselling. So, it was more,
6 yeah, the volume that created a challenge.

7 Certainly with Mr Langford, he did mention the
8 trauma -- or possibly it was yourself, I'm sorry -- but
9 that was something that really featured with so many of
10 the Covid deaths, was trauma, and that does mean,
11 obviously, you know, a counselling response to support
12 that.

13 **Q.** So, increased volume of that response, of the
14 availability of that response?

15 **MS ARNOTT-BARRON:** Yeah, of that complex need, yeah.

16 **Q.** Mr Langford, do you have anything you'd like to add?

17 **MR LANGFORD:** I concur with what Ms Arnott-Barron said.
18 I would also say, to add, that it is partly about the
19 sector. And so concur completely with what has already
20 been said.

21 Also, we exist in a system, and actually the
22 knowledge about how to work with and treat and signpost
23 for prolonged grief disorder is not well known. It's
24 not universal within other support structures and that
25 includes statutory mental health. In some places yes,

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1 written evidence.

2 So, for today's purposes, I'd like to simply
3 highlight the key elements from that.

4 I'll turn first to Mr Langford, and in fact read out
5 what I understand to be the key elements of those
6 recommendations and lessons learned, and then if you'd
7 like to comment.

8 You say:

9 "70. Firstly, increased preparedness for a national
10 major incident could have elevated our adaptability as
11 a sector ...

12 "71. Secondly, an ongoing scoping of which parts of
13 society are most in need could have facilitated for
14 a highly targeted approach to provision.

15 "72. Thirdly, a more targeted approach to
16 partnership working may have helped bereavement support
17 charities reach those most in need of support.

18 "73. Fourthly, having more immediate public
19 messaging, that was adapted to the inherent changes of
20 context, could have further reduced distress, by helping
21 better understand how they can support each other.

22 "74. Fifthly, associated professionals could have
23 been targeted and trained on how to provide some level
24 of bereavement support, in response to needs arising
25 from the pandemic."

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1 but others not.

2 **Q.** So, actually, I'm asked to ask you the next question,
3 but I'm going to extend it. So the question is, how can
4 the sector ensure that such expertise would be available
5 in a future pandemic? But feel free to answer that more
6 widely.

7 **MR LANGFORD:** Absolutely.

8 So you've cited Dr Emily Harrop's research, and we
9 work with Dr Harrop all the time and -- and her and her
10 colleagues, the research that she's cited here, it needs
11 to be more well known. It needs to be more understood.
12 And what we commonly find is that bereavement is often
13 treated as -- in a similar way that people will treat
14 depression or anxiety, but they're different. They're
15 different in the diagnostic manuals. And people who
16 experience them need to be treated as such too.

17 **Q.** Ms Arnott-Barron, is there anything you'd like to add to
18 that?

19 **MS ARNOTT-BARRON:** No, I think Mr Langford has covered that
20 rather well.

21 **Q.** That leads us very nicely on to my last set of
22 questions, which relate to the lessons learned during
23 the pandemic. And you've both set this out in some
24 detail in your written evidence already, and the Inquiry
25 is very grateful, and my Lady will have regard to that

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1 And:

2 "Finally, Operating a sustainable financial model
3 was a challenge. Additional funding for support
4 organisations [would have been] available during the
5 pandemic."

6 You then say -- in fact, no, that is the end of --
7 as I understand it, that's the end of those lessons
8 learned, but if you have any further comments, please do
9 share those.

10 **MR LANGFORD:** Nothing further to add, actually.

11 **Q.** Grateful.

12 Ms Arnott-Barron, turning to you now. You set out
13 similar impacts and learning points, as you refer to
14 them, at paragraph 25 of your statement. And you say
15 firstly that:

16 "Remote bereavement support for adults, delivered
17 via telephone and online platforms achieved outcomes
18 comparable to face-to-face provision and should be
19 regarded as an effective delivery model."

20 Second:

21 "Individuals with learning disabilities, and those
22 requiring translation or interpreter support indicated
23 the need for tailored approaches for these groups."

24 Third, and this is in fact a point that the Inquiry
25 will be considering with family organisations over the

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1 course of this week:
2 "Restrictions on hospital visiting and funeral
3 practices were associated with long-term negative
4 impacts on bereaved individuals, underscoring the
5 importance of balancing immediate risk management with
6 longer-term harm."

7 Fourth:

8 "Volunteer capacity and motivation had
9 a demonstrably positive impact on service continuity and
10 organisational resilience during the crisis."

11 Fifth:

12 "The voluntary sector's flexibility enabled more
13 rapid service adaptation than was observed in many
14 public and private sector organisations, offering
15 transferable lessons for future emergency response."

16 Sixth:

17 "Opportunities to systematically capture and share
18 evidence of effective organisational adaptation were
19 limited, constraining sector-wide learning."

20 Seventh:

21 "Uniform PPE and pandemic protocols were not
22 proportionate across all settings and [there was
23 a resulting] inefficient use of resources ..."

24 Seventh [sic]:

25 "Limited post-pandemic reflection and contingency

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1 there are now some questions from CPs.

2 **LADY HALLETT:** There are, thank you very much.

3 Ms Morris, who is just there.

4 **Questions from MS MORRIS KC**

5 **MS MORRIS:** Thank you, my Lady.

6 Good afternoon, Mr Langford, good afternoon,
7 Ms Arnott-Barron. I ask questions on behalf of the
8 Covid Bereaved Families for Justice UK. I'd like just
9 to address you on one topic, please, that's addressing
10 inequalities via data collection.

11 I think it was yourself, Mr Langford, in your
12 statement the way noted that Cruse doesn't keep or
13 collect data on the stigma or cultural barriers to
14 accessing bereavement support, so I wanted to ask you
15 whether you, whether Cruse and Cruse Scotland, agree
16 with Dr Harrop's recommendation for the collection of
17 client data to really analyse and understand some of
18 those barriers, as a foundation to then providing
19 outreach to those communities?

20 **MR LANGFORD:** We absolutely agree. We see it as an
21 imperative. It's necessary and we've made substantial
22 changes already.

23 **Q.** Okay. You foreshadowed my next question, which was: is
24 data collection and analysis appropriate and sufficient
25 at the moment? And if not, what further work needs to

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1 planning reduced organisations' ability to consolidate
2 learning and improve preparedness ..."

3 And eighth:

4 "Organisations that sustained adapted service
5 delivery, rather than suspending services ...
6 [contributed] to improved organisational resilience and
7 societal outcomes."

8 I feel like I've just spoken a lot there, so is

9 there anything that you would like to add?

10 **MS ARNOTT-BARRON:** Obviously those were the key points that,
11 yeah, really, really keen to bring out. I guess just

12 the other thing to highlight is that bereavement support
13 hasn't gone back to what it was pre-pandemic. You know,
14 we are still working with the results of the pandemic.

15 It's still very alive in what people are presenting
16 with, even if that's in a compare and contrast of a more
17 recent bereavement, you know, "I wish I could have done
18 this for, you know, whoever died in the pandemic".

19 Because I think we keep speaking about this as though
20 it's been a part in time that's happened, and we've
21 moved on, whereas, actually, I think, for many of the
22 bereaved, it's actually still very alive.

23 **MS KASSAMALI:** Thank you. And thank you to the both of you
24 for your evidence.

25 My Lady, those are my questions, but I understand

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1 be done?

2 **MR LANGFORD:** Yeah, absolutely. It's getting there, but
3 there's a journey to be made. The most -- we see
4 a significant way forward in organisations communicating
5 with each other to get an understanding of what
6 collectively there is of data that tells us who is
7 accessing support and who is not. And also, not solely
8 who is accessing support but who is visible to an
9 organisation and how visible organisations are to them.

10 As I indicated before, some groups that concern us
11 most are people we don't know about, who don't contact.

12 And so that really worries us. We'd be keen to
13 understand more, collectively, with the sector.

14 **Q.** Thank you. Is that part of the ongoing scoping and
15 targeted outreach that you mentioned in your evidence
16 a moment ago?

17 **MR LANGFORD:** Absolutely.

18 **Q.** Thank you.

19 Ms Arnott-Barron, is there anything you'd like to
20 add on behalf of Cruse Scotland in respect of data?

21 **MS ARNOTT-BARRON:** I agree with Mr Langford as well that it
22 is about who is not coming forward and those questions
23 of why. But I guess just another point is, I guess,
24 I recognise that even if other communities were stepping
25 forward, I recognise that the offer that may not exist

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1 at the moment may be attractive or applicable to them,
2 and yet I would like to be guided about actually what
3 would be helpful and how we could address that.

4 So, yes, definitely agree with all that Dr Harrop
5 says, and we'd appreciate any guidance on how we can
6 improve on this.

7 **MS MORRIS:** Thank you very much.
8 Thank you very much to you both.
9 Thank you, my Lady.

10 **LADY HALLETT:** Thank you, Ms Morris.
11 Ms Beattie. No good to you up in Scotland, but
12 Ms Beattie is over there.

13 **MS BEATTIE:** Oh, my Lady, the questions have actually been
14 amply covered by questions by Counsel to the Inquiry.
15 Thank you.

16 **LADY HALLETT:** I wondered. Thank you very much, Ms Beattie,
17 thank you for your help.

18 Sorry, you've already covered the questions that
19 Ms Beattie had permission to ask for.

20 Thank you very much indeed for your help with the
21 Inquiry. I know people who were bereaved during the
22 pandemic, and obviously during the course of the Inquiry
23 I've met, sadly, too many more. You don't need me to
24 tell you how important the services your organisations
25 offer are to the bereaved, so thank you for all that you

1 did, and continue to do, to assist those, I think -- was
2 it Cruse that said at the most painful moment of their
3 life?

4 **MR LANGFORD:** Mm.

5 **MS ARNOTT-BARRON:** (Witness nodded)

6 **LADY HALLETT:** So, a very poignant mission, if I may say so.

7 So, thank you both, and please thank all of those who --
8 your staff and the volunteers who also helped you.

9 Thank you very much indeed.

10 Very well, that completes the evidence for today.

11 I shall return for 10.00 tomorrow.

12 **MS KASSAMALI:** Thank you.

13 (4.25 pm)

14 (The hearing adjourned until 10.00 am the following day)

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I N D E X

P A G E

3	MR JOHN LEACH (affirmed)	1
4	MS JOANNE THOMAS (sworn)	1
5	MR MICHAEL SHORT (affirmed)	1
6	MR DANIEL SHEARS (affirmed)	1
7	Questions from COUNSEL TO THE INQUIRY	1
8	Questions from MS DAVIES KC	92
9	Questions from MR WAGNER KC	94
10	Questions from MS BEATTIE	99
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17	MS FIONA ARNOTT-BARRON (affirmed)	155
18	Questions from COUNSEL TO THE INQUIRY	155
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85/11 90/5 92/21 93/3 93/18 98/24 100/12</p> <p>MR SHORT: [46] 1/25 2/4 2/8 4/9 4/13 21/3 24/7 24/12 24/18 24/25 25/6 25/23 26/18 27/4 28/3 31/22 32/10 32/23 33/7 46/23 47/9 48/3 48/7 49/2 49/10 49/17 49/25 50/17 51/7</p>	<p>51/19 51/25 52/10 62/13 62/17 62/23 63/7 70/16 75/13 80/25 83/2 83/11 88/11 91/25 95/15 96/5 103/13</p> <p>MR WAGNER: [1] 94/21</p> <p>MS ARNOTT-BARRON: [35] 156/6 156/11 156/16 158/17 158/19 158/21 158/24 159/7 159/11 159/14 159/21 160/10 163/23 166/21 174/10 174/25 175/9 177/12 178/4 180/10 181/16 181/23 182/2 182/16 183/13 184/4 184/13 184/20 188/18 188/25 189/15 190/19 194/10 196/21 198/5</p> <p>MS BEATTIE: [3] 99/15 103/19 197/13</p> <p>MS BLACKWELL: [7] 104/21 105/5 106/4 125/17 139/1 154/5 154/25</p> <p>MS DAVIES: [2] 92/20 94/18</p> <p>MS KASSAMALI: [4] 155/5 155/17 194/23 198/12</p> <p>MS MORRIS: [2] 195/5 197/7</p> <p>MS RAHMAN: [5] 1/6 1/18 45/21 46/5 92/14</p> <p>MS THOMAS: [38] 2/22 3/1 3/5 4/19 19/12 20/21 30/21 30/25 31/4 40/16 55/5 57/19 57/25 59/1 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112/17 112/23 186/19</p> <p>150 [1] 89/11 151 [1] 70/13 152 [1] 9/19 153 [1] 10/7 156 [1] 63/3 158 [2] 30/8 68/8 159 [1] 13/20 16 [3] 8/12 106/23 109/15</p> <p>162 [1] 13/20 163 [1] 55/2 17 [2] 8/12 179/13 170 [1] 60/3 175 [2] 28/9 60/19 176 [1] 61/24 178 [1] 69/3 18 [2] 155/20 157/10 185 [1] 127/21 188 [1] 128/15 19 [26] 8/14 9/16 11/9 14/5 14/14 27/20 33/24 40/2 73/23 108/22 109/4 112/2 112/14 114/6 119/25 123/18 132/24 161/15</p>	<p>163/17 164/16 167/11 186/22 187/3 187/11 187/16 188/24</p> <p>191 [1] 129/10 195 [1] 129/19 1959 [1] 157/18 196 [1] 68/11 1962 [1] 157/19 198 [1] 131/17 1980s [1] 158/6 199 [1] 63/24 1990s [1] 181/3</p> <hr/> <p>2 2 metres [1] 54/18 2 o'clock [1] 104/16 2.00 [1] 104/19 20 [2] 12/18 172/8 20 minutes [1] 171/19 200 [1] 133/13 2001 [1] 158/9 2002 [1] 158/23 2005 [1] 148/11 2015 [2] 110/3 157/8 2019 [1] 110/3 202 [2] 37/20 133/25 2020 [16] 9/21 14/3 28/9 30/13 37/23 37/24 44/4 59/3 68/9 79/4 90/11 110/1 156/25 162/10 163/19 167/5</p> <p>2021 [8] 30/22 50/14 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