Thursday, 5 March 2026

(10.00 am)

LADY HALLETT: Ms Blackwell.

MS BLACKWELL: Good morning, my Lady. Before we turn to closing submissions, may I deal with two matters, please. First, the legal team has identified an initial list of further documents that we seek your permission to adduce. If I could ask that the list of documents be brought up onto the screen, thank you.

It's at INQ000660170.

This list includes 15 statements of witnesses who have not given oral evidence but whose statements you may wish to rely on when compiling your report, as well as fuller versions of documents which have been part adduced during the hearing.

This may not be the final list, and we may need to seek further permission, but for the present time, we would like your permission to produce in evidence and publish in the coming days the documents set out in this list, please.

LADY HALLETT: Certainly.

MS BLACKWELL: Thank you.

Second, on behalf of the wider Inquiry, please may I seek your permission to publish the final Every Story Matters record. This is not directly linked to

Module 10, but it's an Inquiry-wide record, bringing together all of the stories shared on with the Inquiry over two-and-a-half years. This will ensure that any experience shared after the relevant module record was produced is captured, and that every single story is considered and fed through into evidence. We seek your permission for it to be published so that it forms part of the Inquiry's record.

LADY HALLETT: Certainly.

MS BLACKWELL: Thank you, my Lady. That is all from me, and now I think the first closing submission comes from Anna Morris, King's Counsel, on behalf of Covid Bereaved Families for Justice.

Closing statement on behalf of Covid Bereaved Families for Justice UK by MS MORRIS KC

LADY HALLETT: Ms Morris.

MS MORRIS: Good morning, my Lady.

My Lady, I alongside Mr Weatherby, King's Counsel, Ms Stone and Mr Weaver, represent the Covid Bereaved Families for Justice UK, instructed by Nicola Brook, Elkan Abrahamson, Clare Fletcher, and Zoe McConville of Broudie Jackson Canter solicitors. I recognise that this is the last chance that I have to address this Inquiry on behalf of the Covid Bereaved Families for Justice UK, and in this short closing, my only objective

to try to do some justice and some context to the voices that you've heard over the past two days.

Many of us who have spent the last three years in this room and these corridors have reflected that this Inquiry is unique amongst public inquiries: an inquiry in which all of us in this room have been impacted by the subject matter of scrutiny.

If we all take ourselves back six years from today to 5 March 2020, and what we, as members of the public, knew about Covid-19, on this day it was added to the list of notifiable diseases, there was 115 confirmed cases in the UK, and people were bulk buying hand sanitiser and other household essentials. The UK public was only being provided with weekly updates and yet we were only 18 days away from an unprecedented national lockdown.

As Rabinder Sherwood told you yesterday, people were taking their own precautions, but yet no alarm was raised by the government. We all recall the confusion and the lack of clarity around what measures we should be taking to keep ourselves and our loved ones safe. As a result of our shared experience, everyone in this room and every member of the public has an interest in this public inquiry and the recommendations that you will make about the improvements to planning, preparedness

and decision making for the next pandemic, because it could have been any of us. And it could be any of us in the next pandemic.

But specifically at the heart of your Inquiry, my Lady, should be those who were bereaved by Covid-19, and having listened carefully to the evidence over the last two days, no one could have any doubt why the bereaved fought for this Inquiry. Their experiences and their loss are the reasons why they have come together and campaigned and challenged the official narrative on Covid-19.

The bereaved witnesses from all four nations have been generous enough to share their thanks to the Inquiry for hearing them and their experiences. So may I express our gratitude to the bereaved families who not only fought for this Inquiry but who have continued to fight during this Inquiry. They have fought to find out what happened, and they are still fighting for answers and reassurance that things have changed.

We are grateful to Matt and Jo and all the witnesses, contributors, organisers, campaigners, moderators, and supporters from the Covid Bereaved Families for Justice UK across the UK four nations, for their ability to keep going, keep sharing, and keep challenging.

In their darkest hour, they collectively recognised in each other the unique and complex grief they were suffering before any support services could even grapple with their experience. A searing grief, compounded by the uncertainty, shock, and in so many cases, the significant trauma of knowing that their loved ones suffered harm that was avoidable.

Covid Bereaved Families for Justice UK is engaged not only in the support of the Covid bereaved but also the memorialisation of those who died through the establishment of the national Covid-19 memorial wall and other national and local memorials across the UK, both physical memorials, cultural and social memorials, sometimes something as simple as a heart drawn on a wall, a poignant piece of music played, or a photograph in a frame, sitting on a desk every day in this hearing centre.

This Sunday, 8 March, is the fifth national day of remembrance, and amongst the questions that the bereaved families will be asking themselves that day is what has changed since their loss?

My Lady, in this moment in 2026, accountability and change for the future are everything for the bereaved. We recognise the significance of the public record that you are establishing and the role of that record as

a key part in co-designing for future planning and preparedness. It is vital that the public record of this Inquiry achieves three key aims: first, to understand existing issues and inequalities. Many of the impacts on the bereaved and beyond were caused by unaddressed structural discrimination and/or lack of investment in public services.

Second, to understand what happened, the key decisions that were made.

But thirdly, now in this module, you are able to understand the impact of the decisions that were made and the impact that they caused.

My Lady, you cannot truly extricate impact from the decision making because there are distinct layers of impact that you've heard evidence about in this module.

For example, in your Module 1 report, you found that had the UK been better prepared and more resilient to the pandemic, some of that financial and human cost may have been avoided.

You've heard in this module the cost of that impact of the lack of planning, the lack of preparedness and lack of proper resourcing.

You have also heard in Module 5 and Module 6 that there was no adequate stockpile of PPE for healthcare and social care workers, let alone family members and

visitors for those in hospital and social care settings.

Rabinder Sherwood recalls asking for PPE to see her dying father, to be asked by doctors if she really wanted to take that PPE from a nurse.

A well-prepared and resourced system would not present this Hobson's choice.

In your Module 2 report, you found that the March 2020 lockdown should have been introduced a week earlier. The impact is that there were 23,000 deaths avoidable. One of those deaths was Rivka Gottlieb's father, Michael.

My Lady, every person who lost a loved one through Covid-19 has suffered a distinct loss and suffers a unique and complex grief. You have heard now directly from the bereaved families and nothing that I say could articulate it better. I only seek to underline some key points.

Dr Emily Harrop's report outlines the complex and overlapping layers of grief that the Covid bereaved have suffered, which resonates with the evidence they have given. Most significantly, Dr Harrop highlights a specific and compounding impact of losing someone as a direct result of a pandemic of an unprecedented and untreatable pathogen, Covid-19.

The guilt, the feeling helpless, when in reality

they had no choice to be with their loved ones, that choice was taken away from them. The guilt they've expressed about not being able to there but they weren't allowed to be there.

Dr Glen Grundle from the Northern Irish bereaved families told you on Tuesday, when he lost his beloved mum, "Covid" was every second word, an unwelcome and constant reminder of the source of her death. He also told you the trauma and frustration of repeatedly asking the same questions of different organisations and still not getting an answer.

Given the lack of coroner's inquests or other forms of individual scrutiny -- sorry, independent scrutiny into these individual deaths, this Inquiry cannot now answer them. These questions will still remain.

As Dr Langford from Cruse told the Inquiry: workplaces, community spaces and supportive networks which were often the best support were inaccessible. Many times during the pandemic, the bereaved could not even receive a hug from friends and family members.

And so many of the Covid bereaved bear the additional emotional impact of the disproportionately high Covid death rates within minority ethnic communities, disabled people and older people, and the feelings of anger and injustice of the health and social

inequalities that were exposed by the pandemic.

All of these experiences, traumas and questions, if left unresolved and unaddressed, are a direct cause of complex and prolonged grief. And the impact, as you have heard, is a total lack of acceptance of the loss experienced over five years ago.

The Inquiry also cannot ignore the impact of the failings in the pandemic response. Dr Harrop's evidence outlines a significant negative impact of inadequate care provision for those infected by Covid-19 and inadequate communication with their families.

Mrs Sherwood's evidence, the lack of care her parents received and the grief and trauma that this has caused her and her family, and there are so many more stories within our written evidence and not just in Every Story Matters.

Another member of Covid Bereaved Families for Justice UK, Clare Farnsworth, recalls the horrors that she directly witnessed and that her mum endured while in hospital. She experienced the agony of not being able to be with her mum on many days when she was in hospital and what she calls the "slow car crash" that was her being shamefully unprotected from the virus whilst in hospital and the terrible inevitability of her catching Covid. She describes her precious mum as viewed only as

collateral damage by a hospital completely overwhelmed and lacking in infection control.

My Lady, you cannot have failed to have been struck by the impact on the bereaved of not just being able to say goodbye but the lack of post-death support.

For example, in Rabinder Sherwood's statement an anonymous Covid Bereaved Families for Justice UK member said that the lack of communication led to a tremendous, complicated grief, compounded by the fact she was unable to see her grandad at the time of his death, surround herself with the support network or pursue normal activities that would often help with the grieving process. Personally, she found the fear of contracting the virus or passing it on to a loved one overwhelming and it's taken a long time to recover from the trauma and adverse impact on her mental health.

Time and again the Covid bereaved families have raised in their statements to this Inquiry not just the impact of what Dr Harrop referred to as the "moral code disruption", and experienced in the inability to care for and bury their loved ones in a way of their choosing, but by seeing those that they had to rely on to deliver the pandemic response not being held to the same moral and legal codes.

For example, the Inquiry heard from Maria McArdle

from the Northern Irish Bereaved Families that she lost her mother on the day that Boris Johnson attended a party at Downing Street. This is a key contribution to the disenfranchised grief that Mrs Waterton from the Scottish Covid Bereaved described, and the prolonged grief disorder that Dr Harrop tells the Inquiry trebled during the pandemic.

But, having shared their stories with the inquiry so that you, my Lady, can understand the impact, the Bereaved Families now question what will the Inquiry's impact be. The detail will not just be the careful and detailed public record, the impact will be your recommendations, so may I address you on those now.

Rabinder Sherwood has set out clearly in her written evidence her proposals, and we will also carefully reflect on other core participants' proposals in their evidence and in their submissions today, and make a full submission to you in writing, but I wanted to highlight a few broad proposals for your urgent consideration.

The first is a recognition of the unique, complex, and prolonged grief that the Covid bereaved are suffering from. We underline to you the Cruse recommendations and in particular their recommendation to develop best practice guidance for healthcare settings, with specific regard to managing IPC risk and

balancing that with facilitating patient and family contact. What Dr Royston referred to as the perimortal period.

We urge you to recommend the importance of candid post-death investigations and processes. The bereaved must be able to understand what happened, to have their questions answered. Even though hospitals and healthcare workers were under the most unimaginable pressures, there must be honesty and accountability as to how those were pressures translated into the devastating experiences that the bereaved experienced before and after the deaths of their loved ones.

There was a lack of sufficient independent scrutiny of the deaths of so many of those who died during the pandemic. Many were certified by coroners as deaths from Covid-19, with no consideration of whether their death was caused by avoidable nosocomial infection, inadequate PPE, or inappropriate applications of ceilings of care.

Change must include access to accurate medical records, to allow the bereaved to find what clarity and reassurance is available to them.

There is also an urgent need for a specialist national Covid bereavement support mechanism. Dr Hughes, from Mind, was clear that bereavement support

has to be a core part of mental health services. And as one of our members, Clare Farnsworth, says: considering the evidence given to the Inquiry in Module 10 regarding the likelihood of prolonged traumatic grief experienced by the Covid bereaved, there is now a vital need for this government, in the present, to fund specialist Covid bereavement support.

We also endorse the recommendations from Dr Royston that there has to be a cross-government bereavement support strategy, and the continued lack of which he described as a "notable omission".

Finally, my Lady, there has to be better resilience in the funeral and bereavement sector. The Local Government Association evidence was clear that the pandemic revealed a real vulnerability in the funeral and bereavement sector. Mr Llewelyn said there was a need for strategic direction at a national level but flexibility at a local level to reflect the needs of different groups.

Mr Norris pressed upon you the need for co-design. People at the local level, communities, families, know what is needed, and this needs to be taken in a consideration for the future pandemic, and there needs to be a better understanding of different faith needs.

My Lady, you have been asked directly by the

families how you're going to monitor the implementation of your recommendations. They want to know what the impact translates into. When the doors close at Dorland House today and the Covid bereaved stand on the steps outside this Inquiry, what can they know? What can they rely on is going to change? Because even when the Inquiry is over, Covid is not over.

My Lady, you have said that it will take pressure to implement change and you have asked for help, and you will have it, but institutional structures to implement recommendations are essential. Your Inquiry still has over a year before it formally concludes, and it's within your power to hold further hearings and ask those with the ability to implement your recommendations to update you as to their progress within the existing time frame of your Inquiry.

My Lady, you can also add your voice to the calls by INQUEST, JUSTICE and Dame Elish Angiolini for a new independent public body, a national oversight mechanism, with the singular responsibility for collating, analysing, and following up on the recommendations arising from inquiries, inquests, official reviews, and investigations. You can work with the bereaved families to make sure that other people don't have to suffer.

My Lady, by way of conclusion, as the Inquiry moves

on to its next chapter, we remember that without change, the Covid bereaved cannot move forward. But what has stopped them from getting lost in what Dr Grundle called the "rubble of grief" is solidarity, strength, and hope. Hope that their experiences won't be repeated. They ask you now to take the baton, to take that burden from them and to take it forward and to ensure that those who can make meaningful change know that they now have the moral and legal responsibility to ensure that those hundreds of thousands of lives lost mean something. Let that be the impact and the legacy of your Inquiry, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Morris.

Mr Wilcock, I think you're going next.

Closing statement on behalf of Northern Ireland Covid Bereaved Families for Justice by MR WILCOCK KC

MR WILCOCK: My Lady, I, as you know, represent Northern Ireland Covid Bereaved Families for Justice, alongside Mr Jacob Bindman and Enda McGarrity of PA Duffy & Co, and it goes without saying that we adopt and endorse the submissions you have heard and will hear from our sister organisations in this Inquiry.

It will also not surprise you to know that we have discussed the submissions and recommendations we are about to make you orally in order to minimise the inevitable repetition of what are often the same

concerns, no matter what side of the Irish Sea.

My Lady, one of our founding members, Brenda Doherty, described the reality of those bereaved by Covid as follows:

"There are things in life you take for granted. You hope you are always going to be with a loved one in their final days. You never imagine you're going to be sitting at home waiting on a phone call to tell you that they have died without any of their loved ones being with them. Waiting at the cemetery gate for their coffin to arrive, you just have to accept they're inside, even though you never saw them. No wake, no celebration of life for the person they were. Now they have become a Covid statistic."

Although, under normal circumstances, those grieving can feel lonely and isolated, there is someone calling round to check in on how you are. Not during the pandemic. For those bereaved, the reality was, and often remains, that they were lonely and isolated.

My Lady, Northern Ireland Covid Bereaved Families for Justice was established to provide a collective voice for Covid bereaved families in Northern Ireland, and a supportive space for them to connect, come to terms with their unique bereavement experience, and to apply pressure to ensure accountability and transparency

on the UK and Northern Ireland Government's response to the pandemic and their ongoing approach.

And as Brenda said in her statement, those that I represent "hope that the Inquiry hears enough evidence to not only see how detrimental the reality of death during the pandemic is to those left behind, but also how plans can be put in place so this never needs to happen again."

So, in terms of this module, the campaign has argued, among other things, for proper support for family bereaved, including but not limited to psychological, emotional and practical support, and for the statutory services to take the needs of family fully into account, so as to avoid the appearance of casual cruelty that we spoke about in our opening.

My Lady, having said that, I am going to be deliberately focused in my closing address to you for three reasons. Firstly, in terms of the impact of Covid on the people I represent, I simply cannot improve on the compelling and moving evidence you have heard since Monday from the various Bereaved Families for Justice campaigns within the UK. And as far as Northern Ireland is concerned, Dr Glen Grundle, Marie McArdle and Julia McMurray all told you about the unique grief and damage. You'll remember the phrases "trapped in the rubble", or

"beyond repair" as described by Dr Grundle of those who have lost loved ones to Covid.

And as you know, my Lady, the process of publicly sharing such stories of loss and grief can be extraordinarily hard, and on behalf of the Northern Ireland Covid Bereaved Families for Justice, we echo Ms Morris's words and thank everyone who has come forward to better inform the Inquiry of the dreadful human reality of the consequences of the Covid pandemic and the impact it continues to have.

But the second reason I'm trying to be focused is that I know you will have read with care the huge number of experiences of bereaved families that have been put before you by your team, either through the witness statements provided by core participants representing Bereaved Families, including our own Fiona Humphries in this module, as well as Every Story Matters, roundtable discussions, expert reports, or many of the other ways in which you and your team have diligently sought input from those whose lives have been devastated by the pandemic.

And thirdly, we will be putting in written submissions by the end of the month in which we will use the greater time then available to develop some of the themes which have become apparent from all the material

gathered by your team during this module, as you examine the impact of the impact on society, including, as far as those that I represent, the bereaved's ongoing disbelief, the shock, grief, guilt, and anger exacerbated by government restrictions, especially when seemingly ignored by the very people who had put those restrictions in place, and the bureaucratic insensitivity to the practical problems created by bereavement in the context of a mass pandemic.

So my Lady, it's in this context that I have to say that many of the people I represent were both horrified and insulted to read that the very person who set up this inquiry, Boris Johnson, felt it appropriate in the immediate aftermath of your Module 2 report to use his paid column in a national newspaper to lampoon those he described as, I quote, "still wrangling on" about what went wrong in the government response to the Covid virus.

And you heard Dr Grundle explain why it was that these words are so upsetting when he told you that, and I quote, "If we can't even get information about what happened, there's no possibility of starting to grieve and then to be able to go on and get some accountability. The answer is the truth, the accountability and justice for loved ones." And that's

what we want. And those words could be a mission statement for all the Covid Bereaved Families for Justice campaigns.

We can only hope that anyone who ever thought it would be appropriate to use such dismissive and, dare I say it, mocking language about people whose suffering was in no way the result of their own actions, that such a person takes the time to listen to some of the evidence you have heard called in front of you, and reflect upon whether these sentiments could ever be thought of to be in any way appropriate in the light of the evidence you have now heard.

My Lady, those I represent are not "still wrangling on". They are bravely and often stoically trying to rebuild their lives in the aftermath of events which represented not only individual tragedies, but also impacted society as a whole in extraordinary ways in which we are now experiencing.

My Lady, we are now nearing the end of the mammoth task that you and your team have been set, although we do appreciate that it may feel a little further off for those who have to now write the reports over the coming months, and we have no doubt that when you undertake that task of writing the reports, you will recall the reception the Inquiry received when it came to Belfast,

and certainly, as I know you are aware, many of those I represent were struck by the time you took to speak to them in your visit to Northern Ireland, and by your assurances that you gave that you and your team would fearlessly investigate those matters Mr Johnson included in the terms of reference he tasked you with when he was in power.

And we're grateful to you for the opportunity you have given us to input the experiences and views of people from the north of Ireland into this task, and we appreciate the efforts and recommendations you have already felt able to make.

As I will say, we will elaborate on recommendations and on these submissions in writing over the next few weeks. In the meantime, the recommendations and conscientiousness shown by the Inquiry to date makes us sure that the assurances you gave to those I represent remain as true today in London as they did in Belfast.

And then finally, on Tuesday afternoon, you observed to Marie McArdle that you will need the help of people like her to get your recommendations implemented because it's going to take pressure. We understand why you said that. And for that reason, you should be aware that the group I represent are already working hard behind the scenes, meeting regularly with the First and Deputy

First Minister and their team to ensure that the recommendations you have made in previous modules are being implemented.

And as I'm sure your Ladyship already knows, the Northern Ireland Covid Bereaved Families for Justice stands ready to assist you and your team further in any way required as you continue your task completing your terms of reference, and doing what we can to ensure that as few people as possible ever have to go through the trauma and grief that the Covid pandemic reaked upon society.

That was the impact of Covid, and my Lady, they are our submissions. Thank you very much.

LADY HALLETT: Thank you very much indeed, Mr Wilcock.

Mr Stanton.

Closing statement on behalf of Covid-19 Bereaved Families for Justice Cymru by MR STANTON

MR STANTON: Thank you, my Lady.

Having heard such powerful impact evidence from the Bereaved Families over the last two days, this closing statement on behalf of the Covid-19 Bereaved Families for Justice Cymru is focused on just two main areas: the impact of restrictions and the prolonged nature of Covid-19 bereavement.

First, the impact of restrictions. Families were

kept away from their loved ones for months on end and prevented from properly mourning when they died in an effort to stop the spread of infection. Yet while these restrictions caused so much harm to the mental and physical health of patients, care home residents and their families, levels of infection within hospitals and care homes remained at incredibly high levels, making them some of the most dangerous places in the country.

Further, the restrictions often seemed arbitrary and nonsensical as Ms O'Hanlon explained when describing how patients with mobility were able to meet family or friends in the hospital concourse before returning to their wards while she was prevented from visiting her bed-bound mother.

Many families now consider their compliance with the rules to have been pointless, and some have even described how the experience felt like their loved one had been kidnapped. The failure to be there when a loved one died, to say a proper goodbye and to properly honour them in death has caused huge problems in processing grief. As Ms Thomas told you, my Lady, "There was no rite of passage for my husband. Nothing was done as he would have wanted, as I would have wanted, as my sons deserved."

While we know that the severity of these impacts is

not lost on you, my Lady, we are concerned that not enough is being done to ensure they will never be repeated. It is the group's firm position that any future restrictions on the ability of families to support their loved ones in their time of need and to gather to mourn their passing should only be imposed where the risks to public health cannot be otherwise managed through reasonable and proportionate measures such as adequate and appropriate PPE and ventilation.

As Ms Smith-Higgins told you, rather than to seek to restrict fundamental and essential human behaviours to be with loved ones and to give and receive support in times of greatest need, it is the unsafe environments within health and social care states that need to be improved.

These are not unreasonable and unachievable aspirations. Last week, the Inquiry heard from Ms Wong, on behalf of the Clinically Vulnerable Families, who said that the measures put in place by the Inquiry have made this hearing room probably one of the safest in the country. Yet conditions within our hospitals and care homes remain dire.

As I mentioned in our opening, my Lady, data from 8 February 2026 showed that 79% of inpatient Covid-19 cases in hospitals in Wales were hospital-acquired. The

most recent data, from 1 March, three weeks on, is almost identical, at 78%, with 74 of 95 inpatients with Covid-19 acquiring it while in hospital.

As to the second area, the prolonged and ongoing nature of Covid-19 bereavement, this has many complex features and can develop into prolonged grief disorder, of which there has been a high incidence as a result of the pandemic.

For present purposes, we highlight just some of the common experiences of the group's members that have combined to exacerbate and prolong their bereavement. These include: the impacts of the restrictions as already mentioned, including the feeling that the sacrifice made in staying away from a loved one was both futile and avoidable; the indignity and unnecessary suffering associated with many Covid-19 deaths.

Professor Stewart-Brown reflected in her evidence that there were very few good deaths in the pandemic, and that there are huge implications for the bereaved following a bad death. The knowledge that a loved one died while lonely, scared, confused, and without adequate and appropriate treatment, continues to haunt the bereaved.

Many families were left completely in the dark about what had happened to their loved one, and they faced

numerous barriers in their efforts to obtain answers. This includes during treatment and immediately following death, when timely and effective communication could have resolved so many issues. And later, during difficult, bureaucratic and lengthy complaints processes. It includes the lack of inquests, which the group says was a major omission, given the serious systemic and individual failures associated with the treatment and deaths of so many hospital patients and care home residents.

And it includes the fiasco of the Welsh national nosocomial investigation, which the bereaved now realise was little more than a box-ticking exercise.

This is the context for the group's comments, my Lady, about feeling that they have had to fight for everything.

And it has also created an information vacuum which, in the absence of being told what actually happened, the bereaved have filled with their worst fears, including the horrific photography which you heard about, which filled in the blanks for many families in the worst possible way.

Another issue is that the sheer scale of the pandemic has masked failures that, in normal times, would have been fully investigated, such as the care

home at which half the residents died within a matter of weeks.

And there are many appalling individual circumstances experienced by the Bereaved Families that have similarly not received proper scrutiny. For example, the group member whose husband was sent home from hospital just days before his death, having acquired nosocomial Covid-19 whilst an inpatient, disorientated, dehydrated and dressed in somebody else's clothing.

Another member whose husband was detained in hospital for three weeks, despite being medically fit for discharge, solely because a required wheelchair was sitting in a warehouse an hour away. She became so desperate and frustrated that she drove to the warehouse herself to collect and deliver the wheelchair, only for her husband to contract Covid-19 in the meantime, from which he tragically died.

The circumstances of an elderly patient who acquired Covid-19 in hospital while receiving treatment for a fall, and who, despite being Covid-19 positive and not medically fit for discharge, was nevertheless discharged into a care home against the written advice of their physiotherapist, following which they continued to deteriorate, and died.

And a final example: the dreadful circumstances of a clinically vulnerable woman who was not told for five months that her partner of 23 years had died from nosocomial Covid-19.

Without adequate scrutiny of circumstances such as these, which, as you well know, my Lady, are just the tip of the iceberg, it is extremely difficult to gain closure, and the bereaved continue to carry the weight of these experiences with them.

Guilt is also a typical feature of prolonged bereavement, including the feeling of responsibility for sending a loved one to a place where it was thought they would be looked after, only for them to contract Covid-19 and die, or feeling that they didn't fight hard enough to visit their loved one or to secure their return home. No matter how many times families are reassured that they were not at fault, many find the feeling of guilt impossible to shake.

Feelings of anger are also common, particularly as so few experienced a good death during the pandemic. And Ms Smith-Higgins described the particular feelings associated with a death from nosocomial Covid-19 when she said:

"You have a totally different set of emotions. You're not there hugging the staff and thanking them for

all their help; you're feeling angry ..."

These feelings of anger have exacerbated bereavement.

Finally, a failure to learn lessons and a lack of accountability.

My Lady, you heard earlier this week that the reason Bereaved Families came together and continue to campaign now, as we are, many years on from the pandemic, is to ensure that their voices are heard, to obtain accountability, and to prevent others from ever having to go through the trauma they have experienced.

However, the lack of improvement and, in some respects, the deterioration of health and social care services since the pandemic, coupled with the failure of the Welsh Government to properly explain and take responsibility for their actions, leaves Bereaved Families with an overwhelming sense of injustice that has the effect of prolonging their bereavement.

Despite this, they remain as determined as ever, as they told you on Tuesday when they said, "It's gruelling, it really is. I never thought I would still be here at this point but we have to keep going because actually nothing has changed in Wales yet."

My Lady, those are all the issues that the Cymru Group wish to reinforce in this closing statement. But

before I conclude, these being the final hearings of the Inquiry, may I take the opportunity to thank you and your team, within which there are so many unsung heroes, for enabling and supporting the participation of the Welsh Bereaved Families throughout the Inquiry.

The scope of this Inquiry is unprecedented, and to have delivered hearings across 13 modules, each an inquiry in its own right, and to have gathered and processed for disclosure and publication such a huge volume of material, is a very considerable achievement.

May we also express our gratitude for your personal commitment to the work of the Inquiry, and also for the kindness and compassion that you and your team have demonstrated throughout the Inquiry so evident in this module in your and your team's engagement with the witnesses.

LADY HALLETT: Thank you very much indeed, Mr Stanton. Very grateful.

Ms Mitchell.

Closing statement of behalf of the Scottish Covid Bereaved by DR MITCHELL KC

DR MITCHELL: I appear as instructed by Aamer Anwar & Company on behalf of the Scottish Covid Bereaved.

This Inquiry has been an historic process. For the first time in the history of the United Kingdom,

a spotlight has been cast upon how almost every part of various governments have dealt with the pandemic, the grievous threat to the health and wellbeing of the public over the last hundred years.

As part of this process the bereaved have been able to play their part in history, to record their experiences, and to remember those that they lost too soon. The bereaved have done their best to use their voices in the hope that they may speak through the generations and allow those in the future the opportunity to learn lessons.

The Scottish Covid Bereaved are proud to have played a part in this process.

The Inquiry has heard from the force of nature of Maggie Waterton, who spoke about her mother Margaret Simpson and her husband David Waterton. She spoke of telling us of using her fiery Scots temper and eloquently made sure that her plea for care, compassion and common sense was heard.

Sharon Boswell spoke tenderly of her childhood sweetheart and husband George, who, it is clear, truly was the other half of her. A man who was an essential worker, keeping society going through the dark days of the pandemic, but whose only worry was to protect her from the pandemic.

The Inquiry also heard from Heather Stewart who spoke of her fit and healthy husband Stephen, the time he spent in hospital with Covid-19 was the longest they had spent apart in 32 years. It's difficult to think of a more touching tribute to him than her evidence.

These three members are representative of hundreds more of the Scottish Covid Bereaved, with equally as difficult and distressing experiences of loss.

The bereaved have spoken at length, and far better than I could of the lives of those who have been lost and how that bereavement has and continues to shape their lives. The bereaved are the experts, the ones with the lived experience of the pandemic in a way that the rest of us do not. They were the ones affected in the most dramatic and tragic way.

The Scottish Covid Bereaved wish to thank all of the bereaved groups from the four nations who came to this Inquiry to explain their most difficult, private moments. Their sacrifice means that when the next pandemic comes, we have the opportunity to be better prepared to protect our loved ones.

The Scottish Covid Bereaved make a plea beyond this Inquiry directly to the public, to society, to listen to those suffering from disenfranchised grief. While society may have moved on from the pandemic, the grief

of those who lost their loved ones in the most difficult circumstances have not. As Dr Hughes suggested, we have created a legacy of grief that we still, as a nation, are not understanding.

The reality was, as he suggested, that the entire fabric of how we support people who are dying, their families, and what happened afterwards, completely disappeared.

Grief at any point is hard, but Covid has made it worse in so many different ways. Highlighting this, as the Inquiry has done, is a step towards societal understanding and, hopefully, assistance.

The bereaved have noted over the past few years unwarranted criticism which has been aimed at this Inquiry. There has at times been unacceptable media spotlight on what the Inquiry -- the bereaved consider were wrong and irrelevant issues being raised in the press. Nonetheless, the Inquiry has proceed undaunted and at pace.

At the outset of this Inquiry, the bereaved asked for the gold standard. Nothing else was acceptable. The Scottish Covid Bereaved believe that this has been achieved.

While Module 10 draws the Inquiry's evidential work to an end, the Scottish Covid Bereaved believe this

really is the beginning. The evidence before this Inquiry both records and memorialises testimony before it. It allows for public bodies and experts, who may well have reflected on and made changes already, in light of evidence, to further consider what requires to be done to protect all of us when the next pandemic arrives.

The bereaved note, however, that without action from our governments, our NHS, our public servants, there will be no implementation of important recommendations that will be made by you, the Chair.

The bereaved considers that the baton now passes to them and the bereaved groups throughout the UK to make sure that those recommendations are implemented.

The Inquiry can be in no doubt, the Scottish Covid Bereaved will ensure that feet are held to the fire.

The bereaved's final involvement in this Inquiry is to pass on their gratitude and thanks to those who have contributed, their gratitude to the legal team, in particular Aamer Anwar, April Meechan and all those in the Glasgow office who have supported them every step of the way. And this gratitude I share, for having supported myself, Kevin Henry and other junior counsel, to ensure that at every turn we were assisted in supporting in ensuring that the bereaved's voices were

heard to our best ability.

For the other thanks, they are too numerous to mention, but particular thanks should go to the staff who keep this building up and running, the IT experts who have allowed remote participation viewing of the hearings, those who have made the hearings run smoothly, including Robbie, who has pre-empted every need, and Lawrence, who has pre-empted every document. All of their work has been of great benefit to those in Scotland.

To the Inquiry's legal and administrative teams, to Hestia, who provided support for our core participants, past and present. Counsel to the Inquiry, who dealt with our witnesses and taking evidence with such great care and sensitivity. And of course to you, the Chair, along with the work of the Scottish Covid Bereaved and aforementioned, you have ensured that this Inquiry has been a fitting memorial to those who lost their lives in Scotland, and we are eternally grateful.

These are the submissions on behalf of the Scottish Covid Bereaved.

LADY HALLETT: Thank you very much indeed, Ms Mitchell. Very grateful.

Mr Wagner, I think you're going next.

Closing statement on behalf of Clinically Vulnerable

Families by MR WAGNER KC

MR WAGNER: My Lady, I act for Clinically Vulnerable Families, alongside Hayley Douglas and Margherita Cornaglia, and we are instructed by Kim Harrison and Shane Smith of Slater & Gordon.

My Lady, I start in the same place as my very first submission before you on behalf of CVF back in 2023 -- you know what's coming, don't you? -- it's the CO^2 monitor, which I should say is looking very healthy, at 844 parts per million, well under the 1,000 which we would need for safety.

Back then, I was making two points. The first one was a practical one, about the air quality and the then cavernous, poorly ventilated, and very busy room where that first preliminary hearing in Module 3 was held, and the implications of that poor ventilation for clinically vulnerable people, including my clients, who wished to play a full part in this Inquiry.

The second, wider, point I was trying to make was that clean air was of fundamental importance to the Inquiry's project, both in understanding how Covid spread, primarily through the air, contrary to scientific and public received wisdom for much of the pandemic, and also in understanding how to make all indoor environments safer for everyone, and especially

for clinically vulnerable people.

At this final day of the final hearing of the Covid Inquiry, I will return to three themes which I referred to in my opening. We say that the past three weeks of evidence, and indeed, all of the evidence to this Inquiry, has strongly supported the need for clinically vulnerable people to have safety, support, and status.

Starting with safety. In order to keep those most -- the most vulnerable to Covid-19 and other pathogens safe, physical environments must be made safe and more resilient to outbreaks of infectious diseases.

Professor Herrick put it very simply: we should all have access to clean air.

For clinically vulnerable people and households, the impact of Covid-19 is ongoing. And that's because many indoor environments remain unsafe against infectious diseases, particularly where transmission is airborne. As I said in my opening, clinically vulnerable individuals cannot reliably make themselves safe in indoor settings. The responsibility falls on those who design and manage the environment.

The Inquiry has looked at, in this module, a number of different indoor settings, and in each setting the evidence points in the same direction: clinically vulnerable people were poorly protected then, and they

remain poorly protected now.

The Inquiry, through its recommendations, has the power to do something about that. There's no point waiting until the next pandemic. There is a huge structural challenge which needs to be addressed now if there's any hope that it will be dealt with by the time the next pathogen arrives.

In the workplace, the absence of enforceable rights to adjustments which control the risk of infection continues to leave clinically vulnerable people exposed to danger. A number of witnesses in this module spoke of the impossible decision that clinically vulnerable workers had to make between their livelihood and their safety.

Professor Herrick said that for people who couldn't work at home, you start to get into the set of impossible risk calculations, and especially if your workplace couldn't be made Covid safe, what do you do? Do you put yourselves at risk, having previously been unable to leave your house, or do you decide that actually the risk isn't worth it? And some of the data bears out that many people made the active decision to say: "Actually, you know, I'm going to leave my job because it's not safe."

The TUC witnesses reported about working in

a supermarket where nobody followed the rules indoors. "If I complained because it wasn't safe, I was the problem." And that is a universal point that can be made about the experiences of many clinically vulnerable people.

Professor Nazroo said, "There is certainly a large amount of evidence where people have reported removing themselves from work because of their fear of clinical harm."

And I asked him about the link between fear and legitimate concerns, and he said, "The two go together, so if you're clinically vulnerable then you are concerned about your health, and if you don't have adequate protections, then those concerns will be amplified."

This did not just affect people who were themselves clinically vulnerable; but also people who lived with clinically vulnerable people themselves.

Peter Matejic of the Joseph Rowntree Foundation, when discussing the impact of crowded housing, said, "You'd be stuck at home, perhaps in crowded accommodation, so you've got higher rates of infection likely."

The absence of adequate workplace rules meant that it was in fact a lottery whether you'd be protected or

not. Mr Short of the TUC said, "Our members were concerned, perhaps members who are not clinically vulnerable or clinically extremely vulnerable, but had family members who were, and were relying on the discretion of an employer or the intervention of a trade union to help them."

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

Healthcare environments. Professor Shakespeare recognised that clinically extremely vulnerable or disabled people may need healthcare facilities a lot more than non-disabled people. Now, they felt that those very places were places where they would get ill, so not surprisingly, they didn't go for needed support, and that was a theme which came out very strongly in Module 3 and again in this module.

Sam Smith-Higgins of the Covid Bereaved Cymru, a very powerful witness, if I may say so, and I won't do her justice in reading out her quotes but she said:

"... we were told, 'You can't visit in hospital.' Well, why not? Because actually, if you'd had the right ventilation and you'd had the right masks, there were no issues whatsoever.

"... [hospitals] need to be ventilated. You need to bring regulations for air quality inside hospitals,

a hundred per cent. That needs to be backed up by law. And the same with funerals. Public buildings need to be safe places for people to go. You cannot change the behaviour of people when you can quite easily change the behaviours of the public spaces."

Ms Smith-Higgins said people should be able to sue if they caught Covid despite -- because of poor ventilation, and your Ladyship correctly pointed out that there would be difficulties around causation. That exchange demonstrates an important point. The protection against airborne pathogens has to take place upstream, at source, in the indoor environments where they're most likely to spread, and this has to be through enforceable policies and legal protections, because there is no downstream protection from lawyers who can sue on your behalf when it is, in any event, too late. You have to get the problem at source.

The lack of access in healthcare settings applied to mental health too. Dr Sarah Hughes of Mind said, "If you were a shielding individual it would be very difficult for you to access mental health services. For people with health conditions, physical disabilities, there was an additional layer of structural barriers that they had to experience."

And that's one of the themes of this module, is that

cross-cutting intersectional, as it were, issue that arises when you have different barriers, that intersect with each other.

Cultural settings. Lara Wong said, "The failure to provide even minimum accommodation such as support for those who mask or outdoor events was exclusionary. For clinically vulnerable people, it's about the right to participate in public and cultural life on equal terms."

Faith communities provide online and outdoor services that were particularly useful to vulnerable congregants, but many of those did not continue after the pandemic. Daniel Singleton of FaithAction said it's worthwhile recognising often it was the clinically vulnerable, in particular communities and older people, who were more likely to be frequenting those faith locations.

Finally, in the justice system, Charlie Taylor, HM Inspector of Prisons, agreed that clinically vulnerable prisoners would have been particularly impacted by overcrowded prisons because it limited their ability to reduce exposure.

And CVF members reported that after online hearings reduced down there was less flexibility for remote attendance and pressure to remove masks.

A theme which unites all of these topics is that

stigma and hostility intensify the risks faced by clinically vulnerable individuals.

Dr Sarah Hughes of Mind said, "They suddenly became almost a polarised group of people who often were not just kind of frightened, but in some instances kind of humiliated and mocked for that anxiety in the long term, and all of those factors impacted mental health in the long term."

Rivka Gottlieb yesterday said, "There are ongoing issues today that could be so easily addressed, wider access to vaccination, legislation around air quality. These sorts of things, mask wearing in healthcare settings that would protect the vulnerable. These are simple things but they've become so politicised and this worries me, and the discourse worries me enormously."

That discourse is poisonous, my Lady, and it hurts people.

CVF's second theme is support. Clinically vulnerable individuals and households experienced the pandemic's harms more severely and more persistently, but the support response, both during the acute phase and since, did not reflect that reality.

Lara Wong's evidence and CVF's 2025 Impact on Society Survey, which the Inquiry has referred to a number of times in this module, show that risks and

barriers such as unsafe healthcare environments, lack of tailored mental health support, weak employment protections, and social exclusion, converged with clinical vulnerability.

Lara Wong said, "For many clinically vulnerable people reopening was not experienced as freedom."

Dr Sarah Hughes said, "We heard from individuals that it felt like a cliff edge, that all of the protective factors had disappeared."

Professor Herrick said, "Rules are easy to follow but suddenly, when there are no rules, it's very hard to make personal risk calculations."

When restrictions were lifted, suddenly the idea of protecting others shifted and it became an advice to people who had previously been shielding to kind of reintegrate themselves into society.

For just a few months during the pandemic, the emphasis was on people changing their behaviour to protect vulnerable people but once shielding ended in summer of 2020, that dynamic changed dramatically. Policy decisions shifted responsibility from systems to individuals in circumstances where people lacked the tools to assess their risks and protect themselves effectively.

And on that, CVF's third theme is status. There was

significant issues at the height of the pandemic around the correct identification of those who were particularly vulnerable to Covid-19. And as the Module 1 report said, the lack of preparation was key. You simply cannot prepare without adequate data.

Lara Wong said:

"... our broader message to the Inquiry, is that because we're not recognised as group, because the data wasn't collected ... we are really limited in what we can say. But we do know for a fact that these experiences were very real, and wide-ranging ..."

And this raises an important question. How necessary is it to retain a category of clinically vulnerable people after the pandemic? And the answer is, it's extremely important to do so. The categories of who exactly will be most vulnerable to a new pathogen will vary according to how it spreads.

However, clinical vulnerability did not start with the Covid pandemic. All the pandemic did was illuminate something that was already there. There is a core group of people who are consistently at greater risk from infectious disease because of underlying health conditions and weakened immune systems. And indeed, that group will be at risk, not just from pandemics, but from other civil emergencies. And that's recognised in

emergency planning more widely.

And that core group remains vulnerable in poorly ventilated areas. That's why CVF request that the Inquiry recommends an important step to protect those people: the amendment of the Equality Act to include clinical vulnerability as a protected characteristic, and in any event, better statutory guidance from the Equality and Human Rights Commission about how clinically vulnerable people should be protected in society under existing rules.

To conclude, CVF are grateful to your Ladyship for inviting it to participate in seven of its modules, including being core participants in four. We thank your Ladyship and the Inquiry legal teams and the staff in this building for working so hard to make the Inquiry a worthwhile and safe process.

And I thank the team beside me, of hugely committed lawyers, and especially Lara Wong and Dr Cathy Finnis and the rest of the CVF team, who have worked incredibly hard to fight for the people they represent.

From CVF's perspective, the Inquiry's legacy must be bringing to the fore the challenges which clinically vulnerable people faced and continue to face in playing a full part in society, that clinically vulnerable people will no longer need to carry around CO^2 monitors

because clean air and other protective measures will become the norm, not the exception.

Before the pandemic, clinically vulnerable people were invisible. They must never be invisible again. And we hope that your upcoming reports will ensure that and pave the way for clinically vulnerable people to have the safety, support and status which they need and deserve. Thank you.

LADY HALLETT: Thank you very much, Mr Wagner.

Mr Friedman, would you rather go after the break or go now? It's entirely up to you. I think you were told you'd be after the break.

MR FRIEDMAN: (inaudible).

LADY HALLETT: All right, this is Tweedledum and Tweedledee, isn't it? Very well. We shall take the break and I shall return at 11.20.

(11.05 am)

(A short break)

(11.20 am)

Closing statement on behalf of the Disabled People's Organisations by MR FRIEDMAN KC

LADY HALLETT: Mr Friedman.

MR FRIEDMAN: We act for three disabled people's organisations, or DPO, run by and for disabled people. They are Disability Rights UK, Inclusion Scotland, and

Disability Action Northern Ireland.

And we echo the very heartfelt thanks to you and your legal team and those working in and around the building to make this Inquiry possible, and we also say thanks to the DPO, disabled people, and other civil society groups whose Covid experiences could not have been properly understood, had they not been here today and in other modules.

My Lady, you ask what the impact of the pandemic on society was. Can we address you on numbers, meanings, and possibilities, of what we know now that we might not have known at the start of various shocking numbers?

Six out of the ten of the Covid dead were disabled people. Learning disabled people aged 18-34 were 30 times more likely to die. Black people were four times more likely to be detained in hospital under the Mental Health Act. Pre-pandemic, disabled women were three to four times more likely to suffer domestic abuse, and this was before lockdown that provided a frighteningly conducive context and additional ways of committing violence against women and girls.

You have heard extensive evidence about the rise in mental health conditions and diminishment in wellbeing across the whole population, but for disabled people, mental ill health was triggered by material factors.

Disabled households made up nearly 50% of those living in poverty. Those on legacy benefits, unable to work, were not included in the £20 uplift given to those newly unemployed on Universal Credit. For those in work, the disability employment gap and the pay gap both widened. The social care system collapsed, with waiting lists for care plans and reviews of personal care packages reaching hundreds of thousands.

The additional costs of being disabled, in terms of travel, equipment, and assistance, went from over £500 per month to more than a £1,000. And Statutory Sick Pay was one of the lowest in the 38 OECD countries. We paid people more not to work at all -- sorry, we paid people more not to work at all than to refrain from working while they had Covid.

As I say, for disabled people, mental ill health and distress was also triggered by existential factors. Social care provision diminished into life and limb protection. DNACPR notices could be applied without oversight or consultation. Care could be denied on formal or informal frailty scoring. One could die a Covid death alone without oxygen or other medication.

Then there are the known figures of the dead. The 230,000 people, the 43,000 in care homes, the over 28,000 in England and Scotland receiving care in

home. Cumulatively, these were the fourth highest death rates in OECD countries, and, on one reading, second only to Bulgaria, when compared to the other EU States.

Those were just some of the numbers. The core participants and the experts provided vast data on statistical inequality, showing how pre-Covid social vulnerabilities then explosively increased. But numbers do not do justice to individual loss. They do not tell you about the deeper inequity of what those numbers mean or what is to be done. On that, the DPO offer their final observations, starting with what the numbers might mean.

First, this module, more than any other, underscores that Covid-19 was a disaster.

The central feature of disasters is that they revealed how marginalised people were already being treated and indeed how much of society operates, but many of us not in the crosshairs of that reality were not paying attention. Disasters are an awakening, or they should be.

Second, inequalities were the fundamental drivers of pandemic impact. As Chair, you've started the Inquiry determined to investigate inequality. It is now beyond argument that inequalities were the greatest causes of Covid death, suffering, and marginalisation. The

Inquiry's first two reports have, therefore, recommended practical ways to map the human geography of vulnerable people, through risk assessments, national strategies, data and research, and through the leadership of the independent body for a whole-system preparedness.

No one should argue against any of that work, but, third, we can have all the assessments, plans and strategies we want, but tackling root inequality beyond planning for it is the only way to avoid the high levels and death and suffering that occurred in the UK.

Fourth, one of Covid-19's great anomalies is that highly developed industrial economies like the UK saw some of the greatest mortality rates and failures to protect their socially marginalised populations, whereas other countries with less pronounced discrepancies between richest and poorest, or smaller economies or those with more rigorous cultural commitments to collective wellbeing fared better.

What is it about the UK that singles it out? It was amongst select states that have particularly degraded their public health and care systems, based on post-welfare state economic theories. This has created a pernicious divide between people who can afford to pay for excellent care and everyone else.

The anomaly is something of a challenge to modernity

itself. The pandemic's cost, together with other momentous features of globalisation, have made our inequalities even greater. The asymmetries of wealth, health, and death, pose a significant threat to social cohesion and shared humanity. Some sections of society, who can afford not to think about that, would sometimes rather move on.

But this Inquiry has heard from public servants, experts, and ordinary people who want to live differently, and who do not want how differences of fate to extend to how we die, how we grieve, and to basic respect for human dignity.

For disabled people, that means not going back to the old normal. To that end, there are features of Covid's impact on society that do hold out possibilities for things being different.

First, disasters, for all their terror, are teachers. Rather than panicking, communities came together. They did not loot or riot. They filled the gaps in public services, collected the data that we now rely on, told the stories that were not being heard. Even in grief, the Bereaved Families started organisations that helped others far beyond their own suffering.

These features of disaster with far greater emphasis

on cooperation, offer the possibility of collective resilience. Instead of just expecting them to arise, government in conjunction with civil society need to work out how to make them part of everyday life.

Second, consultation is not the same things as participation, or as Professor Watson puts it: co-production means asking, "How should we solve this problem?" Not "This is what we're going to do, what do you think?"

My Lady has made recommendations about broadening the way in which political representatives and technical experts must consider the potential impact of emergencies on vulnerable people, but you have not yet taken the step to reflect the disability rights requirement, to mandate authorities to actively involve and closely consult with the organisations run by and for disabled people, just as it should do so with the various domestic abuse groups, migrants' rights groups, and Bereaved Families.

The as yet unrealised possibility is that people can move from being consumers of policy to producers, from recipients to participants, from subjects to greater equals. It makes for better governors and better citizens. But it also needs to be funded. To treat it as charity is to demean its value, and to rely only on

the established large charities is to avoid the change that is needed.

Third, what we are urging is not just the now obvious need to improve data collection, but an evolution in the way in which a society generates knowledge about itself. There are practical ways to do this, including developing monitoring mechanisms, but importantly, the failure of basic human accounting in policy making was too extreme to believe that it can be corrected by conventional bureaucracy alone.

The ways of knowing the world that only come from the experience and quality of governments and experts is heavily diminished without the lenses that those with lived experience provide. The recommendations currently call for expanding the pool of experts, but the representative groups need to be brought into the room.

Fourth, intersectionality is not jargon. It is the description of how marginalisation can accumulate, and a method for appreciating gaps in our knowledge of each other and ourselves.

Almost every aspect of the pandemic's impact was experienced through intersectional inequalities. But the capacity for an external observer to see that, or for a disabled person to feel that they can trust decision makers to consider things like their sexuality

or race, are still in the foothills.

The concept is often improperly maligned as identity politics. Intersectionality overcomes identity politics. It helps us to see differences and connections in a deeper way. It requires reflection in data collection and representation.

Fifth, change is needed at the institutional level. This is why the concept of institutional discrimination is important, because it deals with bias, education and culture.

An organisation that does not have contact with marginalised people as equals will likely compound the marginalisation. No institution should be above this self-critique.

What the Inquiry has already found about the culture in Number 10 Downing Street, where the most qualified and accomplished of women were treated as they were, is indicative of how strongly an elite, invulnerable, male version of personhood continues to prevail. It is good for no one.

Finally, disability rights have a role to play for all society. Compassion cannot depend on benevolence alone. Enforceable human rights matter. Disabled people need to be seen as active and equal citizens. Recognition of their inherent dignity must be treated as

an entitlement. Our present anti-discrimination laws are not enough. There must be positive obligations to resource disabled people with support and assistance to be amongst us as equals.

Our final advocacy is, therefore, for the United Nations Convention on the Rights of Persons with Disabilities. My Lady, human rights are about kindness, especially kindness to strangers beyond our immediate concern. They legislate for the inescapable human problem that we might offer that kindness, but we cannot be relied on to do so. We want to care about disabled people, but if, in the words of the Module 2 report, disabled people were more likely to be living in poverty, inadequate housing, at greater risk of sexual and domestic violence, older, dependent upon health and social care services, then, say the DPO, disabled people will always be elected to suffer most in a disaster.

If we could sum up, in a single sentence, of what can be learnt from all of the evidence of this Inquiry, it is that our political and social arrangements are compromised by an essential problem with the golden rule of faith and ethics: we do not necessarily do unto others as we'd have them do unto us when we do not or cannot conceive of being in their position.

Human rights are the practical means to bridge that

gap. They are tools to rethink democracy as a system to support people as they try to live more humane and caring lives.

This is the Inquiry that can champion that change. All of these groups need a person with my Lady's position in law, and now with your investigation of the most significant disaster of our time, to make the case. The opportunity lies with you. If you take it, it will be up to others to follow on.

LADY HALLETT: Thank you very much indeed, Mr Friedman. Very grateful.

Ms Davies.

Closing statement on behalf of the Domestic Abuse Group by MS DAVIES KC

MS DAVIES: My Lady, thank you very much, I'm told it's a dodgy microphone.

My Lady, as you know, I represent the Domestic Abuse Group with Marina Sergides and Angharad Monk, and we're instructed by Public Interest Law Centre.

The Domestic Abuse Group consists of three organisations within the violence against women and girls sector: Southall Black Sisters, Solace Women's Aid, and Latin American Women's Rights Services, and their director, Gisela Valle, gave evidence last week before you.

My Lady, your Module 2 report found that lockdown and other non-funeral interventions were necessary in order to deal with the virus. We agree. You also found that government was unprepared and did not consider the impact of those NPIs. These three weeks of evidence give the Inquiry the opportunity to make recommendations on lessons learned so that, next time, government makes decisions at an early stage, both on measures to control the virus, and seeking to mitigate the negative impact of NPIs. In other words, next time, there should be smart measures or a smart lockdown.

We ask you to find eight negative impacts as far as domestic abuse was concerned, and today we suggest five principal recommendations on lessons learned. More detailed recommendations will be in our written submissions.

First, lockdown led to a rise in domestic abuse. Both in new cases and in its frequency. That evidence is contained in the Domestic Abuse Group's Rule 9 statement, in the roundtable on domestic abuse and safeguarding report, and in Dr Wenham's expert report.

As far as new cases are concerned, Ms Valle, when she gave evidence, spoke of a continuum. Lockdown created the conditions where power and control dynamics are able to flourish and able to be exerted.

My Lady, you are aware of the discrepancy between police statistics and those from the domestic abuse organisations, with there being a myriad of reasons why women are reluctant to report to the police. Despite the police statistics, there is clear evidence before you that domestic abuse levels rose significantly.

Secondly, the domestic abuse organisations noted an increase in the severity of abuse reported to them. They give examples such as more weapons, including knives, being used, women subjected to severe sexual assaults, including rape. So, women approached domestic abuse organisations with more complex mental health needs, more women had self-harmed or had suicidal ideation.

Third, perpetrators developed new forms of abuse, exploiting the particular circumstances of the pandemic and lockdown, including threatening or actually infecting victim-survivors, deliberately coughing on them, controlling access to technology and communications, controlling access to healthcare services or to food.

You will recall the case of an older woman whose husband did not allow her to leave the house. She finally found help when, at her vaccination appointment, the vaccinator recognised signs of domestic abuse.

Fourth, the "stay safe, stay at home, protect the NHS" message was not the right message for victim-survivors of domestic abuse. Against the backdrop of strong "stay at home" messaging, harm was construed as virus related, not the harm of abuse. It was not clear that the victims could lawfully leave their homes in order to escape abuse. And indeed, that slogan actively deterred them from leaving, and information that was available was not translated into other languages or into BSL.

Fifth, this increase in domestic abuse took place in the context of existing structural inequalities for women as described by Dr Wenham. And it's important here to make the point that domestic abuse predominantly happens to women, which is why I've been saying women, and that there are further existing structural inequalities that affect different groups of women and I'll focus here on just two groups although there are more that we shall address in written submissions.

Disabled women. You've heard from the evidence, Mr Friedman has just repeated the statistic, that disabled women were, before the pandemic, three times more likely to be victim-survivors of domestic abuse than non-disabled women. All the witnesses agreed that once social care services were withdrawn and disabled

women were dependent on the care of family members, often perpetrators, they were inevitably at greater risk both of domestic abuse and of being unable to seek help for it.

And migrant women faced a triple threat: of the risk of the virus, the experience of domestic abuse in lockdown, and the fear of immigration enforcement and of destitution if they sought help.

You will recall Ms Valle's compelling evidence when she said that victim-survivors assessed their situations, they're constantly reassessing and making decisions that are best for them, given the circumstances, and potentially, that means that they decide that the best for them is to remain in the abusive situation.

Sixth, along with the risks inherent in locking victim-survivors down with their perpetrators, as a number of witnesses have said, the statutory services were either closed or inaccessible, so that they could not provide services, nor could they point victim-survivors to other help, and Ms Dickie from the Convention of Scottish Local Authorities put it powerfully in evidence at the roundtable. She said, "Not only did we put people in their own homes with a perpetrator, we took all their services away."

Where there were statutory services such as homelessness, you heard the evidence that first, you had to make yourself street homeless in order to access it, and second, that there was frequent use of mixed-sex accommodation or accommodation that was otherwise unsafe for victim-survivors. Participants at the roundtable described the provision of accommodation from local authorities as a postcode lottery.

Seventh, the violence against women and girls sector was left to pick up the strain, consistent with the evidence that you've heard throughout that where the statutory services closed, the voluntary sector step in. Professors Shakespeare and Watson said that about services to people with disabilities as did Dr Hughes from Mind.

They stepped in in the context of years of underfunding to domestic organisations, affecting all domestic abuse organisations, but especially hitting the specialist and the by and for organisations, which include my clients, SBS and LAWRS. The highly motivated workforce rose to the challenge and worked incredibly hard but funding was not immediately made available by government. There were too few refuge spaces.

There was confusion about whether frontline workers in the sector were key workers with access to childcare,

PPE and vaccination, and as a result, that workforce experienced moral injury, akin to that experienced by emergency responders as described by Dr Hughes.

There is now a continuing problem of burnout and a crisis in retention among the workforce, which is predominantly a workforce of women, and in the case of by and for organisations, women from black and minoritised groups. The underfunding of the sector continues today, which raises the question as to how well equipped it will be to face a future pandemic.

And eighth, consistent with evidence you've heard about overall decrease in mental wellbeing, and increase in mental illness during the course of the pandemic, the combination of intensified abuse, isolation from support networks and reduced access to mental health services created a perfect storm of psychological distress that continues to affect some victim-survivors today.

Those are our headline points for your findings, and you'll know that there are more detailed and nuanced discussions of those points in the evidence.

So, how would government go about a lockdown that mitigates, so far as is possible, these negative impacts? In summary, first, government should be planning early, with the full involvement of the frontline violence against women and girls sector,

including the specialist and by and for organisations.

Ms Valle described the massive struggle getting our data across to government departments, particularly given that the police data reaching decision makers wrongly indicated that there was no increase in domestic abuse.

There must be early funding of refuge places and of frontline services including the specialist organisations and the by and for services, and there must be a recognition that violence against women and girls workers are key workers.

Second, we suggest that government establishes at an early stage an external advisory body to advise on social implications of public health measures throughout the period of the pandemic. A social policy equivalent of SAGE. Domestic abuse should be part of that, and the membership should include not only the Domestic Abuse Commissioner but also organisations delivering services on the front line -- again, including the specialist and the by and for organisations.

Third, it is essential that clear and consistent messaging specifically uses the words "domestic abuse". "Escaping injury or harm" is not clear enough in the context of a pandemic. And that messaging explains where a victim-survivor can seek help, including whether

she can go to family or friends.

The messaging should be communicated early, as soon as the possibility of lockdown is announced. It should be distributed through a multiplicity of channels, translated, and available as widely as possible.

Fourth, statutory services must continue during a pandemic with the possibility of in-person appointments for those who need them. You've heard extensive evidence about digital exclusion, and also that control of communications is a form of domestic abuse. Guidance should be given to housing services to identify any available empty properties for emergency accommodation, both for the homeless and for those leaving domestic abuse or leaving refuges, and that is what happened in Scotland.

Fifth, in a pandemic, public health measures must take priority over the immigration enforcement agenda. The government recognised that when it provided for Everyone In, as it was known in England, so that rough sleepers were accommodated regardless of immigration status. That was an essential public health measure. We submit that the same public health principle applies to no recourse to public funds, to healthcare charging and data sharing with the Home Office.

Suspending no recourse to public funds prevents

destitution and it prevents victim-survivors from being deterred from leaving abuse. It also provides clarity, both for victim-survivors and for those providing services for them.

As far as the health charging regime is concerned, you've heard evidence from Ms Valle and Ms Humi that it is immensely complex and operates as a deterrent for migrants seeking healthcare, and so puts their own health at risk and puts at risk the health of those in contact with them.

For migrant victim-survivors of domestic abuse, being deterred from seeking healthcare for the physical or mental consequences of domestic abuse is particularly concerning. Providing for an exemption for Covid-19 treatment does not overcome that deterrent. The deterrent can only be overcome with clear, consistent rules, well publicised, that during a public health emergency NHS treatment is available to all.

Clear, consistent, simple and well-publicised messaging in a public health emergency has been a theme throughout the Inquiry, and applies equally to the plethora of complex regulations that govern migrants' access to public funds and healthcare. We say the principle of Everyone In should be applied to no recourse to public funds and healthcare charging, so

that, in a pandemic, public funds and free healthcare should be available to all as an essential public health measure.

You heard evidence from Ms Valle that a victim-survivor who believes that her data is going to be shared with the Home Office is deterred from reporting crime to the police, or from going to hospital, unless the situation is very high risk. The government is already considering a firewall preventing the police from sharing information with the Home Office in cases of domestic abuse, and we say that this should apply generally throughout a pandemic.

During the pandemic, there were widespread calls for the suspension of no recourse to public funds, including from the Local Government Association, the Domestic Abuse Commissioner, the Victims Commissioner, Liberty, and the Mayor of London, as well as the violence against women and girls sector. There were also calls from the Chief Medical Officer and from the Royal colleges of the different medical specialisms for the suspension of healthcare charging.

The reason why those respected organisations and individuals made those representations was that suspending restrictive measures in a pandemic is a necessary public health tool. It protects the health

of victim-survivors of domestic abuse, and the public in general. The evidence before you, my Lady, supports that submission and we hope that you will accept it.

My Lady, I end with this: for obvious reasons, victim-survivors have not given direct evidence before you. Twenty-nine of their stories appear in our Rule 9 statement, and I will end with just two of them.

Josephine had been in touch with Solace Women's Aid before the pandemic. She'd been subjected to serious physical assaults and had left her perpetrator. When lockdown started, she lost touch with her key worker. She had moved back in with her abuser, feeling that she had no choice as she needed to protect a vulnerable family member who was shielding. She was a key worker and she feared infecting her family member.

Having moved back in, the abuse escalated. She felt trapped and she contacted SOLACE again within a few weeks of lockdown, but from A&E.

And Jenny, who had no recourse to public funds. Before the pandemic, she was abused by her ex-partner, and that abuse included threats and being locked inside or outside her home. She was eventually thrown out of her home by her ex-partner during the pandemic. She was homeless and she was sleeping rough. She said, "No one wanted to take me in, it was too risky for people."

Her abuser would use her lack of status against her. He would say, "Where would you turn to? No one would care." And those fears had kept Jenny trapped for years.

My Lady, you've heard a great deal of very distressing and harrowing evidence over the last few weeks, and you are reflecting on the lessons learned, and it's your opportunity to make recommendations. We ask you to make recommendations so that in future pandemics, those experiencing domestic abuse are not left trapped, isolated, lonely, frightened, and abused.

Thank you very much, my Lady.

LADY HALLETT: Thank you very much, Ms Davies.

Ms Weereratne.

Closing statement on behalf of Migrants' Rights Consortium by MS WEERERATNE KC

MS WEERERATNE: Thank you.

My Lady, as you've heard, the Migrants' Rights Consortium, or MRC, is composed of nine organisations representing the rights and interests of migrant people in the UK. It consists of five charitable organisations, the Joint Council for the Welfare of Immigrants, Kanlungan, Project 17, Together with Migrant Children and JustRight Scotland, two humanitarian medical organisations, Doctors of the World UK, Medact,

and two trade unions, United Voices of the World and the Independent Workers' Union of Great Britain.

As everyone else has, the MRC sincerely thanks your Ladyship and the Inquiry team for giving them the opportunity to participate in this module and to give evidence to ask questions and to make submissions.

The evidence in this module has reinforced three central themes relevant to the pandemic's impact on migrants.

Firstly, the impact of the pandemic was not spread equally throughout society. As was recognised by Counsel to the Inquiry in opening this module, those in society who ended the pandemic period living with vulnerabilities suffered much greater harm than those better off. The evidence heard throughout these hearings has reinforced this basic proposition repeatedly. What is undeniable is that the evidence also shows -- I'm so sorry -- that migrant communities were amongst the hardest hit in society.

Secondly, there is a clear connection between immigration control and the disproportionate and unequal impact of the pandemic on migrants. In short, longstanding immigration policy excluding migrants from the mainstream welfare safety net and protective public services, a set of features that only applied to some

migrants, created a population group that was uniquely vulnerable at the outset of the pandemic.

The prioritisation of immigration control over the health of migrants and public health more generally resulted in grossly disproportionate impacts on migrant people.

These impacts are linked, so that migrants experienced more poverty, were at higher risk of destitution and homelessness, were overrepresented in precarious and frontline jobs, were less able to access healthcare and vaccines, and ultimately they were at higher risk of infection and mortality from the disease.

Thirdly, there is the mismatch between the size of the contribution made by many migrant people during the pandemic, many of whom were key workers putting themselves at risk to help society to function, and the recognition given to them.

And not just the doctor, nurse or care sector, but the HGV driver, security or retail or transport worker as well.

This is reflected in the thousands of pages of documents, including expert reports disclosed within this module in which migrant people are infrequently mentioned.

This clearly cannot be because the pandemic did not

impact them severely, but raises an uncomfortable question about how we regard migrant people rendered vulnerable within our society through readily identifiable policy.

The disproportionate and distinct impact on migrants is readily borne out by the evidence. The truly shocking mortality rates are worth repeating. In April 2020, the Health Service Journal, a publication for healthcare leaders, reported that 63% of healthcare worker deaths were of ethnic minorities and at least 83% of those deaths were of migrants. As a result of this data, the authors of that report advised that migration should be considered as a separate risk factor to ethnicity in the pandemic.

This is a recommendation we urge on this Inquiry in recognition of the clear available evidence. For example, Public Health England's June 2020 report entitled "Disparities in Risks and Outcomes" made similar findings, that migrants had significantly higher mortality rates and that migration is a factor that impacts on people's health.

Moreover, the government was clearly on notice of particular dangers for migrants through immigration law and policy. They'd been told as much, in terms, by the Independent SAGE group in a report dated 3 July 2020.

The report called for the removal of NRPF conditions and the MRC's organisations also had written time and again to the government to notify them of the devastating effects on migrant people in the UK.

Despite these clear warnings of the risks facing migrants at the outset of the pandemic, government did little or nothing to mitigate them. And no official data was gathered in respect of migrant mortality rates. Migrants remained excluded from public funds and barriers to health care remained. The only reasonable conclusion, which we invite the Inquiry to draw, is that immigration control was prioritised over public health.

In her oral evidence, Francesca Humi, for the MRC, also underlined the startlingly high mortality of migrants, particularly of nurses of Filipino nationality. She referred to Kanlungan's research during the pandemic which showed that Filipinos represented an estimated 22% of deaths of NHS nurses while comprising only 3.8% of the nursing staff population.

The disproportionate impact of the pandemic on migrants in the UK, and that they would be amongst the hardest hit, was clearly predictable. The starting point is clear: the lower the socioeconomic position in society, the greater the adverse consequences during the

pandemic. This pattern has been evidenced in all previous pandemics, and it is the overarching finding of the research of Sir Michael Marmot. As he repeated in his oral evidence in this module: the greater the deprivation, the higher the Covid mortality; deep-seated inequalities in society lead inextricably to inequalities in health.

Many migrants entered the pandemic in a position of poverty and vulnerability. Their low socioeconomic status in society is framed and fashioned by measures of immigration control, including the range of measures broadly known as the hostile environment, which exclude migrants from the welfare safety net, which create barriers to accessing health care and other protective public services and push migrants into insecure, low-paid, poor-quality jobs.

And in his oral evidence Professor Nazroo confirmed that the evidence was reasonably clear that immigration control and the hostile environment measures led to and explained unequal infection and mortality in ethnic minority people who are also migrants.

Moreover, the mitigations insofar as they existed were insufficient and unevenly applied. Take access to health care. During Francesca Humi's evidence, Counsel to the Inquiry posited whether the exemption of Covid-19

from the healthcare charging regime could be seen as an example of the government considering the effect of the pandemic on marginalised communities. However, as Ms Humi's evidence made clear, the exemption, Covid-19 was added to a list of communicable diseases pre-dating the pandemic, was largely ineffective. It was not clearly communicated and any secondary healthcare needs arising, for example a long-term disability or Long Covid, were not covered.

Significantly also, Ms Humi explained how the long-term erosion of trust through the ongoing sharing of data between the health, agencies and Immigration Enforcement agencies could not be undone merely by adding Covid to the list of exempted communicable diseases.

Similarly, the Everyone In initiative, which has already been mentioned. The MRC shares the concerns expressed by Shelter that the guidance from government was unclear, and that the initiative was unevenly applied by local authorities as a result. We agree with Shelter that the initiative did not prioritise needs over immigration status, as had been suggested in the Housing Roundtable report.

Or take change of visa condition applications for those with NRPF. The evidence shows that the number of

applications increased by 566% between April and June 2020. However, the application process was complex, the evidential requirements onerous, and it was difficult to complete without legal support.

There was also an inevitable delay while an application was considered, during which time applicants would face the full consequences of their destitution.

In short, my Lady, the evidence before the Inquiry in Module 10 shows a distinct and unmitigated risk facing migrant people during the pandemic which resulted from immigration control, and which did not apply to people from ethnic minority communities who were not migrants.

In the time remaining, we would like to highlight six aspects of immigration control whose impact was most damaging and dangerous during the pandemic.

First, exclusion from public funds meant no welfare safety net. Ms Humi's evidence made clear those subject to NRPF run to millions of people. It does not take a leap of imagination to see how excluding them from the mainstream welfare system would inevitably make them more vulnerable in a pandemic.

Like anyone, migrant people experience health problems, housing problems, financial problems, or problems with their families, including domestic abuse.

But when such problems arise for migrant people, they do not have the safety net which supports the rest of us in society, and the consequences are devastating.

Take the example of Emanuel Gomes, described by Francesca Humi in her evidence. He was the agency cleaner working at the Ministry of Justice. In April 2020 he got ill with suspected Covid, but he couldn't afford to go on sick leave so, instead, kept on working. It was reported by his colleagues that he hadn't eaten in the five days before he eventually died, and after a shift.

Secondly, without a welfare safety net, groups of migrants were pushed into ongoing poverty. Asylum seekers are prohibited from working and are ineligible for mainstream benefits, including the £20 uplift to Universal Credit. By contrast, asylum support payments were increased by just £1.75 per week in June 2020, and by a further 3p per week in October 2020.

This meagre uplift was not capable of meeting the increased costs caused by the pandemic, including the need for essential health items such as masks and hand sanitiser.

Moreover, destitutes asylum seekers relying on the state for accommodation were often moved at short or no notice into hotels, where they were unable to cook for

themselves and unable to socially distance. For those in former army barracks, such as Napier and Penally, the situation was even worse, and the virus ran rife. Almost half of those at Napier contracted Covid in January and February 2021.

Thirdly, the Inquiry has heard about the exclusionary effects of the healthcare charging and data sharing regimes and barriers to GP access, which exacerbated the effects of the pandemic.

Under the charging and data sharing regimes, NHS staff effectively became immigration officers, a role for which they are neither suited nor trained. Mistakes were made in charging and data sharing. Migrants were either wrongly shut out of healthcare and the vaccine, or were often too afraid of immigration consequences to access them in the first place.

Fourthly, the linking of visas to sponsoring employers. As Professor Nazroo said in his evidence, immigration status was used against migrant employees. They were coerced into working in unsanitary, high-risk environments, and when unwell, for fear of losing their visas.

In turn, precarious employment led to both greater individual risk and greater risk to public health generally, when people who were ill continued to work.

Fifthly, immigration control did not stop during the pandemic, and the MRC agrees with the evidence of ILPA and others in the Justice Roundtable on the lack of clarity around the visa concessionary schemes introduced by the government.

Moreover, delays in backlogs in immigration and asylum decision making that were chronic and predated the pandemic were exacerbated during it. Migrants were in limbo for longer and some migrants were destitute for longer.

Finally, immigration detention. Those within the detention estate are inherently in a position of extreme vulnerability, and this has been reinforced by evidence from the Prison Reform Trust, the Howard League and HM Inspectorate of Prisons on the dire conditions within prisons. Whereas the evidence was that some of those problems were less evident in immigration removal centres, IRCs, which did not suffer with as much overcrowding, the problems of isolation remained. Bail for Immigration Detainees' important evidence shows that, in IRCs, many migrants were at higher risk from Covid-19, and many exercised from isolation, social isolation, and worsening mental health.

The impacts of these immigration controls on mental health were severe. Immigration uncertainty was often

reported to outweigh even the fear of the disease itself.

My Lady, to conclude, as Dr Bécares said in her oral evidence, without a focus on the causes of inequalities, there are no lessons to be learned. The MRC is concerned that there has been little if anything thus far about the perilous relationship between immigration control and the unequal impacts of the pandemic on migrants. This makes the work of the Inquiry all the more important, and we urge your Ladyship to make recommendations that address these vital concerns.

We ask that the Inquiry recognise the distinct and unequal impact of the virus on migrants. This is one of the key lessons learned.

However, a recognition, while important, is insufficient in the absence of action. And with this in mind, the primary recommendation sought by the MRC is to prioritise public health over immigration control. And this necessitates removing or at the very least suspending the measures excluding migrants from accessing protective public services, including, in particular, the hostile environment measures and NRPF.

The preference of MRC is for the removal of these policies.

So in short, my Lady, unless this is addressed, it

is entirely foreseeable, we say, that the disproportionate, devastating impact on migrants will be exactly the same in any future pandemic, immigration law and policy which exclude and deter migrants from protective public services during a pandemic.

Thank you, my Lady.

LADY HALLETT: Thank you very much.

Mr Westgate.

Closing statement on behalf of Shelter by MR WESTGATE KC

MR WESTGATE: My Lady, I act for the housing and homelessness charity Shelter, instructed by Rob Brown.

Shelter is grateful for the opportunity to participate in this module and, as newcomers to this process, we particularly thank you and your Inquiry team, both legal and non-legal, for the help and cooperation we've received.

In our opening submissions we noted a large measure of consensus, including about the state of housing at the start of 2020, and how that impacted on the way the pandemic was experienced. The evidence you've heard, and the submissions you've received, broadly confirms this and in the light of that, our submissions necessarily go over some old ground.

We'll try to draw together some of the detail in our written submissions, but for the present, we focus on

four themes: firstly, housing availability and conditions; secondly, how the pandemic impacted on homelessness; thirdly, rough sleeping and Everyone In; and then fourthly, protections from evictions.

But before coming to these, we acknowledge the burden that was assumed by workers and volunteers throughout this sector, and recognise their dedication and hard work. In the time we have now, we end up headlining the shortcomings, but it's important to remember there were successes and much good practice too, and what we have to say doesn't diminish that.

So on the state of housing, many witnesses speak to a chronic and longstanding lack of decent, affordable housing. Ruth Power aptly referred to dysfunction within our housing system and the risk of homelessness being a feature of it. Were it not for this lack, then pressures that caused people to lose accommodation wouldn't result in long-term homelessness because there would be alternatives available. And for the same reason, if they had to apply as homeless, then any stay in temporary accommodation would be short.

As it is, the position now is as it was in 2020: there's a desperate shortage of social housing to rent, and the roundtable referred to years of underinvestment. The private rented sector can't make up for the lack

because rents are so high as to make it inaccessible for anyone without sufficient means, and benefits lag behind rents.

The Inquiry has acknowledged the unequal impact of the pandemic, and it's also heard that poor housing and insecure housing is an indicator of deprivation. It contributes to, and reflects, the overlapping impacts of multiple disadvantage, what Dr Hughes for Mind described as a "spiral of adversity".

During the pandemic, the impact of poor and unstable housing was magnified in a number of ways, each liable to have a grave impact on health and wellbeing. Any loss of income made keeping a home harder to afford, increasing the risk and fear of homelessness. People on low incomes or with precarious jobs, often migrant workers, were especially vulnerable. 14% of those with no recourse found themselves in difficulty with their mortgage or rent, compared to 2% of the rest of the population.

During lockdown, a home that ought to be a place of refuge was liable to feel more like a place of confinement. Shelter's evidence has focused particularly on temporary accommodation but this applies more generally. Sometimes conditions had a direct link to Covid risk, particularly overcrowding, which is

higher in the social rented sector, and is strikingly so among some minority ethnic groups, and may have contributed to higher mortality risk.

Defective housing made living through lockdown much harder to bear. 3.4 million homes failed to meet the Decent Homes Standard with a high incidence of damp and serious hazards, especially in the private rented sector.

Even in the absence of disrepair or similar housing defects, so much accommodation simply didn't meet the needs of occupiers. One study referenced by Dr Pauline Nolan showed that 21% of people with disabilities reported harm to their wellbeing as their homes were inaccessible. It is again this background that Shelter has invited the Inquiry to recognise housing stress as a distinct and significant contributing factor to the adverse impact of the pandemic. Averting it demands concerted investment in the social sector to increase the supply of suitable and truly affordable housing.

Turning to the impact on homelessness, services were already under immense pressure with people in temporary accommodation at what was then the highest level ever. The numbers in temporary accommodation rose during the pandemic, and it was used for extended periods, including in lockdowns, with one in six households being

in emergency bed and breakfast or hotels. We highlighted some of the hardships caused in our opening submissions, and none of the evidence you've heard alters the overall picture, we'd suggest.

Occupiers had to share facilities in a way that was and felt unsafe, and where social distancing was challenging. Many had to endure a lack of basic facilities for preparing and cooking food, washing, or laundry. At the same time, they were cut off from the support of family or friends. Unsurprisingly, Shelter's own surveys found damage to health and wellbeing to be the result.

There were also challenges in accessing homelessness services. Whereas conventional evictions through court proceedings slowed to a near standstill because of other measures that were taken and so were less likely to be a cause of homelessness, there was an increase in the breakdown of informal arrangements, such as sofa surfing, exposing the extent of what has been described as "hidden homelessness".

There was a similar rise in presentations because of domestic abuse, up 14%, as explained by Professors Bambra and Marmot. Both were more likely to affect women, and among these groups there were the hidden homeless who remained hidden because they were not able

to leave or access services and remained in abusive or unsafe situations. You've heard about particular concerns here developed by the Domestic Abuse Group and the Inquiry also heard evidence of people having to stay in households where they were exposed to threats or belittlement because of their sexual orientation or gender identity.

Much delivery of services went online and there's substantial evidence that whilst some found this easier, it wasn't suitable for everyone. Some couldn't use the technology, while others couldn't access wi-fi, including because places where they did so formerly were closed.

Some authorities adopted an unusually -- unduly flexible approach -- inflexible approach, without an in-person option, as shown by the examples given in Shelter's briefing exhibited to Mr Gutteridge's statement.

Moving on to Everyone In, you've heard a lot about this and we will deal with it in writing, but for now we make three points. Firstly, Shelter does maintain that a defect to the initiative was that it didn't make clear that people ought or even could be accommodated despite their immigration status, and that this caused confusion that needed a decision of the High Court to resolve.

If the roundtable report means to say something different, then we respectfully disagree, and we rely on Shelter's evidence that people were turned away for this reason and on evidence you've received from the LGA and others, including on behalf of the Migrants' Rights Consortium and the Domestic Abuse Group.

The apparent difference may in fact be more a matter of emphasis and timing. The initial letter in March 2020 was inclusive, but doubts and refusals soon arose, and the subsequent departmental letter, which is cited by Mr Gutteridge at paragraph 34 of his statement, was ambiguous. And indeed, much of the problem may have been that the initiative was promulgated informally by letters, leaving its status unclear and making it open to interpretation, and greater clarity would have been needed.

Whatever the position, there's a clear lesson here. We've highlighted the need for there to be a mechanism to disapply no recourse provisions in times of emergency, where it may be necessary to provide accommodation to those who wouldn't otherwise qualify.

Shelter continues to advocate for this, and indeed its position is that nobody should be denied support as a result of their immigration status, if that would mean they have to sleep rough. The need for shelter is as

important as any other emergency health service.

But it's clear, having heard the evidence and submissions, that this wouldn't be enough on its own. Firstly, it would need to be accompanied by a firewall, so that information about status should not be passed on or used for immigration purposes. Without it, people at risk may feel they'd rather take their chances on the streets.

Secondly, there needs to be a better publicity, or support will not reach those who may need it most. As Francesca Humi explained, messaging about the initiative didn't reach Kanlungan, the organisation she worked with.

The second point we make about Everyone In is that it highlighted the need for effective co-working between homelessness and health services. This was a pressing issue for former rough sleepers, who may come off the streets with mental health or substance misuse issues, and could be left without the support they needed.

This was recognised at the time and raised in the roundtable. You heard from local government witnesses across the UK about this. They reported there was a challenge to ensure wraparound support or to ensure that placements had appropriately trained staff. And that lack may -- and given the data we put it no higher

than this -- have been associated with an increase in what have been referred to as "deaths of despair" among the homeless.

The third point we make about Everyone In is that it's important not to lose sight of how much of an achievement it was, despite the problems we point to. And that achievement itself is a lesson about how to prepare for any future emergency. There's nothing inevitable or unavoidable about the present level of rougher sleeping, which has again risen to pre-pandemic levels. It's a scandal that can be tackled with sufficient political will, and Everyone In was a missed opportunity to forge a lasting solution.

Shelter Cymru's evidence is instructive here, because Wales has taken steps to remove the priority need filter, which would mean that applicants would no longer be denied a full duty because they're not vulnerable enough.

This isn't an inquiry about ending street homelessness but the health hazards about rough sleeping can't be disputed. If nothing is done, then that's a choice. And the choice will be to maintain, at great human cost, a population at special risk in any future pandemic.

Our last theme is the mitigation measures regarding

possession proceedings. Mr Gutteridge was asked about these, and Shelter later provided additional detail, which the Inquiry will have. In broad terms, and with some exceptions, these increased notice periods for most residential tenancies, together with stays on possession proceedings and evictions. And Shelter recognises that these were important and necessary protections that stop many evictions during the pandemic.

The key qualifications we have are twofold: firstly, it should be recognised that these didn't protect everybody. There were exceptions for some possession grounds, and the limits on notices applied to tenancies that were already subject to statutory control, although they also included people subject to no-fault evictions.

They didn't apply to licencees. The stay applied to all possession proceedings, but not every occupier is protected from eviction without a court order, for example, people who share accommodation with a resident landlord. And these include vulnerable groups like sofa surfers or domestic workers. And in any case, unlawful eviction still continued.

Secondly, the protection was temporary and there was no protection against rent arrears incurred because of the pandemic. Once the stay came to an end, occupiers were again vulnerable to action, including that based on

those rent arrears.

Finally, in opening we made some suggestions about other recommendations and lessons to be learned. We'll come back to this in writing, but one point we made was that future planning should listen to those with lived experience, and it is right to end with one such voice.

This comes from a survey conducted by Shelter, and in answer to a question about one thing respondents would want people to know about their experience of being homeless during lockdown.

"The mental is what's really lasting. The physical you can, kind of -- you can get over, so to speak, after a while, but the mental is something that will never leave you, and I think it's scarred the three of us."

My Lady, thank you.

LADY HALLETT: Thank you very much indeed, Mr Westgate.

Mr Pezzani.

Closing statement on behalf of Mind by MR PEZZANI

MR PEZZANI: Thank you, my Lady. And my Lady, I make these submissions on behalf of Mind, the mental health charity.

Mind's opening submissions observed that measuring the mental health impact of the pandemic looked like a daunting task. But undaunted, this Inquiry has achieved something of great value in the last

three weeks, and has, we think for the first time in history, started to draw up a detailed map of the depth and shape of the scars left by a pandemic on our society.

There have, of course, been pandemics before, but we don't think there has ever been reflection quite like this.

I mentioned earlier pandemics. Historians still pore over accounts of them. Mind's written opening referred to 2023 research into the effects of the plague in London 680 years ago.

The point is that there is reason to expect that the report produced by this module will become a document used by historians for centuries to come. The people working in this building today are creating a record that will long outlive them, and names such as Covid-19 Bereaved Families for Justice will likely be cited in historical studies far into the future.

Those future historians will see, especially from Module 10, that we as a society cared not only about what the panjandrums of the day said and did, but also about the predicament of those who were nowhere near the levers of power.

So, one of the best things that can and should be said about this Inquiry's approach to its remit is that

it didn't flinch from examining what our society really looks like. That as well as looking behind the door of 10 Downing Street, it chose to look at diagrams of Victorian prison cells, and tried to understand what was happening behind the closed curtains of a person with bipolar disorder in the spring of 2020, wondering how they were going to make it through the night, having not seen their community nurse for a week.

That approach is something of which this Inquiry should be proud, and perhaps represents a noble reason for deferring a well-earned retirement.

What should the records say?

LADY HALLETT: I'll forgive you that, Mr Pezzani.

MR PEZZANI: Thank you.

What should that record say? In relation to mental health impact, Mind identifies the following six themes which represent a broad overview of important lessons from this module, and which will be developed in more detail in its written submissions.

First, the value of the VCSE sector. This Inquiry has been beset by acronyms, and here is another one. It means voluntary charity and social enterprise, but what it really means is networks of people who see that something needs to be done in their community and resolve to do it.

Many have provided evidence in this module. The quality of their evidence, the value of their insight, derives from their experience of providing help to local communities of which they are a part. From local Minds, to Shelter, to the Good Things Foundation, all volunteered themselves for the front line during the pandemic. They are well placed to understand impact. And they were, are, and will remain, well placed to operate to the benefit of the communities which they understand. They will be there when the next pandemic hits.

Mind thus urges this lesson to be learned: the VCSE sector will be an indispensable resource not only during the next pandemic but also before it.

In relation to the "during" part of that proposition, recall the evidence, please, of Ms Allen for the Welsh Local Government Association, who said:

"I think if we're honest with ourselves, the voluntary community sector were out of the starting blocks before the public sector was. I think we have all have said that in previous modules. But I think it speaks to the point that you can't always assume that the sector will be present to be able to respond in the way that you may need it to, in a future emergency, if you don't continue investment. It would be remiss of me

[she said] ... not to say that that sector is constantly facing difficulties, financial difficulties, in terms of their core presence."

You may recall Dr Hughes's description of how local Minds tried to step in to fill gaps in local services, particularly at the beginning of the pandemic, to people with serious mental illnesses.

And in relation to the "before" part of that proposition that I mentioned, Mr Norris for the English LGA, when asked by Ms Rahman, King's Counsel, whether the importance of partnership with the voluntary sector was a particularly important part of his lessons learnt, said:

"Yes, it is. I mean, local authorities rely heavily ... on their local voluntary sector partnerships and that's an important part of ... the lesson that we've learnt from this is just how important those are when you come to a whole-system emergency of this kind ... in the future."

The CVSE [sic] has a unique understanding of the topography of impact. That understanding should be incorporated into planning for how our society responds to the next pandemic. There is a need for formal VCSE integration into, and parity within, emergency planning structures and for resources to enable those

organisations to continue their work.

Second, this leads into a lesson about planning for impact mitigation. It is a truth universally acknowledged in the evidence to this module that the pandemic and the measures devised to manage it had a mental health impact that was diverse and profound, and a prominent feature of that evidence is an alarming cascade effect, helpfully brought out by Ms Rahman's questioning of Dr Hughes and Professor Osborn. In summary, that cascade looks like this: people with mental health problems presented later to services and/or the services were not there to present to, and/or the services that would have identified deteriorations were so attenuated, for example, if remote services were inaccessible or inapt, that early symptoms were missed.

As a result of that, people's mental health problems deteriorated to crisis. As a result of that, more people need inpatient mental health treatment often by detention, but once they were admitted, the provision of the treatment that justified that detention was challenging, and at the same time, they were exposed to Covid infection risks and were, as people with serious mental illnesses, more likely to be clinically vulnerable to infection and its consequences.

Yesterday's evidence from Mrs Poole provided

a powerful insight into the shape of this impact on people's lives, and on how quickly the spiral can close for those with mental health problems and their families. She and her father and her family were caught in an ineluctable process, a treated mental illness becoming swift deterioration as a result of loss of treatment, becoming detention, becoming infection and then eventually becoming grief on top of grief.

Mind considers this to be evidence of a complex impact that can and should form a lesson for the future. As long as mental health is not integrated into emergency preparedness planning and as long as it is treated as an adjunct at best to public health planning, as long as there is disparity of esteem and a lack of coordination between mental and physical health care then this maligned sequence is liable to reoccur.

You will recall how Dr Hughes's description of how demand for mental health support surged during the pandemic, and her recommendation for planning for that increase. A national mental health surge plan that is embedded within emergency preparedness structures would serve to mitigate the impacts that we have heard about.

Third, that lesson leads to the related lesson of the need to invest in the mental health workforce. They are the ones who are at the forefront of mitigating the

mental health impact of a pandemic and they felt that pandemic impact themselves, including the moral injury described by Dr Hughes. Recognition of impact is a sterile exercise unless it results in the next logical step, endeavouring to reduce it, and that endeavour is equally futile, absent the resources to implement it.

In answer to a question from my Lady, Professor Osborn said that, "There was huge concern about absence of staff because of people having to isolate and to shield, and especially in those early days where we didn't have testing available. So there were large decreases in staff numbers."

And that is in the context of what Dr Hughes described as "a crisis in the mental health workforce with inpatient units often having to make significant use of agency staff."

People are the key. Planning, including surge planning, requires sufficient personnel to implement the plan. Mind does not favour the construction of aspirational castles in the air when envisaging how the mental health impact of the next pandemic might be mitigated and is thus driven to seek a recommendation from -- for an investment in the people who were indispensable to that mitigation. And it is also important to recognise the implication of institutional

self-defeat were this lesson not to be learned. Ms Rahman's skillful questioning of Professor Osborn highlighted that.

There is a sequence again: delayed treatment leading to deterioration in a condition leading to more care and treatment needed over a longer period leading, in this context, to a long-term burden on, or a longer-term burden on health services. It is a repercussive impact. Mind's submission is that investment that enables prompt treatment will defray the institutional and personal costs of delayed treatment, and thus mitigate the mental health impact of future emergencies.

Fourth, mental health impact included failures in statutory rights and rights-based obligations in the mental health context. That would include the Mental Health Act 1983, the Human Rights Act 1998, and the Equality Act 2010. These laws are the product of anxious scrutiny over years, enacted with the purpose of ensuring protection of all of us all of the time.

We as lawyers tend to be taken aback when a requirement of primary legislation is simply not complied with, but the pandemic didn't care and in its context, some important statutory duties simply fell by the wayside. Not repealed, just not complied with.

An example is the duty in section 47 of the Mental

Health Act to ensure that mentally ill prisoners who need to be treated in hospital are transferred swiftly. If that doesn't happen, the consequence to the impact on a person in prison who is suffering an acute mental health crisis is deep, and has been recognised by the courts to have the potential to imperil their Article 3 Convention rights. That's why the statutory duty is there. During the pandemic, the peril was higher.

A psychotic episode in a prison cell is scary. More so where you're isolated in that cell for most of the hours of the day. More so again, where that goes on for weeks. And more so again, when mental health support in prison had, as Dr Hughes described, flatlined overnight.

That impact also fell on to prison officers who were forced to try and cope with a scenario for which they were not equipped, and with which our laws say they should not have to cope. But we know from the evidence of the Chief Inspector of Prisons that there were prolonged delays in transfers to hospital, contrary to the requirements of section 47, but also contrary to the duties that we as a society have imposed upon ourselves to ensure the safety of those who are vulnerable and in our custody.

This is but one example of impact on the vulnerable and powerless, those in the lawful custody of the state.

In a different context, Mrs Poole provided another yesterday. Those impacts should inform planning and resource allocation for future pandemics because they should cause us alarm, and because they are now foreseeable. It is said that no one truly knows a nation until one has been inside its jails, a nation should not be judged by how it treats its highest citizens but its lowest ones. Nelson Mandela said that, and he should know.

So should we, now, and so should we judge ourselves.

Fifth, the inequality of impact. Much has been said about this already. We cannot ignore the fact that the pandemic had an unequal mental health impact by reference to a wealth of different statuses, including who you were and where you lived. In relation to mental health, Ms Rahman, King's Counsel, cited to Professor Osborn the statement of Dania Hanif of the Association of Mental Health Providers that in 2020 to 2021 people living in the most deprived areas of the UK were twice as likely to be in contact with mental health services compared to those in the least deprived areas.

Dr Hughes said the pandemic accelerated and deepened inequalities for far too many families, particularly those with comorbidities and with mental and physical challenges. Professor Das-Munshi told Ms Rahman that

black Caribbean and black African people were already known to be more likely to be detained for mental health treatment but that her findings suggested that the pandemic magnified those pre-existing inequalities.

It would be curious if we as a society, having over decades refined laws that promote health equality, were to concede their abandonment in the face of challenge. Equality is not dispensable.

In this context, Mind submits that equality impact assessments must be mandatory and time -- must be a mandatory and time-bound component of emergency decision making and that rapid mental health impact assessments should be embedded into and not merely adjunctive to pandemic responses.

A good precedent is recommendation 8 from Module 2. It recommended a framework to identify "People who would be most at risk of becoming infected by and dying from, a disease, and those who are most likely to be negatively impacted by any steps taken to respond to a future pandemic".

And it recommended the identification of steps to mitigate those risks to those people, and that equality assessments should form part of that framework. The evidence we have heard on the inequalities of mental health impact in this module suggest that expressly

specifying mental health impact as part of that framework would be apt.

Sixth, data and its absence. This is linked to inequality of impact. This module and the witnesses who have given evidence have been repeatedly impeded by absences in data. If we do not seek data about impact on sectors of our society, what does that say about whether we care about what the impact on them was, and what it will likely be in the next pandemic, and on how seriously we take the need to mitigate that likely impact?

In recommendation 5 from Module 1, you recommended the collection of data with a view to measuring the effectiveness of a range of different public health measures, and identifying which groups of vulnerable people are hardest hit by the pandemic and why.

Mind encourages you now to develop these recommendations by reference to the evidence in Module 10, by, first, adding "mental health impact" to effectiveness in the first of those, and, second, adding "pandemic responses" to the second of those.

And disaggregation, of course, is vital. Without it, the data at best -- is at best inaccurate and at worst misleading, and serves to achieve the opposite of its purpose, by hiding the impact on the very people

that it is intended to shine a light upon.

So, in conclusion, my Lady, Mind hopes it will be seen that each of these six themes can most usefully be viewed not as discrete points, but as components of a whole that will, it is hoped, mitigate the mental health impact of future pandemics.

Mind invites you to adopt a fully integrated approach that treats mental health as a core component of emergency planning, equal in weight, urgency and resourcing to physical health protection.

"Integration" really is a watchword. Integration of the state and VCSE sectors, integration of mental health treatment with the wider health and social care architecture, integration of people who are at the margins of society with that society, as part of that society, and integration of data about mental health impact with pandemic planning.

My Lady, those are the closing submissions on behalf of Mind.

LADY HALLETT: Thank you very much for your help, Mr Pezzani. I'm very grateful.

We only have two more speakers, but I think we've probably put enough pressure on the stenographer this morning, so we'll take a break now and I shall return -- sorry, Ms Stober. You're okay for this afternoon, are

you?
MS STOBER: Yes, I certainly am.
LADY HALLETT: In which case I'll return at 1.40.
(12.37 pm)
(The Short Adjournment)
(1.40 pm)
LADY HALLETT: Ms Stober.
Closing statement on behalf of the Local Government Association and the Welsh Local Government Association by MS STOBER
MS STOBER: My Lady, I represent the Local Government Association and the Welsh Local Government Association. This submission is, of course, supplementary and in no way replaces the detailed lessons learnt and recommendations set out in the witness statement of the LGA's chief executive, Ms Joanna Killian, adopted by Mr Mark Norris, the principal policy adviser, and Dr Llewelyn, of WLGA.
In relation to both authorities, the evidence heard by this Inquiry shows that English and Welsh local authorities were not operating at the margins of the Covid response, but at its centre.
Councils acted in place, were rooted in their communities, trusted by residents, and were able to respond at speed. They housed people overnight,

supported those who were isolated or grieving, kept essential local services running, and helped businesses survive, often under intense and sustained pressure.
This response was delivered by a workforce that knew their towns, neighbourhoods, and communities intimately. Local government staff worked long hours, faced increased exposure to risks, and carried significant emotional strain. They adapted services at pace, redeployed into unfamiliar roles, and continued to serve their communities with professionalism and care.
All of this took place after more than a decade of financial constraint. Councils entered the pandemic with reduced capacity, stretched services, and a workforce already under pressure from around 15 years of underfunding.
Despite that, local government stepped up, not because systems were flushed with resources, but because people were committed to the places they served.
The contribution of elected members, whose role may not always have been fully reflected in the written evidence or the discussion before this Inquiry, should not go unrecognised.
Alongside the workforce, councillors provided visible and accountable leadership within their communities. They were often the first point of contact

for residents seeking reassurance, clarity, or support. They relayed local concerns in a decision-making structures, helped shape practical solutions on the ground, and played an important role in sustaining trust between communities and public authorities during a period of fear and uncertainty.
As the Inquiry reflects learning and future preparedness, this evidence points clearly to the value of strong, properly resourced local government.
When crisis hit, it is councils acting in place, alongside communities, that turn national intent into practical support. Recognising that role and funding it accordingly is central to being better prepared for what comes next.
My Lady, I now turn specifically to the submissions of the Local Government Association.
Lessons learnt and recommendations.
There are many lessons to be learnt from the experience of local authorities during the pandemic which Ms Killian explains in detail in her witness statement. The Inquiry is asked to consider each of these, and how it will -- it could adopt them in its final report on this module.
In addition, throughout this Inquiry, the LGA had identified a range of lessons learnt from the experience

of local authorities during the pandemic that would place the country in a better position when it faces a whole-system civil emergency.
Drawing on the evidence the Inquiry heard in this module, the LGA would ask the Inquiry to note the following: councillors and council staff live and work in communities they serve and represent. They understand best the needs of their communities. While central government sets the strategic direction of the response, it needs to trust in the knowledge and expertise resting at a local level to deliver the outcomes that protect and safeguard communities and individuals. The Inquiry has heard this point from the LGA in relation to previous modules but also from other evidence during this Module 10. It means that national plans and responses to any future pandemic must be developed and co-designed with local government and other relevant local and national bodies, including the voluntary and third sectors.
The definition of key workers must be agreed upon with local authorities ahead of a future pandemic, and this should take into account vulnerabilities from financial hardship arising from lockdown.
In this module, the Inquiry has heard about the impact of the Everyone In approach to protecting the

homeless and other vulnerable groups. It has also heard about the difficulties local providers encountered when responding at pace to provide people with temporary accommodation. The LGA agrees with the points other witnesses have made during this module about the issues created by the lack of social housing, if we are to be better placed to respond to a future pandemic.

Learning, therefore, from the Everyone In approach, plans must be made for the greater provision of social housing, thereby avoiding issues with access to move-on accommodation, particularly taking into account mental health and addiction needs, and needs arising from the no recourse to public funds.

The Inquiry also heard about the value local communities placed in being able to use the open space and cultural and sporting facilities provided by councils, in terms of both physical and mental wellbeing. There needs to be greater equality of access to cultural and sporting activities in a future pandemic, with greater capacity to access activities that support mental health and wellbeing. Again, that requires a commitment to invest in and sustain these important resources going forward.

Plans to ensure funerals take place safely must be made, including the provision of PPE and vaccinations to

relevant council staff. This requires consideration ahead of time of the advice and guidance to be given to the public, and those providing bereavement services on the impacts of measures like social distancing.

Council staff should not be left unsupported and balancing the needs of families to mourn their loved ones, and also protecting the mourners and staff.

In addition, much better modelling of the likely number of excess deaths and additional temporary mortuaries must be improved to ensure the dignity of the deceased is better preserved ahead of funerals.

My Lady, I now turn to the submission of the Welsh Local Government Association.

Lessons learned and recommendations.

There are many lessons to be learned from the experience of Welsh local authorities during the pandemic. Dr Llewelyn has given specific details in his witness statement, and the Inquiry is asked to consider each of these and how it can adopt them in the final reports on this module.

There are, however, three more general recommendations which Dr Llewelyn makes in his statement that I can set out here today in this short oral submission.

He notes, in particular, the need for early and

continuous consultation on response preparedness planning and actions between governments and local governments, and, as exemplified in this case, with other social partners, including the recognised trade unions and the voluntary and third sector.

The need for more local discretion, with permissive and less rigid and uniform regulations, to allow local flexibility in the application of restrictions, based on local circumstances and risk assessment.

The critical importance of -- of critical importance is that all joint and organisation/service-specific emergency planning is kept under constant review, with plans being reviewed and tested at regular intervals to ensure that category 1 responder partnerships and local authorities are in a state of readiness.

Finally, my Lady, both my clients, the Local Government Association and WLGA, would like to express our deepest sympathy to the families of the bereaved and to those who are still suffering from Long Covid.

It is hoped that your recommendations will send a strong message about the lessons learnt to enable better and effective preparedness when the next pandemic strikes. The LGA and WLGA stand ready to do everything within their powers to assist in facilitating the implementation of your recommendations.

My clients would like to express their appreciation to you and to your team for being given the opportunity to contribute to the Inquiry's investigation on all of the Module 10 modules, not only in relation to the role that they played in relation to the pandemic, but on behalf of their member local authorities.

My Lady, with your permission, I have to say I have been involved in this Inquiry since its inception in 2022. I could not possibly have done it, as designated solicitor, without the enormous help of my legal team, Shelagh O'Brien, Jafor Islam, the lead policy officer, whom you heard last week, Mark Norris and his team, and Nathan Swain and Simon Wilkinson, the lead policy officers at the Welsh Local Government Association and their team.

My Lady, I know this is the end of the public hearings, but there is a lot more work to be done, and the LGA and WLGA stand ready to assist you in any way we can. Thank you.

LADY HALLETT: Thank you very much indeed, Ms Stober.

Ms Peacock, just wait for a second, there's just a document that the usher is very kindly going to bring me.

LADY HALLETT: Ms Peacock, it is probably fitting that you should be the last person to speak because I think -- is

the TUC the only core participant to have been with me in every single module?

MS PEACOCK: My Lady, we weren't in Modules 4 and 5 but I think we have been one of the most consistent presences so far. Thank you, my Lady.

Closing statement on behalf of the Trades Union Congress by MS PEACOCK

MS PEACOCK: These are the closing submissions of the Trades Union Congress.

The theme explored in the evidence has been the recognition of key workers. For some, such as those in manufacturing, there was no recognition. They remained largely invisible throughout the pandemic. For others, recognition was delayed or short lived.

On Monday, my Lady, you referred to the thousands, if not millions, of unsung heroes. As the TUC's witnesses explained, the lack of timely and sustained recognition affected morale and mental health, but it was not merely an issue of recognition; it was the gap between the clapping and the banging of pots and pans and the situation key workers faced in the workplace.

It was referred to on Monday as the gap between being publicly praised while simultaneously experiencing a lack of protection.

It may not be within the Inquiry's gift to ensure

widespread public recognition of all key workers in a future pandemic, but there is, we say, an opportunity through its findings and recommendations to close the gap, to meaningfully improve conditions and safety measures in workplaces for a future pandemic.

In opening, Mr Jacobs identified six overarching themes in the impact on key workers, and in closing, under each of those themes, we identify key lessons to be learned.

My Lady, you identified in your opening statement to this Inquiry in July 2022 your aim of reducing the scope for others to suffer in future in the same way again, and you referred to that enduring aim again this week.

It is to that goal which these submissions are directed.

First, the lack of sector-specific planning. We noted in closing to Module 1 that planning was overwhelmingly focused on managing the dead rather than protecting the living, and was narrowly directed at the healthcare sector. The evidence in this module shows how the lack of sector-specific planning impacted upon health outcomes and experiences for key workers.

The TUC witnesses described the absence of clear guidance as causing widespread confusion, and a feeling that key workers had to adopt a "fingers crossed"

approach to attending work. As Mr Short explained, many of the impacts on key workers could have been avoided with planning, but by the time the pandemic arrived it was too late to solve them.

To take one sector as an example, it must have always been clear that food manufacturing operatives would be essential during a pandemic. However, the guidance on NPIs such as social distancing given to the sector took no account of the realities of working on a production line.

As my Lady has heard, operatives in this sector were amongst those with the highest rates of Covid-19 mortality. The lesson, we say, is clear: planning for future pandemics must take account of the specific challenges in each sector and must be informed by on-the-ground knowledge.

Mr Leach explained on Monday that in transport, he's unaware of any industry-wide debrief to learn lessons from the pandemic, or of any forward-looking plans for the sector. Without this work, when another pandemic strikes, the position in respect of workplace safety will be no better.

I take the second and third overarching themes together. They are unsafe workplaces and pre-existing health inequalities. For a key worker, risk during

a pandemic comprises the risk of transmission faced in the workplace and their own clinical vulnerability, determined to a significant extent by pre-existing structural health inequalities. Lara Wong, on behalf of Clinically Vulnerable Families, described these as the extrinsic and intrinsic risks.

As we have observed before, there is scope to improve safety for all those attending work and to reduce the extrinsic risk as far as possible.

As Mr Shears observed on Monday, over 10 million people continued to attend work during the first lockdown. They were disproportionately those on low pay and in insecure work.

This module has heard evidence of the disproportionate impact on various groups, including people of black, Asian and minority ethnic identity and those with disabilities. The TUC considers that a key way to ameliorate those disproportionate impacts is to make essential workplaces safer. These are the parts of society which cannot close during a lockdown, and into which government policy and enforcement ought to have the greatest reach.

A prerequisite of safer workplaces is effective regulation. We have addressed you in previous modules as to the shortcomings and the work needed to resolve

those.

The evidence in Module 10 has underlined, we say, the necessity of that work. Most relevantly to this module, in-person inspections must continue, and to ensure this is possible, HSE inspectors should be recognised as key workers and prioritised for PPE, testing, and IPC training.

Safe workplaces also rely on adherence with self-isolation requirements. Ms Thomas described that her union, USDAW, received hundreds of calls every week from members about colleagues attending work with symptoms because they could not afford to isolate.

Mr Shears described the enduring toll on those workers. He said: "They are suffering the long-term impacts to this day because they felt they put their colleagues and friends in serious harm's way, and some of them know that they infected people who died."

We addressed recommendations on this issue in closing to a number of previous modules, my Lady, and we don't repeat those in detail here. The key takeaways, we say, are that Statutory Sick Pay needs to be increased to a liveable rate and made available to all workers from the first day of illness, and financial support for self-isolation must be improved.

Workers should not, again, have to choose between

putting food on the table and complying with self-isolation requirements.

Finally, under this theme, assuming it's not possible to reduce extrinsic risk to zero, personal risk assessments will be needed. Evidence in this module has underlined how few key workers received them. The TUC consider that much could be learned from the national risk assessment tool introduced in Wales.

Turning to the fourth overarching theme, structural and institutional racism. Professors Bécares and Nazroo described how ethnic minority workers were more likely to work in shutdown sectors, more likely to be in precarious employment, and less likely to have access to appropriate PPE.

The TUC report, 'Dying on the job - Racism and risk at work', sets out the extent to which institutional racism impacting on safety during the pandemic. It describes minority ethnic workers being singled out for high-risk work and being denied PPE and risk assessments. Professors Bécares and Nazroo suggest in their evidence that the starting place should be tackling institutional racism. We agree.

We addressed you in Module 3 on the Workforce Race Equality Standard in the NHS. It is a framework which requires trusts to analyse nine key indicators, covering

workforce data, staff surveys, and board representation, to identify disparities and implement action plans. We say that a structured, data-driven approach is required in all sectors.

My Lady, the fifth overarching theme, migrant workers. They are overrepresented in key worker roles and in insecure work. Their immigration status creates additional layers of insecurity. For many migrant workers, those disadvantages also intersect with structural and institutional racism. As Ms Weereratne said before the break, they were "uniquely vulnerable".

Witnesses on behalf of the TUC described a shadow workforce who fell between the cracks during the pandemic and relied on employers for information, many of whom were more focused on profit than offering protection. The evidence of Ms Humi, of the Migrants' Rights Consortium, underlined the stark health outcomes.

The lesson to be learned, we say, is the urgent need for greater protection. It may be beyond the scope of this module to say exactly what that ought to entail. We made submissions in Module 3 and Module 6 as to the need in a future pandemic to automatically extend visas, to decouple visa sponsorship from individual employers, and to suspend visa conditions denying access to public funds. Those recommendations apply equally to key

workers considered in Module 10.

An action which we say falls within this module would be to endorse the ninth recommendation of the Windrush Lessons Learned Review: that there should be a migrants commissioner.

We would add to that recommendation that the commissioner should be involved in pandemic planning and in the response during any future crisis.

My Lady, the sixth overarching theme and the final overarching theme is precarious work.

As Professor Marmot described, quality of work and employment conditions are fundamentally important for health. Witnesses on behalf of the TUC described the existence of a two-tier workforce: those who were directly employed in good-quality work and were empowered to press for safety measures, and those who were not.

During the pandemic, unions played a key role in holding their employers to account. For example, in August 2020, Unite persuaded a sandwich factory to provide full sick pay to workers needing to self-isolate. There were numerous other stories like this in the pandemic. However, the work of unions was significantly constrained by employers' effort to keep information about outbreaks and contravention of

guidance out of the public domain.

We say that key workers must be able to report concerns to those with the ability to intervene. The TUC proposes a national whistleblowing hotline should established. It should be possible to raise concerns anonymously, and the data should be shared with relevant regulators, government departments and unions.

Those are the six overarching themes and the lessons learned. Finally, the TUC wishes to address a single recommendation which we say pervades all six themes: the need for improved social partnership.

Great benefit would be derived in a future pandemic from having in place pre-existing national fora for engagement between governments, employers, and trade unions. The evidence in previous modules has demonstrated the benefits: the success of the furlough scheme following work between the Treasury and the TUC set out in Module 9 is but one example.

In this module, the evidence of Professor Stewart-Brown was that members of unions fared better during the pandemic in terms of mental health. The local government witnesses emphasised the important role of tripartite relationships between local government unions and employers in terms of interpreting guidance, protecting workers, and implementing NPIs.

The evidence has underlined the very real need for these pockets of good practice to be replicated.

In closing, my Lady, as you acknowledged on Monday, the TUC has been with you since the outset, the foothills of this inquiry, as Mr Jacobs then described it, and we've been grateful for the opportunity to assist you, and we are grateful to all those on your team and at Dorland House who have been crucial to the smooth running of this Inquiry.

One of the TUC's core values is solidarity. A belief that we can achieve more collectively than we can achieve alone. And the TUC has noted your call to action in relation to implementing your recommendations, and will work hard, as always, to hold the government to account.

Throughout this Inquiry, the TUC has sought to be a voice for working people and their experiences during the pandemic. With Workers Memorial Day approaching in April, the TUC recalls the motto of that day: remember the dead, fight for the living.

The TUC pays tribute to all those who died during the pandemic and in doing so, we urge the Inquiry to be bold in its findings and recommendations, and to address workers' experiences, their suffering, and their safety.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Peacock.

Ms Blackwell, I think that completes the hearings for Module 10.

MS BLACKWELL: Yes, it does. Thank you, my Lady.

LADY HALLETT: And it completes our last module. Thank you.

Closing remarks by THE CHAIR

LADY HALLETT: The evidence called in this module has been both powerful and moving, and I'm extremely grateful to everyone who has provided statements and material, attended the roundtables. I'm especially grateful to those who contributed to Every Story Matters and the impact film, and those who have given evidence during these hearings for Module 10.

It takes great courage to speak in public about loss and trauma.

It was vital to hear those stories, and to understand the full impact of the pandemic. There are people who believe it is time to move on from the pandemic, and they question the worth of this Inquiry. I hope that when they read about the extent of the suffering that we've heard and see the results of the Inquiry's work, they will appreciate the huge scale of loss caused by Covid-19, and they'll understand better why this Inquiry was established.

As I've said throughout and many times, my aim has

been to make recommendations to improve pandemic planning, response and recovery, so as to reduce that scale of loss in any future pandemic. And it's always the answer when I'm asked "Why are you doing it?": "Because I think we can make a difference."

If implemented, my recommendations should reduce the number of deaths, reduce the suffering, and reduce the socioeconomic cost to the country.

I should also like to emphasise that my recommendations are based on a vast amount of material that has been gathered and analysed over the course of the Inquiry by the Inquiry team and the legal teams for core participants. We have received and reviewed over 600,000 documents and disclosed over 300,000 to core participants. We've published ten Every Story Matters records, based on thousands of stories. We've held over 200 sitting days here in London, Edinburgh, Cardiff and Belfast. And we've called, over the 10 or 13 modules, 350 witnesses.

Some may ask: why so many documents, so many witnesses, and so many stories? The answer is simple: because my terms of reference set by the then Prime Minister, Boris Johnson, after public consultation, are the broadest of any public inquiry to date. I was given the task of investigating not just

one tragic event or series of events, but the response to the Covid-19 pandemic and its impact on the whole of the United Kingdom's population.

To complete the Inquiry hearings in under four years from our official start date, and to complete the Inquiry in under five years, as we shall do, is, to my mind, an extraordinary achievement.

And I can say that because I am not taking the credit. The credit goes to all those in front of and behind the scenes. Those who have gathered and analysed the material, especially our paralegals, to those who have arranged and managed the hearings, to the witnesses, to RTS, our tech team, to document managers, especially one stalwart who has been with me throughout, to our long-suffering stenographers, security staff, our lovely team of ushers, the support and safeguarding team, the researchers and policy team, the media and engagement team, the Every Story Matters team, the legal editors, private office teams, and of course the material providers.

They've all done an incredible job, as have the witnesses, some of whom have given evidence several times.

A huge amount of credit also goes to the various legal teams, the Inquiry legal team and the core

participant legal teams. I should like to offer my special thanks to them.

Some of them have been with me throughout, or in nearly every module. They've put up with my interventions with good grace and charm. Thank you all. We wouldn't have got to this stage without your industry and professionalism.

We now move from conducting public hearings, as we have done since 2023, to a new phase of the Inquiry, where I'll be regularly publishing my reports and recommendations. The rest of this year will be focusing on the reports for Modules 3 and 10. Most of them will be published throughout 2026; only the reports for Modules 8, 9 and 10 will be published in 2027.

Again, there are some who may ask: why so long? I asked that question. A huge amount of work goes into getting my recommendations right in the first place and the reports ready for publication, but also, to get them ready for presentation to Parliament. And I confess, I had little idea of the amount of work involved until I embarked upon this Inquiry.

However, I have been publishing my recommendations as soon as they are available. Two reports will be published in the very near future, and I'm publishing them module by module as they are ready, because

I remain well aware that the next pandemic could occur at any time.

I hope that when all ten reports have been published, they will prove the value of this Inquiry, prove the value and worth of the work that you have all done, and justify the costs. I said at the outset that this Inquiry would cost a lot of money and take time. It has done. But I genuinely believe it has been worth it.

I encourage the public and followers of the Inquiry who wish to do so, to push for the changes I recommend, and for those responsible for implementation to implement my recommendations. Whilst I remain in post, I will be monitoring implementation.

The United Kingdom must learn lessons from the Covid-19 pandemic to be better prepared for the next pandemic because we all know there will be one.

This Sunday, March 8, is the National Covid Day of Reflection. The families who lost loved ones, the key workers who risked their lives, and the general public who made enormous sacrifices during the pandemic, deserve to see meaningful change.

For the last time, thank you all.

(2.12 pm)

(The hearing concluded)

I N D E X