

Thursday, 5 March 2026

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(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

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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

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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

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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.

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

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

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

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

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1 visitors for those in hospital and social care settings.

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

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

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

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

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

25 The guilt, the feeling helpless, when in reality

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

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

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

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

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

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

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

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

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

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

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

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

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1 inequalities that were exposed by the pandemic.

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

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

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

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

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

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

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

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

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

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

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

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

25 For example, the Inquiry heard from Maria McArdle
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1 balancing that with facilitating patient and family
2 contact. What Dr Royston referred to as the perimortal
3 period.

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

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

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

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

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

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

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

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

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

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

13 Mr Wilcock, I think you're going next.

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

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

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

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

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

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

25 My Lady, by way of conclusion, as the Inquiry moves
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1 concerns, no matter what side of the Irish Sea.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 While we know that the severity of these impacts is

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

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

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

14 **LADY HALLETT:** Thank you very much indeed, Mr Wilcock.
15 Mr Stanton.

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

18 **MR STANTON:** Thank you, my Lady.

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

25 First, the impact of restrictions. Families were

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

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

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

23 As I mentioned in our opening, my Lady, data from
24 8 February 2026 showed that 79% of inpatient Covid-19
25 cases in hospitals in Wales were hospital-acquired. The

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

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

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

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

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

25

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

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

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

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

27

1 numerous barriers in their efforts to obtain answers.

2 This includes during treatment and immediately following
3 death, when timely and effective communication could
4 have resolved so many issues. And later, during
5 difficult, bureaucratic and lengthy complaints
6 processes. It includes the lack of inquests, which the
7 group says was a major omission, given the serious
8 systemic and individual failures associated with the
9 treatment and deaths of so many hospital patients and
10 care home residents.

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

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

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

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

26

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

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

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

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

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

28

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

2 These feelings of anger have exacerbated
3 bereavement.

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

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

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

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

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

29

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

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

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

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

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

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

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

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

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

19 Ms Mitchell.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 heard to our best ability.

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

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

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

22 **LADY HALLETT:** Thank you very much indeed, Ms Mitchell.

23 Very grateful.

24 Mr Wagner, I think you're going next.

25 **Closing statement on behalf of Clinically Vulnerable**

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

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

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

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

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

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1 **Families by MR WAGNER KC**

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

6 My Lady, I start in the same place as my very first
7 submission before you on behalf of CVF back in 2023 --
8 you know what's coming, don't you? -- it's the CO²
9 monitor, which I should say is looking very healthy, at
10 844 parts per million, well under the 1,000 which we
11 would need for safety.

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

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

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1 for clinically vulnerable people.

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

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

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

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

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

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

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

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

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

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

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

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1 remain poorly protected now.

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

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

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

25 The TUC witnesses reported about working in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 A theme which unites all of these topics is that

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

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

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

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

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

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

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

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

6 Lara Wong said:

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

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

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

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

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

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

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

13 **MR FRIEDMAN:** (inaudible).

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

17 (11.05 am)

(A short break)

19 (11.20 am)

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

22 **LADY HALLETT:** Mr Friedman.

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

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1 emergency planning more widely.

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

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

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

21 From CVF's perspective, the Inquiry's legacy must be
22 bringing to the fore the challenges which clinically
23 vulnerable people faced and continue to face in playing
24 a full part in society, that clinically vulnerable
25 people will no longer need to carry around CO² monitors

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1 Disability Action Northern Ireland.

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

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

13 Six out of the ten of the Covid dead were disabled
14 people. Learning disabled people aged 18-34 were
15 30 times more likely to die. Black people were four
16 times more likely to be detained in hospital under the
17 Mental Health Act. Pre-pandemic, disabled women were
18 three to four times more likely to suffer domestic
19 abuse, and this was before lockdown that provided
20 a frighteningly conducive context and additional ways of
21 committing violence against women and girls.

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

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

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

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

23 Then there are the known figures of the dead.
24 The 230,000 people, the 43,000 in care homes, the
25 over 28,000 in England and Scotland receiving care in
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1 Inquiry's first two reports have, therefore, recommended
2 practical ways to map the human geography of vulnerable
3 people, through risk assessments, national strategies,
4 data and research, and through the leadership of the
5 independent body for a whole-system preparedness.

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

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

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

25 The anomaly is something of a challenge to modernity
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1 home. Cumulatively, these were the fourth highest death
2 rates in OECD countries, and, on one reading, second
3 only to Bulgaria, when compared to the other EU States.

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

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

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

21 Second, inequalities were the fundamental drivers of
22 pandemic impact. As Chair, you've started the Inquiry
23 determined to investigate inequality. It is now beyond
24 argument that inequalities were the greatest causes of
25 Covid death, suffering, and marginalisation. The
50

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

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

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

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

25 These features of disaster with far greater emphasis
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1 on cooperation, offer the possibility of collective
2 resilience. Instead of just expecting them to arise,
3 government in conjunction with civil society need to
4 work out how to make them part of everyday life.

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

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

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

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1 or race, are still in the foothills.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Human rights are the practical means to bridge that

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

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

10 **LADY HALLETT:** Thank you very much indeed, Mr Friedman.

11 Very grateful.

12 Ms Davies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 including the specialist and by and for organisations.

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

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

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

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

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1 she can go to family or friends.

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

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

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

25 Suspending no recourse to public funds prevents
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1 that, in a pandemic, public funds and free healthcare
2 should be available to all as an essential public health
3 measure.

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

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

22 The reason why those respected organisations and
23 individuals made those representations was that
24 suspending restrictive measures in a pandemic is
25 a necessary public health tool. It protects the health
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1 destitution and it prevents victim-survivors from being
2 deterred from leaving abuse. It also provides clarity,
3 both for victim-survivors and for those providing
4 services for them.

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

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

19 Clear, consistent, simple and well-publicised
20 messaging in a public health emergency has been a theme
21 throughout the Inquiry, and applies equally to the
22 plethora of complex regulations that govern migrants'
23 access to public funds and healthcare. We say the
24 principle of Everyone In should be applied to no
25 recourse to public funds and healthcare charging, so
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1 of victim-survivors of domestic abuse, and the public in
2 general. The evidence before you, my Lady, supports
3 that submission and we hope that you will accept it.

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

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

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

19 And Jenny, who had no recourse to public funds.
20 Before the pandemic, she was abused by her ex-partner,
21 and that abuse included threats and being locked inside
22 or outside her home. She was eventually thrown out of
23 her home by her ex-partner during the pandemic. She was
24 homeless and she was sleeping rough. She said, "No one
25 wanted to take me in, it was too risky for people."
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1 Her abuser would use her lack of status against her.
2 He would say, "Where would you turn to? No one would
3 care." And those fears had kept Jenny trapped for
4 years.

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

12 Thank you very much, my Lady.

13 **LADY HALLETT:** Thank you very much, Ms Davies.

14 Ms Weereratne.

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

17 **MS WEERERATNE:** Thank you.

18 My Lady, as you've heard, the Migrants' Rights
19 Consortium, or MRC, is composed of nine organisations
20 representing the rights and interests of migrant people
21 in the UK. It consists of five charitable
22 organisations, the Joint Council for the Welfare of
23 Immigrants, Kanlungan, Project 17, Together with Migrant
24 Children and JustRight Scotland, two humanitarian
25 medical organisations, Doctors of the World UK, Medact,
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1 migrants, created a population group that was uniquely
2 vulnerable at the outset of the pandemic.

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

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

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

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

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

25 This clearly cannot be because the pandemic did not
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1 and two trade unions, United Voices of the World and the
2 Independent Workers' Union of Great Britain.

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

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

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

20 Secondly, there is a clear connection between
21 immigration control and the disproportionate and unequal
22 impact of the pandemic on migrants. In short,
23 longstanding immigration policy excluding migrants from
24 the mainstream welfare safety net and protective public
25 services, a set of features that only applied to some
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1 impact them severely, but raises an uncomfortable
2 question about how we regard migrant people rendered
3 vulnerable within our society through readily
4 identifiable policy.

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

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

22 Moreover, the government was clearly on notice of
23 particular dangers for migrants through immigration law
24 and policy. They'd been told as much, in terms, by the
25 Independent SAGE group in a report dated 3 July 2020.
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1 The report called for the removal of NRPF conditions and
2 the MRC's organisations also had written time and again
3 to the government to notify them of the devastating
4 effects on migrant people in the UK.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 reported to outweigh even the fear of the disease
2 itself.

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

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

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

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

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

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

6 Thank you, my Lady.

7 **LADY HALLETT:** Thank you very much.

8 Mr Westgate.

9 **Closing statement on behalf of Shelter by MR WESTGATE KC**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 important as any other emergency health service.

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

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

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

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

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

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

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

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

25 Our last theme is the mitigation measures regarding
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1 those rent arrears.

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

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

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

15 My Lady, thank you.

16 **LADY HALLETT:** Thank you very much indeed, Mr Westgate.
17 Mr Pezzani.

18 **Closing statement on behalf of Mind by MR PEZZANI**

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

22 Mind's opening submissions observed that measuring
23 the mental health impact of the pandemic looked like
24 a daunting task. But undaunted, this Inquiry has
25 achieved something of great value in the last
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1 possession proceedings. Mr Gutteridge was asked about
2 these, and Shelter later provided additional detail,
3 which the Inquiry will have. In broad terms, and with
4 some exceptions, these increased notice periods for most
5 residential tenancies, together with stays on possession
6 proceedings and evictions. And Shelter recognises that
7 these were important and necessary protections that stop
8 many evictions during the pandemic.

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

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

22 Secondly, the protection was temporary and there was
23 no protection against rent arrears incurred because of
24 the pandemic. Once the stay came to an end, occupiers
25 were again vulnerable to action, including that based on
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1 three weeks, and has, we think for the first time in
2 history, started to draw up a detailed map of the depth
3 and shape of the scars left by a pandemic on our
4 society.

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

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

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

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

24 So, one of the best things that can and should be
25 said about this Inquiry's approach to its remit is that
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1 it didn't flinch from examining what our society really
2 looks like. That as well as looking behind the door of
3 10 Downing Street, it chose to look at diagrams of
4 Victorian prison cells, and tried to understand what was
5 happening behind the closed curtains of a person with
6 bipolar disorder in the spring of 2020, wondering how
7 they were going to make it through the night, having not
8 seen their community nurse for a week.

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

12 What should the records say?

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

14 **MR PEZZANI:** Thank you.

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

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

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

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

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

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

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

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

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

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

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

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1 organisations to continue their work.

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

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

25 Yesterday's evidence from Mrs Poole provided

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

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

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

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

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1 self-defeat were this lesson not to be learned.
2 Ms Rahman's skillful questioning of Professor Osborn
3 highlighted that.
4 There is a sequence again: delayed treatment leading
5 to deterioration in a condition leading to more care and
6 treatment needed over a longer period leading, in this
7 context, to a long-term burden on, or a longer-term
8 burden on health services. It is a repercussive impact.
9 Mind's submission is that investment that enables prompt
10 treatment will defray the institutional and personal
11 costs of delayed treatment, and thus mitigate the mental
12 health impact of future emergencies.

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

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

25 An example is the duty in section 47 of the Mental

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

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

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

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

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

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

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

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

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

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

11 Fifth, the inequality of impact. Much has been said
 12 about this already. We cannot ignore the fact that the
 13 pandemic had an unequal mental health impact by
 14 reference to a wealth of different statuses, including
 15 who you were and where you lived. In relation to mental
 16 health, Ms Rahman, King's Counsel, cited to
 17 Professor Osborn the statement of Dania Hanif of the
 18 Association of Mental Health Providers that in 2020 to
 19 2021 people living in the most deprived areas of the UK
 20 were twice as likely to be in contact with mental health
 21 services compared to those in the least deprived areas.

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

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

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

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

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

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

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

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

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

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

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

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1 that it is intended to shine a light upon.

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

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

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

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

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

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

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1 you?

2 **MS STOBER:** Yes, I certainly am.

3 **LADY HALLETT:** In which case I'll return at 1.40.

4 (12.37 pm)

5 (The Short Adjournment)

6 (1.40 pm)

7 **LADY HALLETT:** Ms Stober.

8 **Closing statement on behalf of the Local Government**
9 **Association and the Welsh Local Government Association by MS**
10 **STOBER**

11 **MS STOBER:** My Lady, I represent the Local Government
12 Association and the Welsh Local Government Association.
13 This submission is, of course, supplementary and in no
14 way replaces the detailed lessons learnt and
15 recommendations set out in the witness statement of the
16 LGA's chief executive, Ms Joanna Killian, adopted by
17 Mr Mark Norris, the principal policy adviser, and
18 Dr Llewelyn, of WLGA.

19 In relation to both authorities, the evidence heard
20 by this Inquiry shows that English and Welsh local
21 authorities were not operating at the margins of the
22 Covid response, but at its centre.

23 Councils acted in place, were rooted in their
24 communities, trusted by residents, and were able to
25 respond at speed. They housed people overnight,

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1 for residents seeking reassurance, clarity, or support.
2 They relayed local concerns in a decision-making
3 structures, helped shape practical solutions on the
4 ground, and played an important role in sustaining trust
5 between communities and public authorities during
6 a period of fear and uncertainty.

7 As the Inquiry reflects learning and future
8 preparedness, this evidence points clearly to the value
9 of strong, properly resourced local government.

10 When crisis hit, it is councils acting in place,
11 alongside communities, that turn national intent into
12 practical support. Recognising that role and funding it
13 accordingly is central to being better prepared for what
14 comes next.

15 My Lady, I now turn specifically to the submissions
16 of the Local Government Association.

17 Lessons learnt and recommendations.

18 There are many lessons to be learnt from the
19 experience of local authorities during the pandemic
20 which Ms Killian explains in detail in her witness
21 statement. The Inquiry is asked to consider each of
22 these, and how it will -- it could adopt them in its
23 final report on this module.

24 In addition, throughout this Inquiry, the LGA had
25 identified a range of lessons learnt from the experience

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1 supported those who were isolated or grieving, kept
2 essential local services running, and helped businesses
3 survive, often under intense and sustained pressure.

4 This response was delivered by a workforce that knew
5 their towns, neighbourhoods, and communities intimately.
6 Local government staff worked long hours, faced
7 increased exposure to risks, and carried significant
8 emotional strain. They adapted services at pace,
9 redeployed into unfamiliar roles, and continued to serve
10 their communities with professionalism and care.

11 All of this took place after more than a decade of
12 financial constraint. Councils entered the pandemic
13 with reduced capacity, stretched services, and
14 a workforce already under pressure from around 15 years
15 of underfunding.

16 Despite that, local government stepped up, not
17 because systems were flushed with resources, but because
18 people were committed to the places they served.

19 The contribution of elected members, whose role may
20 not always have been fully reflected in the written
21 evidence or the discussion before this Inquiry, should
22 not go unrecognised.

23 Alongside the workforce, councillors provided
24 visible and accountable leadership within their
25 communities. They were often the first point of contact

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1 of local authorities during the pandemic that would
2 place the country in a better position when it faces
3 a whole-system civil emergency.

4 Drawing on the evidence the Inquiry heard in this
5 module, the LGA would ask the Inquiry to note the
6 following: councillors and council staff live and work
7 in communities they serve and represent. They
8 understand best the needs of their communities. While
9 central government sets the strategic direction of the
10 response, it needs to trust in the knowledge and
11 expertise resting at a local level to deliver the
12 outcomes that protect and safeguard communities and
13 individuals. The Inquiry has heard this point from the
14 LGA in relation to previous modules but also from other
15 evidence during this Module 10. It means that national
16 plans and responses to any future pandemic must be
17 developed and co-designed with local government and
18 other relevant local and national bodies, including the
19 voluntary and third sectors.

20 The definition of key workers must be agreed upon
21 with local authorities ahead of a future pandemic, and
22 this should take into account vulnerabilities from
23 financial hardship arising from lockdown.

24 In this module, the Inquiry has heard about the
25 impact of the Everyone In approach to protecting the

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

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

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

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

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

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

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

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

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

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

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

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

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

14 Lessons learned and recommendations.

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

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

25 He notes, in particular, the need for early and

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

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

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

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

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

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

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1 the TUC the only core participant to have been with me
 2 in every single module?
 3 **MS PEACOCK:** My Lady, we weren't in Modules 4 and 5 but
 4 I think we have been one of the most consistent
 5 presences so far. Thank you, my Lady.

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

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

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

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

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

25 It may not be within the Inquiry's gift to ensure
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1 approach to attending work. As Mr Short explained, many
 2 of the impacts on key workers could have been avoided
 3 with planning, but by the time the pandemic arrived it
 4 was too late to solve them.

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

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

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

23 I take the second and third overarching themes
 24 together. They are unsafe workplaces and pre-existing
 25 health inequalities. For a key worker, risk during
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1 widespread public recognition of all key workers in
 2 a future pandemic, but there is, we say, an opportunity
 3 through its findings and recommendations to close the
 4 gap, to meaningfully improve conditions and safety
 5 measures in workplaces for a future pandemic.

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

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

14 It is to that goal which these submissions are
 15 directed.

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

23 The TUC witnesses described the absence of clear
 24 guidance as causing widespread confusion, and a feeling
 25 that key workers had to adopt a "fingers crossed"
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1 a pandemic comprises the risk of transmission faced in
 2 the workplace and their own clinical vulnerability,
 3 determined to a significant extent by pre-existing
 4 structural health inequalities. Lara Wong, on behalf of
 5 Clinically Vulnerable Families, described these as the
 6 extrinsic and intrinsic risks.

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

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

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

23 A prerequisite of safer workplaces is effective
 24 regulation. We have addressed you in previous modules
 25 as to the shortcomings and the work needed to resolve
 116

1 those.

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

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

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

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

25 Workers should not, again, have to choose between
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1 workforce data, staff surveys, and board representation,
2 to identify disparities and implement action plans. We
3 say that a structured, data-driven approach is required
4 in all sectors.

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

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

18 The lesson to be learned, we say, is the urgent need
19 for greater protection. It may be beyond the scope of
20 this module to say exactly what that ought to entail.
21 We made submissions in Module 3 and Module 6 as to the
22 need in a future pandemic to automatically extend visas,
23 to decouple visa sponsorship from individual employers,
24 and to suspend visa conditions denying access to public
25 funds. Those recommendations apply equally to key
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1 putting food on the table and complying with
2 self-isolation requirements.

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

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

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

23 We addressed you in Module 3 on the Workforce Race
24 Equality Standard in the NHS. It is a framework which
25 requires trusts to analyse nine key indicators, covering
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1 workers considered in Module 10.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Thank you, my Lady.

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

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

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

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

6 **Closing remarks by THE CHAIR**

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

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

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

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

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

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

9 I should also like to emphasise that my
10 recommendations are based on a vast amount of material
11 that has been gathered and analysed over the course of
12 the Inquiry by the Inquiry team and the legal teams for
13 core participants. We have received and reviewed over
14 600,000 documents and disclosed over 300,000 to core
15 participants. We've published ten Every Story Matters
16 records, based on thousands of stories. We've held over
17 200 sitting days here in London, Edinburgh, Cardiff and
18 Belfast. And we've called, over the 10 or 13 modules,
19 350 witnesses.

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

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

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

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

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

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

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

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

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

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

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

23 For the last time, thank you all.

24 (2.12 pm)

(The hearing concluded)

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

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

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

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

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

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