

People's Covid Inquiry February-June 2021

Citizen Witness Statement

Ellen Clifford

Session 4 7 April 2021

Impact on the population (1 of 2) Including families, social care, disabled people

STATEMENT

I (name) Ellen Clifford

Job title/ role/ occupation Representative of Disabled People Against Cuts

will say as follows: _____

1. I make this statement for the purposes of the People's Covid Inquiry, which is to be held on 7 April.
2. I am able to attend and give evidence. If unable to attend, I agree to my statement being considered by the Inquiry.
3. What is your job/ role/ occupation – how long doing this for/ brief summary of background/ experience - if possible, attach CV to statement

I have been a member of the National Steering group of Disabled People Against Cuts (DPAC) since October 2011. I am author of *The War on Disabled People: Capitalism, Welfare and The Making of a Human Catastrophe* published in June 2020 by Zed Books, now an imprint of Bloomsbury. I have worked in the disability sector for more than 20 years, largely within Deaf and Disabled People's user led organisations but also specialising in service user involvement. I am a mental health service user. [CV attached.]

4. What is your connection/ interest/ background/ experience relevant to the pandemic in England?

My knowledge and experience of the pandemic centres around the impact on disabled people. In the UK, disabled campaigners mobilised early on to challenge government policy that was either overlooking the needs of disabled people or discriminating against us. We were intensely busy sharing information, collating experiences, drafting submissions to the various Parliamentary committee inquiries that took place, lobbying the government and MPs, using social media and attempting to get mainstream media attention to raise our issues and working with public lawyers on legal challenges. In July 2020 I co-ordinated an international meeting for disabled activists linked to DPAC from across the world on the subject of "[Eugenics, Covid and International Solidarity](#)".

Towards the end of the year, I was invited to write a chapter for a rapid response health and social care policy book on Co-production and Covid to be published by Bristol Policy Press entitled “Disabled People’s Deaths Don’t Count”. I attach a rough first draft of the chapter (before I needed to reduce the scope of the chapter to meet word count).*

I live on a housing estate in South East London and this has provided me with personal experience of the pandemic as lived by people facing socio-economic disadvantage.

**Please note that this is not for circulation but for information in case useful, in particular the references.*

5. How are you able to assist the Inquiry – what is your expertise/ knowledge/ specialism?

I am able to talk about the impact on disabled people from my perspective as a disabled person with disabled family members and friends, as a campaigner and commentator on disability issues and as a professional who has worked within the disability sector for the past two decades. I am currently involved in an advisory capacity on a number of university research projects exploring flaws in the current social security system, what the pandemic has taught us about these and what a better system could look like.

With respect to Covid-related deaths there is a significant overlap between disability and older age – when I refer to disabled people within this witness statement, I am referring to disabled people of any age, including disabled older people, unless specified otherwise.

Definition of disability under the Equality Act 2010: You’re disabled under the Equality Act 2010 if you have a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on your ability to do normal daily activities.

Social model of disability – the social model distinguishes between the bodily conditions we live with (impairment/illness/difference) and disability where disability refers to the layer of oppression that society imposes on top of our conditions.

6. What in your view were the original vision and principles underpinning the NHS?

I understand that the NHS was established by the post-World War II government as one of a series of welfare reforms designed to guarantee basic levels of personal and social security for all. I am strongly committed to the importance of a universal health service that is state-funded, free at the point of delivery and based on clinical need, not ability to pay.

It is important however to recognise that disabled people’s needs were overlooked within the early development of the welfare state including the NHS. In relation to the social security system, this was a deliberate omission in order to preserve a so-called “work incentive”. At the time of the founding of the NHS many disabled people were shut away from the community within long stay hospitals under the control of local authorities. Little changed to this set up until the 1980s when closures of the large institutions began in response to a number of abuse scandals and campaigning by disabled people against segregation.

Although disabled people thus moved out into the community, two things have never changed:

- 1) Public attitudes influenced by eugenic ideas that see disabled people's lives as worth less than those of others.
- 2) Provision of social care support for disabled people based on availability of resources and in this way operating in an opposite way to the founding principle of the NHS of resource following need.

Disabled people have never enjoyed equal access to the NHS. Stating this is in no way to detract from the excellent work of the NHS in so many respects and the invaluable role it plays within the lives of disabled people who are disproportionately reliant on its service. However, incidences of discrimination, neglect and abuse within both NHS-run and NHS-funded settings are well documented. Investigations started by the charity Mencap in 2007 exposed institutional discrimination within the NHS against people with learning difficulties, leading to 1,200 avoidable deaths in England every year.

There furthermore exists a conflict between medical approaches to disability and more liberatory models. This can be understood as a consequence of the physician's central purpose to treat and cure the patient which necessitates a focus on the identification and treatment of bodily deficits. For disabled people, our bodily and mental conditions may be lifelong; they may also not inevitably represent a deficit under different social and economic structures. Within a medical framework, the life of a disabled person may appear to have less value than that of another person who better fits normative standards of wellness and autonomy. Practices such as quality of life judgements and treatment rationing de-prioritise the lives of disabled people under those of non-disabled people.

Attitudes towards disabled people within public service delivery have improved over recent decades not least since the introduction of the Disability Discrimination Act in 1995, however discrimination and abuse experienced by disabled people within the NHS need to be understood within a context of under-funding and resourcing pressures even before the pandemic. These negatively impact on the ability of universal health services to work with patients who have additional/complex social and communication needs.

[See attached extract from the War on Disabled People with references]

Links:

Barleon, B. (2013). [More than 1,200 people with a learning disability die of avoidable causes](#), *Guardian*, 18 April.

BBC News (2020). [Hospital patient 'died after blood sugar mistakes'](#), 30 September.

McNichol, A. (2015). [NHS trust investigated 'too few' deaths of mental health and learning disability patients](#), *Community Care*, 9 December.

Sky News (2018). [Southern Health NHS Trust fined £2m over 'avoidable' deaths of two patients](#), 26 March.

Samuel, M (2020). [Staff abused women at learning disability unit, finds CQC](#), *Community Care*, 23 September.

Please briefly outline your testimony below or attach or reference an article which will provide the panel with relevant information.

Disabled people have been disproportionately impacted by Covid-19 – being most at risk of dying or having serious impacts from the virus whilst also being most likely to fall into categories de-prioritised for treatment at times of pressure on NHS resources.

According to ONS data disabled people made up 59.5% of Covid-related deaths from January until November 2020 out of a sample where they made up just 16% of the population. Due to data gaps the ONS had to rely on census data from 2011 to ascertain disability status. At that time disabled people made up just 18% of the population while we now make up 21% of the population. The ONS data therefore reflects **only a minimum estimate and the mortality rates of disabled people compared to non-disabled people are likely higher.** They also vary between different impairment groups and across intersectional equalities strands. People with learning difficulties were found to be six times more likely to die of Covid than non-disabled people with **younger people with learning difficulties up to thirty times more likely to die of Covid than non-disabled people of the same age; disabled women under the age of 65 were found to be 3.5 times more likely to die of Covid than non-disabled women of the same age.**

Age profile and co-morbidities alone do not explain these statistics. Analysis by the Office for National Statistics (ONS) indicates that, even after adjusting for these factors the mortality rate was higher than for non-disabled people, and particularly so for disabled women and those with learning disabilities. **Other factors placed disabled people at risk, regardless of their age or health condition.** A third (35%) of those who died from COVID-19 lived in residential care homes, rising to almost half of those with Down's syndrome. A quarter (25%) lived in supported living settings. For disabled people in general, **measures of deprivation were the biggest factor** accounting for some of the increased risk of catching and dying from the virus.

The dominant narrative concerning disabled people's disproportionate deaths from Covid presents these deaths as **somehow inevitable and as less significant** than the deaths of those who are without underlying health conditions or younger. This messaging has been reinforced through government rhetoric and media portrayals and has succeeded in **shifting attention away** from the degree to which the **higher mortality rates of disabled people were avoidable and can be attributed to political decisions, to health and social care policy and practice under pandemic conditions, and to socio-economic factors.**

Examples include:

- **The political decision not to lockdown hard and early and failings in the government's test-and-trace system.** Britain had more infections than any other European country when they took decisions to lock down – as well as fewer intensive care beds than many. 6.6 beds per 100,000 people, fewer than Cyprus and Latvia, half number in Italy and about a fifth of that in Germany.
- **Discharge of patients with Covid into care homes.** The National Audit Office found that the government's testing strategy and lack of testing capacity led to some patients being discharged to care homes without being tested for covid-19 between mid-March and mid-April. On 15 April, the policy was changed to test all those being discharged into care homes. It is not known how many patients discharged to care homes had covid-19 at the point they left hospital." Before the new policy of testing everyone before their admission to care homes was rolled out,

around 25 000 people were discharged from NHS hospitals to care between 17 March and 15 April, the NAO said. [<https://www.bmj.com/content/369/bmj.m2375>]

- **Delayed and inadequate provision of PPE affecting social care settings as well as disabled people living in their own homes and reliant upon daily personal care support.** It was not until 21 April that the Department for Health and Social Care (DHSC) finally published guidance for disabled people who employ their own personal assistants (PAs). This was more than five weeks after DHSC produced written advice for the wider social care sector that ignored the needs of disabled people in this situation and more than a month-and-a-half after DHSC published its first COVID-19 action plan (on 3 March). [<https://www.disabilitynewsservice.com/coronavirus-pa-guidance-is-finally-published-five-weeks-late/>]
- **Treatment rationing guidelines and use of Do Not Attempt Cardio-Pulmonary Resuscitation orders (DNACPRs) restricting disabled people from access to critical care and life saving treatment.** The Joint Committee on Human Rights has stated that ‘decision-making relating to admission to hospital, in particular critical care, for adults with COVID-19 has discriminated against older and disabled people’.

Disabled campaigners were able to pressure NICE into a review of their “rapid COVID-19 critical care guideline” by threatening legal action, but the revision failed to establish equal access to healthcare. Secretary of State for Health and Social Care, **Matt Hancock dismissed the need for national guidance establishing disabled people’s equal rights to life-sustaining treatment as non-disabled people.** This left disabled people completing home-made “hospital passports” emphasising the valuable roles they play in the community and their contributions to society in case of falling ill with Covid.

Despite evidence that intensive care treatment is of “crucial importance” for survival, only one in nine people who died of Covid-19 were given it. A study published on 4 May comparing the number of deaths from the virus taking place on normal wards against the number of intensive beds said to be available in UK drew the conclusion that **intensive care was being withheld overzealously.**

Throughout the pandemic there have been reports from care home providers of unlawful use of blanket DNACPRs as well as complaints from individual disabled people of attempts to coerce them into agreeing to a DNR order being placed on their medical records. In response the Care Quality Commission carried out an investigation. Its final report, published in March 2021, entitled [Protect, respect, connect – decisions about living and dying well during COVID-19](#) calls for the establishment of a Ministerial Oversight Group – working with partners in health and social care, local government and the voluntary sector – to take responsibility for delivering improvements in this area.

Additionally, **essential medical resources have been withheld from disabled people.** For example, there have been reports from many people with neuromuscular conditions who were told by their NHS trusts that they could not be sent new anti-bacterial filters for their ventilators because they were needed for patients with COVID-19.

<https://www.disabilitynewsservice.com/coronavirus-hancock-refuses-to-publish-treatment-guidance/>

Shovlin, C. and Vizcaychip, M. (2020) *Implications for COVID-19 triage from the ICNARC report of 2204 COVID-19 cases managed in UK adult intensive care units*, <http://orcid.org/0000-0001-7894-873X> [Marcela P Vizcaychipi3,4](#)

Joint Committee on Human Rights (2020). *The Government must urgently consider the human rights implications of COVID-19 measures, says Joint Committee on Human Rights*. [press release] 21 September. Available at: <https://committees.parliament.uk/committee/93/human-rights-joint-committee/news/119291/the-government-must-urgently-consider-the-human-rights-implications-of-covid19-measures-says-joint-committee-on-human-rights/>

NICE (2020). *NICE updates rapid COVID-19 guideline on critical care*. [press release], 25 March. Available at: <https://www.nice.org.uk/news/article/nice-updates-rapid-covid-19-guideline-on-critical-care>
<https://www.disabilitynewsservice.com/regulators-face-call-to-act-over-figures-linking-covid-deaths-with-health-system/>

- **Structures of residential support provision for disabled people and under-funding within the sector.** The social care sector is notoriously under-resourced with the result that staff to resident ratios in groups home may be in line with health and safety requirements under usual circumstances but insufficient to provide the individualised support required to enable residents to enjoy the same life chances as non-disabled people under usual circumstances. **Under the pandemic conditions this will have made enforcing social distancing within certain residential homes and supported living arrangements more difficult.** As highlighted by retired disability consultant Jenny Morris: “These are circumstances in which, generally, people do not have sufficient choice and control in their lives.” Public Health England linked the shockingly high mortality rates of people with learning difficulties to the greater likelihood of co-morbidities such as obesity and diabetes – in effect blaming them for their own deaths – while ignoring external factors that put them at greater risk of being exposed to Covid as well as, in the first place, to health conditions. **Loneliness and isolation arising from the ban on care home visits has particularly impacted on disabled older people, reducing their will to continue living and making individuals more likely to agree to DNACPRs.**
<https://jennymorrisnet.blogspot.com/2021/03/why-have-so-many-disabled-people-died.html>
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbydisabilitystatusenglandandwales/24januaryto20november2020#main-points>
<https://www.bristol.ac.uk/media-library/sites/sps/leder/Deaths%20of%20people%20with%20learning%20disabilities%20from%20COVID-19.pdf>

- **Inadequate personal protective equipment (PPE) and greater exposure to risk for disabled frontline workers.** In a report published in June 2020, the NAO said it had also heard concerns from a range of health and social care organisations about the supply of PPE, with central sources up to mid-May meeting only around half of the modelled requirement. Anecdotally, mental health service users have spoken about a complete lack of social distancing on acute health wards. A study by UCL researchers published in October 2020 found that at least 38% of older adults in psychiatric wards in London were infected with COVID-19 at the height of the pandemic. 15% died. The researchers found that psychiatric wards were slow to receive tests and PPE.

Lack of safety equipment and precautions impacted negatively not only on patients and residents but also put disabled frontline workers at risk. Disabled people are disproportionately represented in low paid jobs as are people from Black Asian and Minority Ethnic (BAME) communities. Additionally, these are higher prevalence rates of disability among the BAME population. A report published by the TUC in November 2020 found that whilst the disability employment gap had narrowed slightly since 2019, the disability pay gap had drastically increased from 15.5 per cent to 19.6 per cent. Several UK national data sources indicate

substantial ethnic differences in the prevalence of activity-limiting long-term health conditions and impairments.

<https://www.nao.org.uk/report/readying-the-nhs-and-adult-social-care-in-england-for-covid-19/>

<https://www.ucl.ac.uk/news/2020/oct/high-covid-19-rates-psychiatric-hospitals-highlight-inequalities>

<https://www.tuc.org.uk/research-analysis/reports/disability-pay-and-employment-gaps>

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/214455/rrep684.pdf

- **Unwillingness of some employers** to allow disabled workers to shield alongside a too narrow Clinically Extremely Vulnerable (CEV) category. Research by Scope found that one in five disabled workers had work from home requests turned down during pandemic. The survey also found disparities between different age groups and geographical areas. A third of 18 to 34-year-old disabled workers had been refused a request to work from home, while 20% had been refused redeployment and 15% had been refused furlough. Disabled workers in London were most likely to be refused their request; almost a third were not able to work from home, while 21% were refused furlough. There have been concerns raised by disabled people that those classified as CEV did not include all those who were most at risk as a result of underlying health conditions and who had been advised by their GP that they should shield.

We are extremely concerned that official **shielding guidance ended on 31st March** before everyone on the CEV list has received their first vaccine jab let alone both. Those in paid employment have thus been left with **no legal protections against employers who insist they return to workplaces on threat of losing their jobs.**

<https://www.personneltoday.com/hr/a-fifth-of-disabled-workers-had-covid-work-from-home-requests-turned-down/>

<https://www.tuc.org.uk/blogs/government-must-urgently-rethink-sending-shielders-back-work>

- Disabled people **unable to afford to shield.** Shielding increases essential household costs such as purchase of PPE, online delivery costs and higher energy bills yet the government refused to apply the £20 Universal credit uplift to legacy benefits – of the more than 2.2 million benefit claimants still on legacy benefits, three quarters are disabled. A legal challenge against this has been launched on the grounds that this is discriminatory. The government's justification that disabled people can move onto Universal Credit is flawed in that many disabled people are significantly financially worse off on UC. **Disabled asylum seekers have been in impossible situations, living on just £5 per day without bank accounts or technology with online access.**

And contextually:

- **Fragmentation of the social care system through privatisation**

- **Abrogation by central government of responsibility towards the population's social care needs** at the same time as massive cuts to local authority budgets leading to falling levels and standards within social care provision and a social care market at tipping point - elements which contributed to the UN Disability Committee finding in 2016 that the **UK government was responsibility for grave and systematic violations of disabled people's rights**

- **Growing inequality and poverty as a direct result of the austerity and welfare reform programmes** – in 2018 the Equality and Human Rights Commission reported that disabled people were now three times more likely to live in severe material deprivation than non-

disabled people resulting in rejection of government-imposed lockdown measures and official social distancing advice in poorer and more disadvantaged communities. The intrinsic relationship between poverty and disability mean that disabled people are more likely to be living in such areas.

Disabled people have experienced a whole range of adverse impacts as a result of existing structural inequalities and the way the pandemic has been handled. During the first wave many disabled people including both those who were already housebound and those who needed to shield found themselves unable to get online deliveries. This revealed a shortcoming in supermarkets' inability to identify disabled customers. The Coronavirus Act introduced easements to both the Care Act 2014 and the Children and Families Act. Both community and acute mental health services were closed or experienced reduced operational capacity.

Experiences during the pandemic have further highlighted the many flaws within the current social security system and the urgent need for change. Existing Universal Credit claimants have benefitted not only through the £20 uplift but as a result of a number of other temporary measures suspension of both conditionality and sanctioning and the Minimum Income Floor as well an increase in the Local Housing Allowance. Officially work coach powers to sanction claimants deemed not to be complying with their claimant commitment, undertaking actions such as 35 hour per week job searches in return for their benefits, were re-introduced from 1 August 2020. However, implementation has not yet resumed (to our knowledge).

New Universal Credit claimants among the millions who applied since the pandemic started have nevertheless struggled under the system. The [Welfare at a \(Social\) Distance research project](#) found that many benefit claimants were struggling with a considerable gap between their basic cost of living and the amount of benefit they received. Findings showed that almost 60% of new benefit claimants and 43% of existing claimants had experienced a **drop in their income** which they were not able to manage by simply reducing their spending. **One in six new claimants and one in five existing claimants had skipped a meal** in the previous two weeks because they could not afford food.

The government has portrayed a binary choice to the public of "Public health versus the economy". This is a false dichotomy; a successful strategy would have encompassed both whereas the UK government has instead failed disastrously on both as demonstrated by New Zealand's example. One can only speculate on the motivations behind the UK government's strategy but there has been the appearance of a **grab for profit alongside a complex mix of devaluation and ignorance of disabled people's lives**. Comments attributed to Dominic Cummings then advisor to the Prime Minister, in the early days of the pandemic, suggested he considered the lives of disabled and older people worth "sacrificing" to keep the economy open.

This represents a miscalculation in that there is a significant overlap in terms of those most at risk from coronavirus while also being at the forefront of keeping the economy running. Common perceptions of disability under-estimate prevalence (currently 21% of the population) while equating it with visible physical impairments; in fact, only 8% of disabled people need use of a wheelchair. Older people do make up a growing proportion of the disabled population but disabled people nevertheless make up 20% of the working age population according to figures from December 2020. Disabled people do not live as a separate group within society; although congregated predominantly among those in lower income deciles, we are workers, carers, parents and individual employers of social care staff rather than the passive recipients of care that society commonly views us as. What that means is that **when we get ill and die, it has a significant impact on the population as a whole.**

It is the way that **disability is so widely misunderstood within wider society** that has enabled the government to get away with falsely presenting their strategic choice as this binary between protecting the economy for the good of the many and protecting the lives of a relatively few older and disabled people. Thus, the government has set up a situation of divisions and hostility within society, encouraging a narrative that blames older and disabled people – already commonly perceived as a burden on society – for the privations of everyone suffering through lockdown.

For disabled people, the **increasingly casual way in which our lives are being described as dispensable** heaps further hurt onto the experiences of the past decade where our lives have been driven deliberately and systematically backwards as a result of deliberate political decisions voted in by the electorate. There is widespread talk of how damaging the pandemic has been for the population's mental health and yet lockdown conditions are still a step above those that hundreds of thousands of disabled people have been increasingly consigned to as their social care packages have dwindled through austerity cuts: most non-disabled people trapped within their own homes due to lockdown can still access food, water and toileting facilities while inside whereas too disabled people are now **routinely left for hours without the most basic of human needs**.

Disabled people are extremely concerned about the prospect of fresh assisted suicide legislation being introduced to Parliament after May. Matt Hancock has recently signalled that he thinks the UK's current legislation needs re-evaluation. It is doubtful that his motivation lies with compassion for the UK citizens reportedly denied the chance to travel to Dignitas in Switzerland to end their lives during the pandemic, and more with economic considerations for how to save money on health and social care funding in the long-term to keep people alive. [insert link]

Disabled campaigners are calling instead for a very different approach. We want to see a complete turn around in the way that social care is viewed - **away from perceptions that supporting people with no economically productive value is a drain on society and towards the idea that funding in this sector represents a social and economic investment.**

A fundamental principle within the disabled people's movement is the right to independent living. By this we do not mean doing everything for ourselves - although that is how central and local government have subverted our language to justify cuts over recent years; according to Article 19 of the United Nations Convention on the Rights of Disabled People, the right to independent living means:

Recognition of the equal right of all disabled people live in the community, with choices equal to Others with full inclusion and the right to equal participation in the community. This includes:

- a) the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;*
- b) access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;*
- c) that community services and facilities for the general population are available on an equal basis to disabled people and are responsive to their needs.*

Article 19: United Nations Convention on the Rights of Disabled People

We are calling for a national independent living support service [see attached vision document]. The core demand of our vision is as follows:

“A new universal right to independent living, enshrined in law and delivered through a new national independent living service co-created between government and Disabled people, funded

through general taxation, managed by central government, led by Disabled people, and delivered locally in co-production with Disabled people.”

This is very similar to and entirely compatible with proposals for a national care service. One key difference is the essential importance of disabled people being involved at all levels of design and delivery. All too often we are seen as nothing more than recipients of social care without agency or dignity or a right to equal consideration, and the way that social care is delivered entrenches the othering of disabled people within society.

One of the ways that our humanity is downgraded within the sector, is the increasingly common usage of the term “care” as opposed to “social care”. Presumably the intention is to make the profession more relatable and attractive to prospective workers. For disabled people the change in terminology is unwelcome yet our views are rarely if ever sought about the services our lives rely upon.

The term “care” has negative connotations for disabled people on multiple levels – for example, it reinforces the idea of disabled people as without agency; its relatability belies the extent to which social care work is highly skilled and requiring of attitudes and talents that are unfortunately hard to come by; the word “care” on its own is suggestive of a less formal and more intimate relationship and whilst the reality of social care work is physically very intimate, informal and un-boundaried “care” is too frequently the cause of negative experiences in disabled people’s lives ranging from unhappiness at the hands of over-bearing and resentful parents to extreme psychological distress occurring as a result of sexual, emotional and physical abuse to which disabled people are at disproportionate risk compared to non-disabled peers.

There are many excellent workers in the sector but the structure of social care settings and the nature of the work mean that service users are at **higher risk of abuse than non-disabled people**. within conditions within social care settings. There is considerable evidence that people with learning disabilities in particular are at [much greater risk of sexual abuse and assault](#) than the general population.

Lived experience means that disabled people themselves are more aware of the multiple issues and disadvantages that disability involves, as distinct to the myths and misperceptions that shroud common ideas about disability held even by those who work in the sector.

This is why disabled people and other benefit claimants are also playing a leading role in developing **proposals for the future of social security through the work of a [Commission of Inquiry](#)** funded by Trust for London in partnership with the University of Warwick and London School of Economics. There has been considerable support for the Commission’s work and our initial proposals from across the UK. One of these is that Universal Credit should be replaced with a Guaranteed Decent Income set in line with minimum income standards. This would lift many people out of poverty – putting them at lower risk from future pandemics.

I confirm that the opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.



03.04.2021

SIGNED

DATE

Please return to inquiry@keepournhpublic.com

Thank you
Olivia O'Sullivan
Secretary to the panel
The People's Covid Inquiry

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