

Written evidence submitted by the Oxford University Disability Law and Policy Project (CVD0008)

About the Oxford University Disability Law and Policy Project

The [Oxford University Disability Law and Policy Project](#) develops initiatives to increase academic teaching and research on disability and related issues at its intersection with law and policy. In doing so it aims to bring new perspectives to academic analyses of law and policy and to generate policy-relevant research which better engages with the issues faced by our diverse population of people with disabilities.

About the Bonavero Institute of Human Rights

The Bonavero Institute of Human Rights is a dedicated institute within the Faculty of Law at the University of Oxford. The Institute is based at Mansfield College, Oxford. Here we undertake world class research in the field of human rights law and foster public engagement in human rights issues beyond the academy. As part of its mission, the Institute will establish a vibrant community of graduate students, host outstanding scholars of law and other disciplines, and collaborate with practitioners engaged in the most pressing contemporary human rights issues around the world.

Executive Summary

The coronavirus pandemic has led to far reaching changes to law and policy affecting disabled people in the UK, impacting upon every aspect of our daily lives. From restrictions around the 12 week ‘shielding’ of vulnerable individuals to reducing the number of professionals needed to make a hospital order under the Mental Health Act 1983, and ‘easing’ the requirements on local authorities to provide care for disabled people under the Care Act 2014, the [Coronavirus Act 2020](#) has wide ranging and damaging implications for the rights and freedoms of disabled people in the United Kingdom. The government’s policymaking in response to the pandemic has failed to fulfil its own [Public Sector Equality Duty under the Equality Act 2010](#) with respect to disabled people and its obligations under the United Nations Convention on the Rights of People with Disabilities.

The voices of disabled people have been largely excluded during the crisis and yet the impact on our lives has been dramatic. In June, the [Office for National Statistics Data](#) has revealed that almost 60% of deaths from coronavirus in the UK have been people with disabilities. Disabled women are 2.4 times more likely to die from Covid-19 and men with disabilities 1.9 times more likely to die. These risk levels *rise* to 11.3 times for disabled women aged under 65 and 6.5 times for men. The ONS think these estimates are "conservative". Their data also reveals the disproportionate [rates of morbidity and infection amongst BAME groups](#). As the United Nations observes the ‘heavier burden of the immediate and long-term economic and social consequences of the pandemic’ on ‘[p]ersons with disabilities experiencing intersectional and multiple discrimination as a result of their gender identity, age, ethnicity, race, sexual orientation, origin, location and legal status’. Urgent work is needed to understand these immediate intersectional impacts on disabled people in the UK and to put in place action to mitigate the long-term consequences.

There has been a failure of the government to embed [social and human rights models](#) of disability in its pandemic response. This is writ large in its approach to determining its

shielding list – those people who should stay at home for 12 weeks. [Many of those who ought to have been included in this register have been omitted and face no access to food without leaving their homes](#) despite being severely disabled and being affected by chronic illness. The government’s messaging that the [“virus does not discriminate”](#) misunderstands the differential impact of the extensive changes to daily life for disabled people. There has been a failure to properly support disabled people to cope with these changes and for reasonable adjustments to be made where appropriate and safe to do so. This has led disabled people to feel like they are not important, and to lose trust in government.

The unequal impact of the coronavirus crisis, charted in the essays in this report, comes after a decade of austerity. In 2017, the United Nations Committee on the Rights of Persons with Disabilities [raised concerns about the treatment of disabled people during this period in their Concluding Observations on the initial report of the United Kingdom](#). Our report reflects the themes of articles of [the United Nations Convention on the Rights of Persons with Disabilities](#) (UNCRPD), ratified by the United Kingdom in 2009. It does so to demonstrate the widening inequality for disabled people during the coronavirus crisis in all parts of our lives, and to reflect the insufficient incorporation and uneven implementation of the Convention across all policy areas, by the government, in response to the crisis.

This Report is based on material submitted to the House of Commons Women and Equality Committee inquiries on [the unequal impact of Covid-19 and the Coronavirus Act 2020 on People with protected characteristics](#) and papers given at our webinar on [Disability in the Context of the Coronavirus Crisis](#). Each paper is summarised in this section alongside the associated recommendations.

General Recommendations:

- 1. We urge the government to undertake an immediate review of legislation passed during the coronavirus crisis and communication thereof.** In doing so, we ask that the government changes the Coronavirus Act and all its policymaking to meet its duties under the Equality Act 2010, and commitments to the United Nations Convention on the Rights of Persons with Disabilities, taking steps to avoid or mitigate any potential disadvantage for disabled people.
- 2. The Government must put in place a disability inclusive Covid-19 response and recovery action plan, for the immediate and long-term economic and social consequences of the pandemic, that reflects the multiple and intersecting identities of, and forms of discrimination faced by, persons with disabilities.**

Professor Anna Lawson, Director of the Centre for Disability Studies and Co-ordinator of the Law School’s Disability Law Hub, University of Leeds, focuses on legal obligations, both in the United Nations Convention on the Rights of Persons with Disabilities and in Great Britain’s Equality Act 2010. She does so to highlight the need to ensure that policy and practice responses to the Coronavirus Crisis are disability-inclusive. Her paper focuses on obligations imposed on providers of services and public functions, including the government. In particular, it highlights the importance and relevance of the anticipatory reasonable adjustment duty. It draws attention to two cases, in which hundreds of disabled people allege that the government and supermarkets respectively breached this duty in the early months of the coronavirus crisis. It is to be hoped that these obligations will serve to highlight to providers of services and functions the importance of routinely anticipating and

considering how to minimise the disability-related disadvantage of potential policies and practices that respond to the new demands of physical distancing and other infection-reduction requirements.

Recommendations:

1. **Government should comply with the Equality Act's proactive duties to consider the disability impact of its COVID-related policies and practices**, and to anticipate and take steps to avoid or mitigate any potential disadvantage which might otherwise be caused to disabled people.
2. **Government should work with disabled people's organisations and the Equality and Human Rights Commission to produce authoritative guidance for providers of services and public functions on ensuring that infection-reduction policies and practices are developed and implemented in ways that do not disadvantage or exclude disabled people, in line with the UN's [Disability-Inclusive Response to COVID-19](#).**
3. **Government should implement recommendations made by [the 2016 House of Lords Select Committee Report on the Equality Act 2010 and Disability](#), and by [the Women and Equalities Committee](#)**, on enhancing the enforcement of the Equality Act 2010, both by removing deterrents to individuals bringing disability discrimination cases; and by measures which embed the monitoring and enforcement of relevant duties in the work of regulatory and inspection bodies.

Writing on disabled people's access to healthcare services, Lindsay Lee, former WHO technical officer, gives an overview of the [Policy Brief of the UN Secretary-General: A Disability-Inclusive Response to COVID-19](#) and unpacks the disproportionate impacts of coronavirus on disabled people's health and access to healthcare services. Disabled people face [three distinct but related dimensions of increased risk of COVID-19](#): increased risk of contracting the disease; increased risk of developing a severe case of the disease once contracted, and; increased risk of negative secondary consequences from the COVID-19 response. It is important to unpack the distinct reasons for this disproportionate impact, in order to target solutions that can address the problems.

Recommendations:

1. **Ensure all public health information is accessible for disabled people.** This includes providing information in inclusive formats such as captioning, sign language, Easy Read, and formats usable by electronic screen readers. Accessible public health information should also be distributed directly to community networks of disabled people.
2. **Ensure that disabled people have access to health care services they need over the course of the outbreak.** This includes regular health care services, but also services related to COVID-19 treatment. Disabled people must have access to scarce health resources such as ventilators on an equal basis with others.
3. **Ensure that the reasonable adjustments disabled people had in place prior to the COVID-19 outbreak remain operational.** This includes any [provision of water](#),

[sanitation, health care waste management, hygiene and environmental cleaning infrastructure in healthcare facilities](#), care services and transportation.

Professor Jonathan Herring, DM Wolfe-Clarendon Fellow in Law, Vice Dean and Professor of Law, Faculty of Law, University of Oxford, writes on shielding the vulnerable. COVID-19 and the resulting guidance has brought out into the open the disadvantages and prejudices associated with disability. Those labelled extremely vulnerable are defined and dominated by their medical diagnosis. Their identities as parents, carers, doctors, lovers are lost by their medical diagnosis. They are rendered invisible in the public discourse and it is seen as their responsibility to meet their needs. The guidance fails as it is based on an ablist idealisation of the autonomous disease free individual, which bears no relation to our lived in reality as caring, relational, vulnerable communities.

Recommendations:

- 1. To ensure advice to shielding people takes account of their caring responsibilities and relational welfare.**
- 2. To ensure pandemic response and recovery measures better accommodate those shielding to promote their wellbeing. For example, if a future lockdown is needed, to provide times of the day when only those shielding are permitted outside.**

Dr Brian Sloan, a Fellow of Robinson College, University of Cambridge, covers legislative changes affecting the social care of disabled people in their homes and in residential care settings. One of the many effects of the Coronavirus crisis on social care has been the relaxation of already modest duties owed by local authorities to service users under the [Care Act 2014](#). While somewhat understandable in the context of an under-resourced system facing an unprecedented threat, the so-called ‘easements’ pose grave risks to the dignity of disabled and older people. The reliance on Convention rights, albeit purporting to provide a minimum level of protection while more extensive duties are attenuated, is limited in its effectiveness because of the deference shown by courts to policymakers in this area. It is vital that the ‘easements’ are repealed, and that the crisis prompts a wholesale review of social care policy and funding.

Recommendations:

- 1. Repeal the so-called ‘easements’ of local authorities’ duties under the Care Act 2014 as soon as is feasible.**
- 2. Reconsider reliance on European Convention on Human Rights to provide a minimum level of protection for social care users, given their limited effectiveness in this context, and add a duty to protect from a risk of abuse and neglect.**
- 3. Establish an emergency cross-party working group to produce a White Paper setting out draft new legislation to ensure that social care is adequately, fairly and sustainably funded to ensure the dignity of its users and workers.**

Kamran Mallick, Chief Executive Officer at Disability Rights UK, describes the charities vision to create a society where disabled people have equal power, rights and equality of

opportunity. He writes about the lived experiences of disabled people during the Covid-19 crisis and what policy makers, institutions and individuals to remove the barriers that exist for us at this time. As we adjust to another 'new normal' as we begin to exit lockdown measures in July, and with the shielding programme due to end later in the year, he asks how we win back our hard fought rights so eroded by the Coronavirus Act 2020? How can disabled people gain a seat at the decision-making table as the government plans the economic and social recovery from the pandemic? He argues that we need government to establish a Covid-19 Inclusive Response and Recover Group, of experts by experience with disabilities and Disabled People's Organisations. He urges disabled people to join Disability Rights UK and become part of that movement to inform policy work and lobbying as part of this work.

Recommendations:

- 1. Government must establish a Covid-19 Inclusive Response and Recover Group, of experts by experience with disabilities and Disabled People's Organisations, to ensure disabled people are central to decision-making on the economic and social recovery to the pandemic and ongoing healthcare guidance.**
- 2. Government must provide local authorities with resources to enable them to hold Citizens' Assemblies for *Homes fit for the Health of the Nation*, in order to place disabled people's independent living at the heart of 'building back better'.**
- 3. Government must produce urgent guidance on supporting access to food for disabled people during the current coronavirus crisis and future pandemics which is aligned with duties under the Equality Act 2010 and the United Kingdom's commitment to the UNCRPD.**

Dan Holloway, Futures Thinking Network, The Oxford Research Centre for the Humanities, writes on the effectiveness and accessibility of Government communications and the effects of poor communications on mentally ill and neurodivergent people. The paper highlights the failure of government communications to address the uneven distribution of the effects of Covid-19 on people with disabilities. Dan argues that it is especially at times of crisis that we need to prioritise those whose needs are greatest and the role narrative plays during such crises in fashioning society. Dan provides some examples of the ways in which Covid-19 messaging has excluded or directly harmed mentally ill and neurodivergent people and suggests a series of seven questions, developed as a field kit for communications officers, which are important to ask before sending out any communications message. It is essential to ask these questions to us as a community too, and work with us to co-produce the policies and communications which are developed. This always matters. It matters doubly so in times of crisis.

Recommendations:

- 1. Ensure the communications on policies at times of crisis does not create negative narratives which create further discrimination against those with disabilities and other protective characteristics.**
- 2. Ask these seven questions when producing government communications: 1. If I am asking people to do something, does it seem easy? 2. Does it seem simple? 3. Am I making assumptions of privilege that could alienate some people I am**

addressing? 4. Am I confusing wellness with illness? It is important to consider everyone's health. But people who are ill often have specific needs that are different. 5. Is there a danger what I say now conflicts with what I have said in the past in a way that singles out disabled people? 6. Am I ignoring people's hardship? Am I falsely equating people's situations?

3. **Involve people with disabilities at every stage of the development of communications on pandemic response and recovery.**

Dr Sara Ryan, Senior Research Lead at University of Oxford, writes on people with learning disabilities and the impact of Covid-19. She asks what light has the current pandemic shone on the treatment of and responses to disabled people? She documents how the government's response to COVID19 is working (whether deliberately or otherwise) to generate additional impediments to the freedom of disabled people to lead flourishing lives, reinforcing this notion of disposability. Notably, the approach to prioritisation of particular patients over others based on judgements of value and the placing of Do Not Resuscitate orders on people without their knowledge or permission. The cumulative effect of impediments to the flourishing of disabled people is added to by the Coronavirus Act 2020's easing of social care duties and the 'relaxation' of duties upon local authorities to provide Education and Healthcare Action Plans for young people with special Educational needs and disabilities. Dr Ryan locates these changes in the broader historical context, highlighting the exclusion of learning disabled people in particular have faced and challenging government and society to move beyond the systemic **dehumanisation of learning disabled people** and take action to remove impediments that hinder the realisation of human capabilities of disabled people.

Recommendations:

1. **The impact of COVID-19 on all marginalised groups needs urgent examination and review.**
2. **We need to end the longstanding disregard and dehumanisation of learning disabled people.** To achieve this, the government must enshrine the [human rights model](#) of disability in law. This model focuses on the inherent dignity and inestimable value of each human being and places the individual centre stage 'in all decisions affecting him/her and, most importantly, locates the main "problem" outside the person and in society'.
3. **Reverse the so-called 'relaxation' of duties under the Children and Families Act 2014 on local authorities to provide Educational Health Care Action Plans to young people with Special Educational Needs and Disabilities.**

Inclusive Services and Public Functions: Remembering the Equality Act 2010

- Professor Anna Lawson, Director of the Centre for Disability Studies and Co-ordinator of the Law School's Disability Law Hub, University of Leeds. @CDSLeeds

Catalina Devandas Aguilar, the UN Special Rapporteur on the Rights of Persons with Disabilities) has [recently said](#):

“COVID-19 is hitting hard in our community, feeding on and deepening the historical and structural discrimination against people with disabilities. Governments must act fast to guarantee that all COVID-19 responses are accessible, and disability-inclusive.”

Disability-inclusive responses to emergency situations, including pandemics, are required by [Article 11 of the United Nations Convention on the Rights of Persons with Disabilities](#).

Closer to home, the All-Party Parliamentary Group on Disability has sent a [letter to Boris Johnson](#), stressing that the government's responses to COVID-19 must be disability-inclusive and urging the government to do much more to ensure this. The Equality Act 2010 includes important duties which can help drive disability-inclusive responses to the COVID-19 situation. Importantly, the Coronavirus Act 2020 has not rolled these obligations back – so Equality Act duties still apply in full force.

Relevant obligations under the Equality Act include the [Public Sector Equality Duty](#) (PSED) which requires public authorities to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between disabled and non-disabled people. This is a process rather than an outcome duty – regulating what should be taken into account when decisions are made, but not the ultimate outcome or content of those decisions. Process is extremely important, however, and taking disability equality into account when decisions are made will change very many outcomes.

Another important Equality Act duty is the [reasonable adjustment duty](#) – the duty to take reasonable steps to ensure that disabled people are not subjected to any disadvantage because of physical features; provisions, criteria or practices; or the failure of a duty-bearer to provide some kind of aid or service. In the employment context, these reasonable adjustment duties are entirely reactive, in that they require responses to remove a potential disadvantage encountered by a specific individual. In the provision of services and public functions, however, they have a strong anticipatory element. They are owed to disabled people generally and need to be carried out regardless of whether any particular individual has requested an adjustment or encountered a problem. They impose a duty on providers of services and public functions to continuously anticipate what barriers their actions, their decisions, their policies, their practices and their physical space and features may have for different groups of disabled people, and to take such steps as are reasonable to ensure that disabled people are not actually disadvantaged. They thus carry obligations of process and also obligations of outcome or content – and failure to comply amounts to disability discrimination.

During the lockdown phase of this crisis, disabled people have turned to the anticipatory reasonable adjustment duty as a means of bringing legal action against the government and others for disadvantage they have experienced. One example concerns the [accessibility of the televised government coronavirus briefings which, for many weeks, did not have live sign language interpretation](#). A discrimination case, based on these facts, is currently being brought by about 300 sign language users. Another example concerns supermarkets and access to food. Many shops seem to have understood the ‘extremely vulnerable’ [list so as to alleviate themselves of duties to make adjustments for people not on that list](#). This meant that, contrary to the anticipatory reasonable adjustment duty, some shops did not take steps to adjust their COVID-related policies and practices in order to minimise wholly predictable types of disadvantage for disabled people. For example, websites were sometimes inaccessible or difficult for disabled people (for example, with visual impairments) to use, but

no phone option was provided as an alternative. Queuing can be extremely difficult for disabled people who cannot stand for long, but frequently no seats were provided. Many disabled people need assistance in identifying and locating items, but policies preventing more than one person entering a shop at a time meant they could not be accompanied and assisted by a member of their own household or carer with whom they already had regular contact. On the basis of facts such as these, disabled people have again come forward in their hundreds to bring cases of disability discrimination against supermarkets.

These cases are very significant. This is partly because of the numbers involved – they are the first major disability discrimination class actions in the UK. They are also important because they heighten the profile of the Equality Act’s proactive duties and their requirement for government and for providers of services to take disabled people into account in their responses to the Coronavirus Crisis. The purpose of the Equality Act is not just to provide successful claimants with damages for breach. It is to drive systemic change and to ensure that we as a society become more rather than less inclusive.

Equality Act obligations, such as the PSED and the anticipatory reasonable adjustment duty, must be at the heart of plans for the lifting of lockdown and longer-term management of the pandemic in the UK. We must remember that the anticipatory reasonable adjustment duty applies not just to public bodies, but to any provider of services to the public. Providers of services and public functions must anticipate how their plans to reduce the rate of infection might disadvantage disabled people, and take reasonable steps to avoid or minimise these problems. Do possible one-way physically-distanced systems mean using routes which are not step-free – and, if so, would there be alternative routes or could the steps be removed? Will those routes be navigable for people who cannot see visual markings, and are there things that could be done to provide greater clarity to visually impaired people? Is there a risk that requiring the wearing of face masks could prevent people with hearing impairments lip-reading – and, if so, could transparent masks be required at least for staff in public-facing roles? These are the types of question that the Equality Act duties require providers of services and public functions to address. How they do so will be critical to the inclusion of disabled people in the months and years to come.

Recommendations:

- 1. Government should comply with the Equality Act’s proactive duties to consider the disability impact of its COVID-related policies and practices**, and to anticipate and take steps to avoid or mitigate any potential disadvantage which might otherwise be caused to disabled people.
- 1. Government should work with disabled people’s organisations and the Equality and Human Rights Commission to produce authoritative guidance for providers of services and public functions on ensuring that infection-reduction policies and practices are developed and implemented in ways that do not disadvantage or exclude disabled people, in line with the UN’s [Disability-Inclusive Response to COVID-19](#).**
- 2. Government should implement recommendations made by [the 2016 House of Lords Select Committee Report on the Equality Act 2010 and Disability](#), and by [the Women and Equalities Committee](#), on enhancing the enforcement of the Equality Act 2010, both by removing deterrents to individuals bringing disability**

discrimination cases; and by measures which embed the monitoring and enforcement of relevant duties in the work of regulatory and inspection bodies.

Disabled people's access to healthcare services

- *Lindsay Lee, former World Health Organisation technical officer.
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The United Kingdom as a signatory of the UNCRPD should recognise ‘that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability’ and shall provide health services needed persons with disabilities specifically because of their disabilities (Article 25). In particular States Parties shall prevent ‘discriminatory denial of health care or health services or food and fluids on the basis of disability.’

With this in mind, this paper summarises some key points from [Policy Brief of the UN Secretary-General: A Disability-Inclusive Response to COVID-19](#). It is well established that [COVID-19 has disproportionately impacted disabled people](#) and the [effects of the coronavirus pandemic has heightened the anxiety we face](#). It is important however to unpack the distinct reasons for this disproportionate impact, in order to target solutions that can address the problems.

Disabled people face [three distinct but related dimensions of increased risk of COVID-19](#):

1. Increased risk of contracting the disease;
2. Increased risk of developing a severe case of the disease once contracted;
3. Increased risk of negative secondary consequences from the COVID-19 response.

Disabled people have an increased risk of contracting COVID-19. This higher risk results from environmental barriers that limit protection against infection. One barrier is the [lack of timely and accessible public health information](#), without which disabled people may not receive the necessary information, or receive it too late. Other barriers include lack of necessary accommodations to facilitate the implementation of basic public health behaviours, such as [as frequent hand-washing and maintaining physical distance](#). Case patterns have shown that in places [where physical distancing is a challenge, such as institutional settings, disabled people and older people are more likely to contract the disease](#).

Disabled people have an increased risk of developing a severe case of COVID-19 once contracted. [ONS data](#) shows disabled people are disproportionately represented among severe cases and deaths of COVID-19 in the UK. Though more research is needed on the causes of this, we can assume that that disabled people are disproportionately represented among severe cases and deaths, firstly, because many disabled people have [underlying health conditions that are exacerbated by COVID-19](#). Secondly, disability increases with age, and [current data show clearly that COVID-19 affects older populations more severely](#).

Beyond underlying health conditions that increase risk of severe infection, **disabled people may also develop severe cases of COVID-19 due to inaccessible health care.** It is well known that in general, [disabled people experience barriers in accessing health services](#). In the context of the COVID-19 response, these barriers are exacerbated. Barriers to transportation may also prevent disabled people from even reaching a health-care facility in time to receive needed care. Furthermore, once in the facility, physical barriers, or barriers in communication

or attitudes may be present. Indeed, evidence is mounting on the inconsistency with World Health Organisation standards of the UK's Government's guidance on combating coronavirus in care. All of these barriers may worsen in the context of an emergency situation such as COVID-19. Additionally, during the outbreak, some health systems have become overburdened in their efforts to provide care to a large number of people, in part due to limited resources such as in emergency care beds and ventilators. This can lead to resource allocation decisions being made that [put disabled people at a high level of disadvantage](#). Such barriers in the UK context have [left disabled people in doubt about their right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability](#).

Disabled people have an increased risk for negative secondary consequences from the COVID-19 response, even if they don't contract COVID-19 themselves. As described in Professor Jonathan Herring's powerful essay on shielding (see below), measures to keep the outbreak under control can lead to poorer health outcomes for disabled people. Firstly, although country lockdowns and mandates can have positive consequences for controlling the outbreak, there can be negative consequences for disabled people. Lockdowns can lead to restricted access to essential goods and medicines and can also lead to restricted access to the personal care needed for disabled people to perform activities of daily living. Restrictions in access to public spaces can also make it harder for disabled people to undertake healthy behaviours such as physical activity or socialising. Not performing healthy behaviours can have direct physical and [mental health consequences, including an increased risk of depression](#).

Secondly, in order to provide the level of care needed to control the outbreak of COVID-19, governments may reduce other health services to an absolute minimum. The disruption of these necessary services puts disabled people, who often require [access to health-care services more frequently](#), at a disadvantage in maintaining their general health.

Recommendations

- 1. Ensure access to accessible public health information for disabled people.** This includes providing information in accessible formats such as captioning, sign language, Easy Read, and formats accessible by electronic screen readers. Accessible public health information should also be distributed directly to community networks of disabled people.
- 2. Ensure that disabled people have access to health care services they need over the course of the outbreak.** This includes regular health care services, but also services related to COVID-19 treatment. Disabled people must have access to scarce health resources such as ventilators on an equal basis with others.
- 3. Ensure that reasonable adjustments disabled people had in place prior to the COVID-19 outbreak remain operational.** This includes any [provision of water, sanitation, health care waste management, hygiene and environmental cleaning infrastructure in healthcare facilities](#), care services and transportation.

Shielding the Vulnerable from the Coronavirus

– Professor Jonathan Herring, DM Wolfe-Clarendon Fellow in Law, Vice Dean and Professor of Law, Faculty of Law, University of Oxford. @jojohjhj

This paper discusses the [Government Policy of shielding in relation to the extremely vulnerable](#). I should disclose as a conflict of interest I fall within that group. I will start with some comments on the use of the word “vulnerable” before discussing the policy of shielding.

Around twenty years ago the word vulnerable was commonly used in Government and legal documents to identify individuals or groups of people who were at risk of harm and so needed to be looked after. That all changed when the 2014 the Care Act removed from the legislative framework for care any reference to vulnerable adults and instead using the language of ‘those in need’. The primary argument in favour of this shift in terminology was that the word vulnerable carried a stigma. Since then the term vulnerability has largely slipped out of the legal lexicon and it now only found in niche areas of the law.

A very different challenge to the concept of vulnerability has come from academic writing promoting the concept of Universal Vulnerability ([Fineman 2008](#), [Herring 2019](#)). This argues that all human beings are in their nature vulnerable. Society and the law may be organised around the image of the autonomous, self-sufficient and independent man, but the reality is that we are all deeply dependent on others; all vulnerable to disease; and all impaired in our decision making. So rather than identifying particular groups as falling short of this idea and therefore vulnerable; we should recognise our mutual vulnerability.

It is, therefore, striking that with COVID-19 we see the resurrection of the idea of vulnerable groups in Government Documents. In fact, the Government guidance defines three vulnerable groups: “the clinically extremely vulnerable” “the clinically vulnerable” and “vulnerable people (non-clinical)” (HM Government 2020).

Shielding

Clinically extremely vulnerable people are required to be shielded. Shielding is like house arrest, but worse. The original Government advice was clear: “you’re strongly advised to stay at home at **all times** and **avoid any face-to-face contact**.” This was updated in June 2020 to state “you’re strongly advised to stay at home **as much as possible** and **keep visits outside to a minimum**.” The guidance does not exactly prohibit you being in the same room as someone else, but you should keep 2 meters from them and keep time spent together to a minimum. You should sleep in a separate bedroom from anyone else and should not use the same bathroom. You are encouraged to eat alone. The guidance seems premised on the assumption you have lavish accommodation including a spare bedroom; a spare bathroom; and rooms with what estate agents call ‘generous proportions’.

I believe this guidance makes manifest views about disability, health and the human nature that are profoundly mistaken. I make three points.

We are all vulnerable

It is tragically apparent that everyone is vulnerable to the virus. The government’s policies and the actions of others may make others more or less at risk. The allocation of PPE,

government testing policy, the behaviour of those with the virus will render some less vulnerable and others more so. But the virus highlights the fragile status of our bodies. They are dependent on the environment and on other bodies. To highlight vulnerability resting in the particular bodies of some is to distract from the vulnerability of everyone and the way government policies and social forces generate powerful sources of vulnerability.

We are relational beings

The guidance for shielding is harsh. Partners may not sleep together and should minimise time spent together. Parents should not cuddle their children or hold their hands. Comfort must be offered at a two metre distance. Mealtimes should be solitary. The lifestyle promoted is starkly monastic. Disability campaigners have long argued that disabled people are portrayed as isolated, unproductive and sexless. They are now.

The government advice is based around an image of unencumbered individual who has no responsibilities. The guidance seems written from another planet for the shielded person caring for a parent with dementia; looking after a child on the autism spectrum or living with a partner with depression. It seems based on the premise that the disabled and ill are passive recipients of care and cannot having caring responsibilities of their own.

We are people of relationships. We are people whose selves are constructed through and out of our relationships with others. Requiring people to isolate themselves in this way for months is out of proportion to the risk of associating with members of one's household. Prohibiting physical interaction strikes at our souls.

Health is communal

The guidance is designed to protect and promote health. But it should be noted that it advocates a very old fashioned understanding of health. That is that health it is the absence of a disease or illness, in this case the absence of the virus.

But health is not an individual thing. Robinson Crusoe, living alone on his desert island, might have been disease free, had the most wonderful physique and a BMI to die for, but his loneliness and lack of human interaction meant he was healthy in only the narrowest sense. If we look for a health we should not strive for disease free individuals, but healthy communities and relationships. Healthy communities do not seek to hide out of sight and out of mind "the extremely vulnerable".

Recommendations:

- 1. To ensure advice to shielding people takes account of their caring responsibilities and relational welfare.**
- 2. To ensure pandemic response and recovery measures better accommodate those shielding to promote their wellbeing. For example, if a future lockdown is needed, to provide times of the day when only those shielding are permitted outside.**

COVID-19 and the Care Act 2014

Dr Brian Sloan, Fellow of Robinson College, Cambridge. @briandsloan

Social care is a system, [providing daily living assistance to disabled and elderly people](#), that was [already](#) overstretched and struggling to secure the dignity of its users in the context of increasing need and a disputed funding model before the coronavirus arrived. The impact of COVID-19 has been [devastating](#).

A concrete legal reaction has been to ease the social care duties owed by local authorities under the [Care Act 2014](#) in response to the pandemic. It is both striking and controversial that those already modest duties were attenuated five years after their introduction, and at a time of crisis when demand will obviously [remain high](#) and more informal sources of support for disabled people are at risk.

The name given for this process of attenuating a Care Act duty in the [guidance](#) is an 'easement', which is an unusual use of a [Land Law term](#). [Schedule 12 of the Coronavirus Act 2020](#) lists a host of duties under the Care Act and related regulations with which local authorities in England no longer have to comply. These include duties to assess an [adult](#) or a [carer's](#) need for care and/or support, and to determine whether someone's needs meet the Act's [national eligibility threshold](#). These provisions do not actually prevent a choice to carry out a needs assessment. But overall, local authorities' discretion is increased. The reality is that before the 2020 Act, [local authorities had considerable effective discretion](#) about which needs to meet despite the national eligibility threshold. Now they will have discretion over whether even formally to *assess* needs.

[Schedule 12](#) provides that a local authority's duty to *meet* a need for care and support under the Care Act is limited to situations where the authority considers it necessary to meet those needs to avoid a breach of the adult's [European Convention](#) rights. At first sight, this might provide some reassurance, purporting to ensure a minimum standard of protection for disabled people despite the pandemic. The [statutory guidance](#), moreover, emphasises that the 2020 Act does not give authority to withdraw whole services.

But any optimism must be qualified, since the protection provided by the Convention is limited at the best of times. This is illustrated by the case of [Elaine McDonald](#), who had help to reach a commode at night withdrawn such that she was forced to rely on incontinence pads, despite not being medically incontinent. [Subject to the local authority's procedural obligations](#), the substance of the local authority's decision there was held not to breach Ms McDonald's right to respect for her private life under Article 8. A breach of that right [might not be found](#) in this context unless it amounts to a breach of the rights to be free from torture, or inhuman or degrading treatment for the purposes of Article 3, which [carries a high threshold](#). So the 2020 Act's safeguarding of Convention rights may not provide much comfort to disabled people worried about maintaining their dignity at the present time, even if [it is unclear that the national eligibility threshold would have helped Ms McDonald](#).

As for the length of time that the situation will last, the [basic principle](#) is that the 2020 Act will expire two years after it was passed, in March 2022. That principle is [immediately undermined](#) by the fact that the Act's application can either be terminated early or extended for up to six months at a time by regulations. But perhaps there is no real alternative in contemporary conditions. It must be acknowledged that the present crisis involves a lot of

unknowns and that extraordinarily difficult decisions will almost inevitably have to be made. The social care system was stretched before the pandemic hit and issues such as care workers needing to self-isolate or falling ill themselves are likely to make matters even more difficult.

[Anecdotally](#), many care workers are going to considerable lengths to try to maintain a high quality of life for the people they support. The Government's [statutory guidance](#), moreover, makes clear that local authorities should do everything they can to continue meeting their pre-existing duties. When they're unable to do so, they are urged to follow a structured and fully informed decision-making process before taking advantage of the Act's relaxations. There is a notification procedure for doing so. At one time, at least [seven](#) or [eight](#) local authorities had formally triggered the provisions. While that has [recently reduced to one](#), there are suspicions that more are doing so informally, and any 'second wave' could cause a subsequent increase in reliance on the provisions.

The purpose of the so-called easements is to enable local authorities to streamline and prioritise so that the most urgent and acute needs are met. It is arguable, moreover, that a failure to allow a local authority the flexibility to prioritise in the context of scarce resources could have made matters worse, by encouraging formalistic compliance. But the [guidance](#) is not straightforwardly binding, and it is necessary to keep a watchful eye on legal limits that the state imposes on its duties to meet the needs, and ensure the dignity, of people who require support in order to lead fulfilled lives.

While it is easy to be bleak about social care's future, there is a chance that, analogously with the NHS, the present crisis will cause society properly to realise that social care needs to be adequately and fairly funded and both its users and its workers properly valued. Such aspirations, however, still seem a long way from being realised.

Recommendations:

- 1. Repeal the so-called 'easements' of local authorities' duties under the Care Act 2014 as soon as is feasible.**
- 2. Reconsider reliance on European Convention on Human Rights to provide a minimum level of protection for social care users, given their limited effectiveness in this context, and add a duty to protect from a risk of abuse and neglect.**
- 3. Establish an emergency cross-party working group to produce a White Paper setting out draft new legislation to ensure that social care is adequately, fairly and sustainably funded to ensure the dignity of its users and workers.**

Disabled people's access to food and the effectiveness of the Government's response to reported problems

**- Kamran Mallick, Chief Executive Officer, Disability Rights UK.
@KamranMallick**

Disability Rights UK's vision is to create a society where disabled people have equal power, rights and equality of opportunity. Our mission is to campaign for the rights of all disabled people to be included in every aspect of life. We bring the lived experiences of disabled people to everything we do. We challenge policy makers, institutions and individuals to remove the barriers that exist for us. We strongly believe in the lived experience of disabled people; that drives everything we do. We collaborate creatively to propose new ways of working, challenging policymakers, institutions and individuals to remove all the barriers that exist for us in every part of society.

Four strategic priorities guide our work. Firstly, building a movement of disabled people; bringing the lived experience of thousands of disabled people into our policy work. Second is independent living; we campaign for disabled people to have equality in everyday life and for the support that we need to live the lives that we choose, with choice and control over how we live them. Our third priority area is around inclusive economic opportunities. We want to ensure that disabled people have opportunities to work and have the money they need to meet the additional costs of disability. This includes having a fairer benefits system and enabling us to thrive in employment and enterprise. Finally, we focus on influencing public attitudes and behaviours by creating a positive narrative about our lives and the contribution we all make to our society.

During the Coronavirus Pandemic, we have listened to disabled people across the country to understand how they are being affected and integrated our findings into our policy work. The latter has focussed on healthcare, social care, and access to food. Lindsay Lee's contribution clearly describes what should happen, if United Nations and World Health Organisation guidance is followed, to create a disability inclusive response to Covid-19. However, the reality, for disabled people in the United Kingdom falls far short of this. Disabled people have reported receiving Do Not Resuscitate letters, unsolicited by them and without their consent to this form of care. They have received follow-up telephone calls from doctors and GPs to talk to them about signing these Do Not Resuscitate documents, in case they end up in hospital with coronavirus, in order to authorise that course of action in advance! Imagine being one of those disabled people receiving such a letter, already fearing the greater risk of contracting coronavirus and being hospitalised by it. Just what does this approach say about the value of your life and the kind of value the government and society places on disabled people and our wellbeing? This is counter to Article 11 of the UNCRPD which requires states to prevent 'discriminatory denial of health care or health services or food and fluids on the basis of disability'.

Brian Sloan's essay (above) eloquently sets out the problems with 'easing' duties on local authorities in their provision of social care. In addition to these issues we have highlighted issues around access to adequate protective equipment and infection control guidance across social care settings, particularly for the 70,000 people receiving that care in their own homes. For example, it took many weeks for guidance to be to those individuals on the need to self-isolate or what should be put in place if the team of care workers they employ have to isolate.

The food crisis which has affected disabled people during the pandemic, reflects the government's failure to consider our needs, prevent discriminatory practice and consult disabled people and disabled people's organisations during their response to Covid-19. As Professor Anna Lawson points out, this is now subject to a class legal action. The problems arise as disabled people have been segregated into different groups. The shielded group (those regarded 'clinically vulnerable'), the nearly two million people eligible for the government's food parcels and support packages, and the almost ten million disabled people in the UK who are not on this list. This latter group, for whom standard methods accessing food safely vanished during lockdown, have also found it impossible to access food delivery slots online and the allocated shopping slots at supermarkets. In part this was because they are excluded from the shielding list but also because the shopping slots for older people and carers of those shielding were too early in the morning and because there was no protocol in place to embed socially distanced support assistance from supermarket staff.

These circumstances call into question the adequacy of the due regard paid by both the government and supermarkets to their Equality Act duties in enabling access to food orders and delivering food. Disabled people have also reported the exclusionary impact of social distancing and queuing measures adopted by supermarkets in their buildings, especially for those who are blind or visually impaired or those who have a learning disability.

The other big concern for us has been about the terminology and language that's been used by government and the wider response to the pandemic. Many disabled people have found the return to describing disabled people as 'vulnerable' problematic. For many of us, this is because such language obscures our status as rights holders, with personal autonomy, casting us being perceived as 'weak' or 'at risk'. The shift obfuscates our protections under the Equality Act 2010 and the UK's commitments to the UNCRPD.

As we adjust to another 'new normal' as we begin to exit lockdown measures in July, and with the shielding programme due to end in September, how do we win back our hard fought rights so eroded by the Coronavirus Act 2020? How can disabled people gain a seat at the decision-making table as the government plans the economic and social recovery from the pandemic? We need government to establish a Covid-19 Inclusive Response and Recovery Group, of experts by experience with disabilities and Disabled People's Organisations. For disabled people, I'd urge you to join Disability Rights UK and become part of that movement to inform our policy work and lobbying.

Recommendations:

- 1. Government must establish a Covid-19 Inclusive Response and Recovery Group, of experts by experience with disabilities and Disabled People's Organisations, to ensure disabled people are central to decision-making on the economic and social recovery to the pandemic and ongoing healthcare guidance.**
- 2. Government must provide local authorities with resources to enable them to hold Citizens' Assemblies for *Homes fit for the Health of the Nation*, in order to place disabled people's independent living at the heart of 'building back better'.**
- 3. Government must produce urgent guidance on supporting access to food for disabled people during the current coronavirus crisis and future pandemics which is aligned**

with duties under the Equality Act 2010 and the United Kingdom's commitment to the United Nations Convention on the Rights of Persons with Disabilities.

On the effectiveness and accessibility of Government communications and the effects of poor communications on mentally ill and neurodivergent people

- Dan Holloway, Futures Thinking Network, The Oxford Research Centre for the Humanities. @agnieszkasshoes

There are few better indicators that an individual or an institution does not understand the uneven distribution of the effects of Covid-19 than statements welcoming a newfound sense of community or questions looking eagerly to the future asking how we might carry forward the positives that have come out of this crisis.

And there is nothing so telling about an institution's attitude to its members with the greatest needs as the responses given when those communications are questioned.

It is very easy, and seems eminently reasonable, to argue that exceptional times require emergency measures; that in moments of crisis we must simplify our strategy and focus only on the urgent – and in a way I agree. I just don't agree with many about what it is that is urgent.

I would argue that it is especially at times of crisis that we need to prioritise those whose needs are greatest. And that is because of the role narrative plays in fashioning society. In particular the foundation myth. In times of crisis, how we survived matters – that is what becomes the foundation myth for the society we rebuild. And if we survive by considering our most in need expendable then what comes next will become a dystopia that is all too easy for many of us – and I want to talk here particularly about those of us who are mentally ill and neurodivergent but it applies to many more – to imagine.

The importance of the narratives we choose to frame our societies, particularly in moments of crisis like the current pandemic, are hugely significant. I will provide some examples of the ways in which Covid-19 messaging has excluded or directly harmed mentally ill and neurodivergent people. Then I suggest a series of questions, which I have developed as a field kit for communications officers – questions which are important to ask before sending any communications message.

When an institution, especially an institution of government, communicates it makes a choice whether or not to exclude us. The erasures, the harms, may not be conscious – but the failure to ask the questions that would bring them to light are deliberate; the failure to place those in greatest need at the heart of your crisis communications is deliberate; the fact that you do not understand how we are erased comes from a deliberate decision not to address your privilege. It also comes from a failure to pay due regard to your legal duties, in ways described by others in this Report (see Professor Lawson's paper). What I ask is that institutions own those decisions. That we stop hearing "we didn't mean" or "we didn't realise" and start to hear "we chose to ignore".

Turning to some of the areas in which we have been affected by the failure of crisis communications to consider. I would recommend the [MMHPI's new guide to customer service minimum standards](#) for the finance sector which has a fantastic list of ways to avoid many of these problems:

- **The gap between policy and guidance.** From the moment the Coronavirus Act 2020 was passed, there was a messaging gap between law and guidance. In particular there was over simplistic messaging around exercise and leaving the home. Even when the written guidance had to be clarified to reflect the needs of autistic people under the Equality Act 2010, the messaging remained at odds with it. As a result, in real life and across social media, autistic people were shamed. That fear of shame led many not to go out at all. What is amazing is that this is surprising. We know that half of people in the UK would challenge someone they didn't think looked disabled accessing the things they need – in the light of this, deliberate or not, failure to account for this empathy gap in messaging can only be seen as culpable endangerment. And we are about to see it again in respect of face masks.
- **Most damaging to trust between disabled people and institutions has been the speed with which adjustments have been enacted for everyone, such as remote working, that we spent decades being told were not possible.** What conclusion are we to reach other than we were never valued and what was denied us was a lack of choice? I have yet to see a single communication around “new working practices” which recognises the hurt this has caused. Now they *are* available our new needs are being ignored – around online interviews and meetings for example, or the need for transcription on remote video calls.
- **Finally there is furlough and the unequal opportunities for those not furloughed.** Messaging has gone out, certainly in Oxford, that no one will be adversely affected yet it is clear that those who are unable to “improve themselves” while on furlough **will** be adversely affected in terms of future opportunity for reward and promotion. Even the messaging that congratulates those who “carry on working through” ignores – at best – those who are unable to.

So let me finish with 7 simple questions every communications officer should ask before putting out a message. Questions which have been developed as part of a communications field kit designed to make policy, and the communication of policy, less exclusionary of mentally ill and neurodivergent people. These questions would have avoided – or led to the government and other institutions owning – the harmful outcomes which have arisen.

1. **If I am asking people to do something, does it seem easy?** If it does, that may be a sign that I have failed to consider things that make it difficult for some people. For example if you say “wear a face mask” you might be missing the fact that for autistic people, for example, cannot do so without sensory overload, and many deaf people rely on lip reading.
2. **Does it seem simple?** As above. For example “telephone your manager” ignores the fact that for many people telephones are an inaccessible means of communication.
3. **Am I making assumptions of privilege that could alienate some people I am addressing?** For example, talk about exercising at home or doing things in the garden, or even working on a table all assume that these things are available to people. For many of those with the greatest needs, they may not be.

4. **Am I confusing wellness with illness? It is important to consider everyone's health. But people who are ill often have specific needs that are different.**
5. **Is there a danger what I say now conflicts with what I have said in the past in a way that singles out disabled people?** For example, if you are now proposing remote working, is this something you have previously denied to disabled people who have asked for it? If so, before you communicate, think how upset they might be and address that.
6. **Am I ignoring people's hardship?** We often want to be positive and keep people's spirits up, but for some people life will be incredibly hard. Disabled people maybe finding it impossible to focus on anything except staying alive. It is vital that they realise you understand this.
7. **Am I falsely equating people's situations?** We often want to show solidarity and we say things like "we all..." or we equate our experience with that of disabled people, but this can be both patronising and simply untrue. We know that being sad is not the same as depression. Likewise finding Zoom tiring isn't the same as finding video communications inaccessible, and being frustrated by lockdown isn't the same as being housebound for years.

Of course, it is hard for people to stop and ask questions they don't fully understand and draw from them answers to which they don't fully relate to – even if they have the deepest desire to do so. And that is why the most important thing any institution can do is to ask these questions to us as a community, and ideally to do that as a matter of course because we are systematically embedded in the teams that make policy and communicate it. This always matters. It matters doubly so in times of crisis.

Recommendations:

1. **Ensure the communications on policies at times of crisis does not create negative narratives which create further discrimination against those with disabilities and other protective characteristics.**
2. **Ask these seven questions when producing government communications: 1. If I am asking people to do something, does it seem easy? 2. Does it seem simple? 3. Am I making assumptions of privilege that could alienate some people I am addressing? 4. Am I confusing wellness with illness? It is important to consider everyone's health. But people who are ill often have specific needs that are different. 5. Is there a danger what I say now conflicts with what I have said in the past in a way that singles out disabled people? 6. Am I ignoring people's hardship? Am I falsely equating people's situations?**
3. **Involve people with disabilities at every stage of the development of communications on Covid-19 response and recovery.**

People with learning disabilities and Covid-19

- Dr Sara Ryan, Senior Research Lead at University of Oxford. @sarasiobhan

There is an argument that the pandemic has revealed the [fragility and inhumanity](#) of the neoliberal system that characterises British society. For some people, including disabled people, this has been self-evident for a considerable time. For learning disabled people, in particular, life in the UK has had a fragility and inhumane coating for decades. Just one example, from a 1981 documentary called [Silent Minority](#). Nigel Evans, the filmmaker spent some time in two long stay institutions. In Borocourt Hospital, Reading, he filmed a patient called Terry Green sitting in a wheelchair. A nurse noticed Green seemed to be trying to reach for the wheel. A different chair was found and he tentatively moved forward. Evans commentary:

‘After 40 years in bed, 10 years on a bean bag, Terry Green takes his first inching steps towards independence. For decades, the full panoply of the medical profession has trooped through this ward and no one had the wit, initiative or imagination to give Terry this opportunity. This kind of neglect invites a whole new definition of the phrase ‘mental handicap’.

Nearly 40 years later, learning disabled people are still treated as disposable people with inferior bodies and mind. People die on average 20-30 years before their peers from drowning, scabies, constipation, ignorance and neglect.

We are all implicated in this. All of us, including academics. In 2016 I did a content analysis of the publications in the journal *Disability and Society* between 1994-2013. This was my son [Connor Sparrowhawk’s](#) life time. A small number of articles involved learning disabled participants and the subject matter of these were about learning disability. Learning disabled people were excluded from wider, disability related research, a grotesque exclusion within what you would assume is barrier free. There is a wider history here. Francis Galton presented his eugenic aims at the first meeting of the Royal Sociological Society in London 1904 and there is [clear evidence of derogatory perceptions](#) of disability in early US sociological meetings. It is clear that sociologists have long failed to see the epistemological and methodological value disabled people bring to the discipline.

So, what light has the current pandemic shone on the treatment of and responses to disabled people?

A series of measures have been taken that directly impact on and underline the disposability of certain people; people marked as different and of less, or no, value. The Coronavirus Act 2020 has introduced an easing of duties that have too often been enacted poorly (see also Dr Brian Sloan’s paper). The weight of this easing is causing undue pressure and stress on people and their families. This is happening in education where there are temporary changes to the law relating to education, health and care (EHC) assessments and plans. For example, the absolute obligation to deliver the provision in EHC plans under the Children and Families Act 2014 has been temporarily ‘eased’. Instead local authorities must now use ‘reasonable endeavour’ to ensure it is made.

[Care Act easements](#) have been enacted by at least eight local authorities in the UK allowing these councils to suspend social care duties to disabled adults. This means they no longer

have a duty to carry out assessments of individuals' and carers' needs, the provision of detailed care plans, or the duty to meet the needs of someone assessed as eligible for care and support. Again, a deeply concerning move.

There has been considerable coverage about the prioritisation of particular patients over others based on judgements of value and the placing of Do Not Resuscitate orders on people without their knowledge or permission. Poorly worded guidance was rescinded in March after disability rights organisation and campaigners wrote an open letter raising their concerns. However, research by [Learning Disability England published in May](#) showed that DNR orders are still being placed on people in some social care provision. Turning Point raised concerns that it has received 13 "unlawful" DNRs from hospital specialists and GPs since the beginning of April.

Alongside the DNRS, there was [initial resistance](#) by NHS England and the Department of Health and Social Care to publish the numbers of learning disabled and/or autistic people who have died across all care settings including hospitals. This is in part because robust data is not collected. As such [those with learning disabilities and autism, were not being recorded and accurately included in the overall numbers of deaths reported](#) At the same time, the [Care Quality Commission has revealed](#) a stark increase in the numbers of deaths in care settings compared to this time last year which is around twice the increase in deaths of the wider population. The patchy and poor quality data are concerning given the pre-pandemic mortality rates for learning disabled and/or autistic people. We need to understand who is dying in order to act to reduce further deaths.

In addition to systemic assaults there have been micro assaults. Fears about an overburdened and struggling NHS has generated a space in which people are allowed to say the unsayable. In response to a piece in the Health Services Journal, for example, an anonymous medic commented that concessions for learning disabled and/or autistic people to go out more than once a day allowed them 'to go out and kill'. It took nearly two days to get this comment removed. These unpalatable truths have long been promoted by the likes of [Toby Young who published a recent attack on 'valueless' members of society](#). We cannot allow a normalisation of views that would, outside of a pandemic, be denounced and challenged. There is a growing creep of what is dressed up and passed off as unpalatable truths.

I want to finish with a nod to Amartya Sen. Sen argued state action is required to remove impediments that hinder the realisation of human capabilities. The government's response to COVID-19 is working (whether deliberately or otherwise) to generate additional impediments to the freedom of disabled people to lead flourishing lives, reinforcing this notion of disposability. We come back full circle to Terry Green and his wheelchair; a wilful disregard to engage with certain people as fully human.

Recommendations:

- 1. The impact of COVID-19 on all marginalised groups needs urgent examination and review.**
- 2. We need to end the longstanding disregard and dehumanisation of learning disabled people.** To achieve this, the government must enshrine the [human rights model](#) of disability in law. This model focuses on the inherent dignity and inestimable value of each human being and places the individual centre stage ['in all](#)

decisions affecting him/her and, most importantly, locates the main “problem” outside the person and in society’.

- 3. The government must reverse the so-called ‘relaxation’ of duties under the Children and Families Act 2014 on local authorities to provide Educational Health Care Action Plans to young people with Special Educational Needs and Disabilities.**

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