IN THE MATTER OF THE UK COVID-19 PUBLIC

INQUIRY BEFORE BARONESS HALLETT

MODULE 3 PRELIMINARY HEARING

SUBMISSIONS FROM THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

These submissions are provided on behalf of The Federation of Ethnic Minority Healthcare Organisations ("FEMHO") in advance of the first Module 3 preliminary hearing on 28 February 2023. They address the following items identified by Counsel to the Inquiry ('CTI') in the Note for Preliminary Hearing on 14 February 2023: (1) Outline of scope of Module 3 (2) Rule 9 Requests for information (3) Disclosure (4) Experts (5) Listening exercise – Every Story Matters (6) Approach to evidence of circumstances of individual death.

[A.] INTRODUCTION

1.1. A comprehensive investigation into the government's decision-making processes and policies is necessary to uncover any systemic failures and wider socio-economic factors that may have contributed to the disproportionate impact on minority healthcare workers ("HCWs") and their communities. The failure to adequately protect these workers not only undermines their fundamental human rights, but also poses a serious threat to the health and well-being of the wider community. A thorough and fearless exploration of these issues is essential for the Public Inquiry to fulfil its mandate and to restore trust in the government's response to the pandemic. If it were to fail to fully explore these issues, the Public Inquiry risks not only perpetuating the structural inequalities that have plagued healthcare delivery to minority communities, but also failing to identify and address the underlying causes of the pandemic's disproportionate impact. We urge the Inquiry to take this matter seriously and to demonstrate its commitment to justice and equality for all.

[B.] OVERARCHING SUBMISSIONS

2.1. FEMHO is a multi-disciplinary consortium comprising of over 55,000 individual members belonging to over 40 organisations and networks. The federation brings together existing organisations with shared interests and goals and form a united voice to advocate on behalf of Black, Asian and Minority Ethnic HCW's at all levels within the health and social care sectors. FEMHO consists of a broad spectrum of healthcare workers including but not limited to doctors, nurses,

midwives, dentists, pharmacists, biomedical scientists, physiotherapists, radiographers, speech and language therapists, healthcare assistants, paramedics, social workers, medical secretaries, public health practitioners, managers, IT staff, chaplains, cleaners, porters, catering and other support staff.

2.2. Under Article 2 ECHR. state bodies are under a general "systemic obligation" to put in place a framework of laws, precautions, procedures, training and means of enforcement which will, to the greatest extent practicable protect life.[1] This systemic obligation applies within any context of any activity where the right to life might be at stake and requires the state to take positive and protective steps to safeguard the lives. The Covid-19 pandemic laid bare the structural health inequalities, left unchecked by successive UK governments, that have plagued the delivery of health and social care to ethnic minority communities across the four nations of the UK. Our clients were directly and significantly affected and faced the brunt of the biggest challenges to the healthcare system during the pandemic. They saw and experienced first-hand not only how Covid-19 impacted on the 12 key areas identified in the provisional outline of scope for Module 3 but how inequality had a pervasive and exacerbating effect on every aspect of the healthcare system before, during, and after the pandemic.[2]

2.3. The NHS, the largest employer of Black, Asian and Minority Ethnic people in the country,[3] entered the pandemic already weakened by over a decade of austerity. That the public healthcare sector was able to carry on during the pandemic was due to the commitment of front-line workers,[4] with Minority Ethnic HCW's overrepresented in lower levels of NHS grade hierarchy.[5] FEMHO's members were on the frontline and behind the scenes throughout the pandemic and have worked tirelessly under brutal pressures and conditions to research, test, treat, care and vaccinate and keep the United Kingdom's public health services going. Many of them lost their own lives, colleagues, friends, family and loved ones along the way, whilst suffering physical and mental burnout because of the conditions they were required to work in.[6]

2.4. Deeply entrenched systemic factors left FEMHO's members particularly exposed. An early and striking feature of the Covid-19 pandemic was that health sector workers from Black, Asian and Minority Ethnic communities were becoming infected and dying at alarmingly disproportionate

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[1] Savage v South Essex Partnership NHS Foundation Trust [2009] 1 AC 681, para 31; Osman v UK (2000) 29 EHRR 245, para 115; see R (on the application of Middleton) v. HM Coroner for West Somerset [2004] 2 AC 182), para. 2; R (AP) v HM Coroner for Worcestershire [2011] EWHC 1453 (Admin), paras. 50-52); Kakoulli v Turkey, para. 110; McCann v UK (A/324) (1996) 21 EHRR 97

[2] The unequal impact on Black, Asian and Minority Ethnic nursing staff was highlighted by Dame Donna Kinnair in an article published by the Royal College of Nursing on 30 October 2020.

[3] NHS People Plan for 2020/2021, published July 2020, p.24.

[4] People's Covid Inquiry Report: Misconduct in Public Office

[5] The King's Fund: April, 2020: Ethnic minority deaths and Covid-19: what are we to do?

[6] ONS article December 2020, highlighted the facts that healthcare professionals are more exposed based on work and that minority ethnic groups were over-represented. Also, EHRC, "Experiences from health and social care: the treatment of lower-paid ethnic minority workers", 9 June 2022 found 57% of people reported to have caught COVID-19 at work were from the health and social care sectors.

rates.[7] The British Medical Association reported that in the early stages of the pandemic: "*95% of doctors who died were BAME"* and *"64% of nurses who died were BAME*".[8] The disparity in the devastating and direct health outcomes for ethnic minorities were well known and widely publicised early in the pandemic,[9] with the medical director at Public Health England noting the limited data and need for "*detailed and careful work*" on this "*really important issue*" and the BMA Council Chair calling for a government directive for hospitals to record ethnicity of Covid patients, provide daily updates on the ethnicity of those in hospital and ill in the community and to take steps to protect minority ethnic communities.[10] A lack of data reduced understanding of minority ethnic health inequalities and the ability to accurately predict and identify effective responses.[11] An Independent SAGE report published in July 2020 called for action to address this as one of the most urgent issues in the pandemic in the UK.[12]

2.5. A Public Health England review suggested racism, discrimination, and social inequality were contributors to the increased risk of death from covid-19 among ethnic minority groups.[13] The workforce culture of the public health and coronavirus response structures impacted disproportionately harshly on minority ethnic HCWs including discrimination by patients and the public, or managers and colleagues,[14] substandard and inadequate PPE,[15] lack of risk assessment,[16] increased risk of COVID-19-related physical[17] mental health outcomes,[18] the lack of cohesive guidance and protocols across services; and the absence of proper epidemiological data and mapping of the disease. This was compounded by minority ethnic HCW being the least empowered to speak up about these issues.[19]

2.6. The MacPherson report published in February 1999 following the inquiry into the death of Stephen Lawrence conceptualised institutional racism, namely **"***the collective failure of an organisation to provide an*

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[7] 6 in 10 healthcare workers who died in early stages of pandemic were from an ethnic minority group: EHRC "Experiences from health and social care: the treatment of lower-paid ethnic minority workers", 9 June 2022

[8] https://www.bma.org.uk/advice-and-support/covid-19/your-health/covid-19-the-risk-to-bame-doctors.

[9] Two thirds of healthcare workers who have died were from ethnic minorities, in a report by Tim Cook, professor of anaesthesia at the Royal United Hospital Bath and the University of Bristol, published by the BMJ in April 2020.

[10] 'Covid-19: Disproportionate impact on ethnic minority healthcare workers will be explored by government', A. Rimmer, BMJ 2020;369:m1562, 17 April 2020.

[11] Royal Society of Medicine's COVID-19 Series - Episode 85: Health inequalities in the pandemic, Chaired by Sir Michael Marmot, August 2021.

[12] The Independent SAGE Report 6, '*Disparities in the impact of COVID-19 in Black and Minority Ethnic populations: review of the evidence and recommendations for action'*, The Independent SAGE, 3 July 2020.

[13] SAGE Report 33 Covid-19: racialised stigma and inequalities (January 2021)

[14] University of Kent analysis of 2019 NHS England survey as set out in EHRC "Experiences from health and social care: the treatment of lower-paid ethnic minority workers", 9 June 2022

[15] A report published by the Runnymede Trust in August 2020 found that Black, Asian and Minority Ethnic frontline workers were being given substandard or inadequate PPE for their roles and risk of exposure. See further below under section [B].

[16] EHRC "Experiences from health and social care: the treatment of lower-paid ethnic minority workers", 9 June 2022.

[17] NHS England officially recognised Black, Asian and Minority Ethnic staff as being at high risk of complications and severe illness from Covid-19 and asked for risk assessments to be undertaken in a July 2020 notice:

18 UK REACH: The United Kingdom Research study into Ethnicity And COVID-19 outcomes in Healthcare workers (UK-REACH): Protocol for a prospective longitudinal cohort study of healthcare and ancillary workers in UK healthcare settings (25 Feb 2021)

[19] BMA analysis of the The CRED (Commission on Race and Ethnic Disparities) published its Race report on 31 March 2021.

appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people." This was said to persist, "*because of the failure of the organisation openly and adequately to recognise and address its existence and causes by policy, example and leadership. Without recognition and action to eliminate such racism it can prevail as part of the ethos or culture of the organisation. It is a corrosive disease*." Over two decades later, the UK Covid-19 Public Inquiry has an opportunity to reduce and ameliorate the systemic and underlying inequalities faced by our clients and their communities by highlighting and addressing the starkly disproportionate impacts of the Covid-19 pandemic faced by our members.

[C.] <u>SCOPE OF MODULE 3</u>

3.1 This Inquiry's commitment to placing "*possible inequalities*" at the "*forefront*" of its investigation must involve fearless and thorough exploration of whether institutional and structural racism and inequality played a part in governmental and societal responses to the pandemic,[20] and the impact on those vulnerable groups in the healthcare system across the UK within the scope of Module 3. Answers must be sought as to why and how government decision-making failed to adequately protect against the disproportionate deaths, poor health outcomes and wider socio-economic consequences suffered by ethnic minority HCW and their wider communities.

3.2 The Inquiry must investigate issues as regards inequality as set out in the ToR, that has committed to "*consider any disparities evident in the impact of the pandemic on different categories of people…*". However, in line with the Chair's commitment to keep possible inequalities at the forefront throughout the investigations, FEMHO implores the Inquiry to go further than merely examining the impacts and to investigate the root causes of the underlying inequalities. The Public Sector Equality Duty ('PSED') to have due regard to discrimination and advance equality of opportunity between differing protected characteristics has simply not embedded in public authority culture. It is vital that Module 3 fully examines:

3.2.1 Whether, and if so how, structural inequalities and cultural competencies influenced the capacity of healthcare systems and workers to respond to the disparate impact and disproportionate death rates experienced among Black, Asian and Minority Ethnic HCWs and communities. To do this it must examine the historical factors that contribute to health inequalities

3.2.2 Socio-economic factors such as the disproportionate impact of poverty, discrimination, and social exclusion on Black and minority ethnic communities. It must explore how these factors contributed to the higher rates of Covid-19 infection and mortality in these

[20] <u>BMA analysis</u> of the The CRED (Commission on Race and Ethnic Disparities) published its Race report on 31 March 2021.

communities and whether the pandemic exposed and exacerbated pre-existing health inequalities.

3.2.3 Specific challenges faced by ethnic minority HCW's, including inadequate access to PPE and occupational health support (see below at §2.3), disproportionate representation in high-risk clinical roles, and increased exposure to the virus due to workplace factors.

3.2.4 The impact of government policies and decisions (or lack of them) on Black and minority ethnic people in the healthcare system. It must consider whether the government's response to the pandemic was adequate in identifying and addressing their specific needs and whether its policies and decisions contributed to or worsened existing health inequalities. For example, the government's policies on testing, contact tracing, and vaccine distribution, as well as its handling of the pandemic in care homes and other settings where vulnerable groups are concentrated.

3.2.5 Intersectional factors: This inquiry must take an intersectional approach that recognizes the multiple and intersecting factors that contribute to health inequalities and the impact of the pandemic on vulnerable groups in the healthcare system. This approach must take into account the ways in which different forms of discrimination and marginalization interact and intersect with one another, such as the intersection of racism, sexism, and other forms of discrimination that may be experienced by ethnic minority women in the healthcare system.

3.3 We welcome the Inquiry's recognition of the areas that expressly fall within Module 3 shall include several areas of decision-making by which our clients have been directly and significantly affected. Of particular concern is (1) PPE and infection control. Minority ethnic HCWs, were shown to have been more likely to find themselves in hazardous work situations without adequate PPE compared to white colleagues[21], and were the least empowered to speak up about it. A survey revealed, for example, that only 43% of minority ethnic nurses received eye and face protection equipment, compared to 66% of white British nurses[22] and 49% of minority ethnic nurses had been asked to reuse single use equipment, compared with just over a third of white British respondents.[23] PPE that was provided was often poorly fitting and therefore of limited value; research has shown that a lack of adequate consideration for variation of facial anthropometrics between ethnicities may account for this.[24] Others were not provided with PPE that was compatible with religious and/or

[21] 'Experiences from health and social care: the treatment of lower-paid ethnic minority workers', Equality and Human Rights Commission, 9 June 2022, p.32.
[22] (RCN, 2020);
[23] The Independent SAGE Report 6, 'Disparities in the impact of COVID-19 in Black and Minority Ethnic populations: review of the evidence and recommendations for action', The Independent SAGE, 3 July 2020, p.6.
[24] See, for example, 'The influence of gender and ethnicity on facemasks and respiratory protective equipment fit: a systemic review and meta-analysis', J. Chopra, N. Abiakam & H. Kim et al, BMJ Global Health 2021, 11 November 2021.

cultural dress.[25] The Inquiry is invited to investigate the decision to downgrade Covid-19 from High Consequence Infectious Disease (HCID) status, thereby permitting use of Personal Protective Equipment and not Respiratory Protective Equipment (RPE). (2) Risk assessments, designed to address risks for those working in high-risk settings, failed to take into account ethnicity as a relevant factor and thus were not effective. Many of our members felt they simply paid lip service to inclusivity and were not designed in a way that would illicit effective outcomes. Outsourced workers in the NHS were often not given a risk assessment: "*because it wasn't clear who was responsible for doing them*".[26] One of our member organisations, BAPIO, devised its own risk assessment model[27] to address these failings which met with some success as it was rolled out in Wales as well as parts of England. (3) Guidance and protocols within healthcare settings to help control and prevent the spread of Covid-19 were haphazard and ineffectual varying widely from setting to setting. The Inquiry should explore the frequency and availability of testing and whether there were any disparities in this between the demographics. The varying restrictions on patient's family members visiting them in hospital also took an additional physical and mental toll on healthcare workers who had to provide additional support and deal with distraught loved ones. (4) As to redeployment of staff, this issue should include an exploration of why ethnic minorities were overrepresented on high-risk wards and what risk assessments or safeguards or policies were put in place to mitigate the known risk. Many staff recruited from overseas have visas tied to their employment and feel less empowered to speak out about concerns as a consequence. (5) The lack of diversity, race consciousness, consultation and inclusion in leadership positions and forums caused a blockage in the system and ultimately delay in acknowledging and addressing the needs of vulnerable ethnic minority community groups.

3.4 These systemic themes run parallel with recent examples of the wider consequences of inequality as highlighted in other recent investigations such as the stark disparity in racial disproportionality of those who that died at Grenfell Tower, [28] the inquest into the death of Awaab Ishak the toddler who died of black mould after being victims of prejudice,[29] and the recently published seminal report into race, death and British Policing by INQUEST which found racial disparities in deaths in custody in Britain.[30] It is with this perspective that the Inquiry need to consider every policy, action and service in the healthcare setting.

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[25] E.g. that fitted and were effective with individuals who wear turbans, have beards etc. – see, for example, https://www.telegraph.co.uk/news/2020/04/01/hospitals-inspect-doctors-beards-tell-days-stubble-shave/

[26] 'Experiences from health and social care: the treatment of lower-paid ethnic minority workers', Equality and Human Rights Commission, 9 June 2022, p.32.

[27] https://www.bapio.co.uk/bapio-releases-an-interactive-covid-19-risk-assessment-web-app/

[28] As discussed in this Guardian Article of July 2020

[29] Guardian: The appalling death of Awaab Ishak shows how social housing tenants are treated as an underclass

[30] Guardian: Black people seven times more likely to die after police restraint in Britain

3.5 No investigation of the impacts of Covid-19 on the healthcare system can be complete without full and thorough consideration being given to matters of inequality, and, the starkly disparate impact on Black, Asian and Minority Ethnic HCWs. It is vital that the disparate impact on minority ethnic HCWs and patients is a theme that permeates the entire Inquiry; it should be a lens through which the impacts under investigation are examined. Such impacts are wide-ranging, indisputable, and well documented in contemporaneous reporting. To ensure that the Inquiry's investigation is grounded in the experiences and perspectives of those most affected by the pandemic, it must engage with and listen to the voices of ethnic minority HCW's, their representative bodies, and other organizations that represent the interests of vulnerable groups in the healthcare system. This engagement must be respectful, open, and inclusive, with a focus on creating an environment in which individuals and groups can share their experiences and perspectives freely and without fear of retaliation. We hope to be able to fully engage with and assist the Inquiry in representing these issues as a Core Participant in Module 3 going forwards.

3.6 FEMHO would also welcome confirmation that, as per the Chair's ruling in relation to Module 1, a list of issues will be provided in respect of Module 3 as soon as possible. This is essential to provide clarity on the remit the Inquiry envisages for the various planned areas of investigation and for CPs to have the opportunity to raise any concerns in advance should there be any issues they consider critical that fall outside of this.

3.7 Finally, FEMHO would be grateful for clarity on the Inquiry's plans for future modules where there is potential overlap with Module 3 issues. For example, the Inquiry has listed vaccines, therapeutics and anti-viral treatment, the care sector, PPE and health inequalities amongst the system and impact issues to be explored in future modules. It would be helpful to understand how the Inquiry intends to explore these issues and to what extent in Module 3 and/or in future.

[D.] <u>RULE 9 REQUESTS</u>

4.1 FEMHO notes the Inquiry's decision that Rule 9 requests will not be disclosed to Core Participants, rather the Inquiry intends to provide monthly updates to Core Participants on the progress of Rule 9 work. FEMHO respectfully requests the Inquiry reconsider this decision. Without sight of the requests themselves, and with disclosure expected to be released on a rolling basis, we consider that it will be near impossible for CPs to determine whether there are any gaps in good time ahead of the evidential hearings. This approach therefore runs the risk that there will be no time for such gaps to be addressed and/or that there may be delays to the timetable to obtain the material necessary to fill any such gaps.

[E.] <u>DISCLOSURE</u>

5.1 FEMHO notes the Inquiry's intention to start the process of disclosure of Module 3 material to CPs during the summer of 2023 and the estimated start date for evidential hearings of 2024. At this stage we would merely ask that the Inquiry maintain flexibility in these dates and ensure that sufficient time is allowed for CPs to review the disclosure and properly prepare for the hearings.

[F.] EXPERTS

6.1 FEMHO welcomes the Inquiry's commitment, made at paragraphs 53-59 of the note from Counsel to the Inquiry dated 14th February 2023, to providing CPs with an opportunity to make observations on the identity of the expert witnesses they appoint, and the questions and issues they will be asked to address in their reports, and that it will consider suggestions from CPs as to who should be appointed.

6.2 FEMHO considers that Module 3 requires expert evidence from a specialist in race equality to speak to potential underlying systemic issues of health inequalities in HCW and service users both prior to and during the pandemic in public health structures in the UK, preparedness, and structural racism. Further, the expert should be invited to consider the issues against broader root-causes of race discrimination which include the disengagement with the issue of race and inequality across the public sector and crucially the lack of diversity and inclusion in senior leadership within key structures such as the NHS. Increased diversity within decision making processes exponentially improves outcomes.[31] For example the failing of the NHS to engage rapidly with and utilise existing informal networks across diverse community and religious groups undoubtedly negatively impacted upon outcomes. This was a missed opportunity which could and should be improved upon by more inclusion of diversity within senior leadership, as well as embodying a better reflection of society at large. A critical analysis of these matters is an important opportunity for this Inquiry to improve its preparedness to protect the most vulnerable in future civil emergencies and in so doing to ameliorate and lessen disparity.

6.3 FEMHO would be happy to engage further with the Inquiry on this issue but invites the Inquiry at this stage to confirm that Module 3 will be assisted by the instruction of a race equality specialist who is able to critique various aspects of the pandemic and assist in informing questions for the witnesses of fact being called.

[G.] LISTENING EXERCISE – EVERY STORY MATTERS

7.1 We note the Inquiry's approach to the listening exercise and welcome its commitment to hearing the human impacts of the pandemic. Racial inequality in the healthcare setting for the workforce and service users has long been an issue of public concern and should have prominence in this exercise. A large number of the FEMHO members come from communities that were at the coal-

[31] McKinsey & Company: Diversity wins: How inclusion matters May 19, 2020 | Report

face in the early stages of the pandemic and which have suffered disproportionately throughout. Within the health and social care workforce, FEMHO members number highly among the lower band roles with less professional autonomy, combined with a ward culture that makes minority ethnic HCWs more likely to be placed in ICU and high-risk settings resulting in more frontline exposure to patients and the wider public. As such, FEMHO have a significant interest in, and first-hand experience and knowledge directly relevant to all 12 of the key areas identified for investigation in Module 3.

7.2 At the same time, as has been recognised and acknowledged in commentary for many years, individuals from ethnic minority communities are often more hesitant to deal with and trust institutional powers. Some may therefore be naturally cautious in engaging in sharing their story through a process such as this. FEMHO members are open to participating in Every Story Matters, however they are keen to understand more about how the information will be fed into planning for and carrying out the detailed investigations under the modules before committing the time involved. We would therefore be greatly assisted by further clarity and transparency about the process, including who is involved and what steps have been undertaken to consider any conflicts of interests, what areas of expertise any appointed suppliers possess, and details as to how this exercise will operate and meaningfully feed in to the modular investigations in practice.

[H.] APPROACH TO EVIDENCE OF INDIVIDUAL DEATH AND 'PEN PORTRAIT' MATERIAL

8.1 FEMHO welcomes the Inquiry's acknowledgement that some evidence relating to individual deaths "*may well be relevant*" to its investigation where it relates to possible systemic failings and in particular that "*healthcare workers may well have relevant evidence to give on issues that affected them."* FEMHO members would be ideally placed to provide such evidence on the systemic failings and underlying inequalities within the healthcare sector and respectfully request that when the time comes, representative members from FEMHO are permitted to do so.

[I.] INTERIM RECOMMENDATIONS

9.1 The Covid-19 pandemic remains a live issue which poses an ongoing threat to the physical and mental health of those working within the health and social care sector. FEMHO encourages the Inquiry to make urgent interim recommendations where there are appropriate opportunities to improve things and safeguard against further harm rather than waiting until the conclusion of hearings and the final report.

[J.] CONCLUSION

10.1 In conclusion, if the Covid-19 Public Inquiry is truly committed to placing "possible inequalities" at the "forefront" of its investigation, it must be fearless and thorough in exploring questions of PSED adherence and the impact of institutional and structural racism and inequality

on the pandemic response and its impact on vulnerable groups in the healthcare system across the UK. By exploring the areas outlined above, the inquiry can demonstrate its serious and genuine commitment to this goal and ensure that its investigation is grounded in the experiences and perspectives of those most affected by the pandemic. This Public Inquiry has a responsibility to fully explore the impact of the pandemic on all segments of society, including racially minoritised healthcare workers and their communities. As we have seen, this group has been disproportionately affected by the pandemic, and it is imperative that we understand why and how this happened.

21 February 2023

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