IN THE MATTER OF THE UK COVID-19 PUBLIC INQUIRY BEFORE BARONESS HALLETT

MODULE 2
SECOND PRELIMINARY HEARING

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

I. Introduction

1. These submissions are made on behalf of The Federation of Ethnic Minority Healthcare Organisations ("FEMHO") in advance of the second Module 2 preliminary hearing on 1 March 2023. We made written and oral submissions for the first preliminary hearing which we reiterate, but do not intend to rehearse. These submissions principally address two main areas: i) a background highlighting the framework for FEMHO's involvement in this Inquiry and core issues of concern in Module 2; and ii) FEMHO's comments on some areas raised in the counsel to the inquiry's ("CTI's") note dated February 17, 2023, for this second preliminary hearing.

2. By way of reminder, 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 healthcare workers ("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.

II. Background and core issues of concern

3. In the first preliminary hearing of Module 2, FEMHO submitted that 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 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. We urged that 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.

4. FEMHO seeks to reinforce these submissions in this second preliminary hearing. Our position is rooted in the state's duties under Article 2 ECHR. The state is 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] The UK government held this systemic obligation regarding its decision making in the pandemic. There was a duty to ensure that where the right to life of its citizenry was at stake, the UK government would take positive and protective steps to safeguard lives.

5. In discharging its statutory obligation, this Inquiry has acknowledged – and indeed, committed to in its terms of reference ("TOR") - the need to place "*possible inequalities*" at the "*forefront*" of its investigation; and "*consider any disparities evident in the impact of the pandemic on different categories of people*…" To this end, FEMHO wishes to reiterate that the Inquiry must be fearless and thorough in its exploration of how *institutional* and *structural racism* and *health inequality* played a part in government decision making and the contemporaneous responses to the pandemic.[2]

6. Adherence to the Public Sector Equality Duty ("PSED"), s149 Equality Act 2010, which places a positive duty on public authorities to have due regard to the elimination of discrimination and to advance equality of opportunity, should also be thoroughly explored in the context of government's decision making, especially during the early stages of the pandemic. Answers must be sought as to how and why central and local government decision-making failed to properly consider issues of inequality and protect against the

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

disproportionate deaths and poor health outcomes suffered by ethnic minority HCW and their wider communities.

7. FEMHO urges the Inquiry to place heightened scrutiny on these three areas in its investigation into government decision making:

Implementation of government pre-planning

8. Government emergency planning and work in building pandemic resilience should have envisaged that health inequality – occasioned by structural racism – would exacerbate vulnerabilities and probably result in disproportionately adverse health outcomes within communities of colour. We trust this will be explored within the remit of Module 1.

9. It follows that such government pre-planning should have been evident in decision-making, given the high percentage of certain illnesses within particular ethnic and racial groups that would heighten vulnerabilities to respiratory illnesses; and the high percentage of Black, Asian and Minority Ethnic staff that are in public facing roles that were likely to be put at higher risk of exposure to *SARS-CoV-2* and other respiratory viruses. As such, the Inquiry must pursue the following lines of enquiry:
    a) Did the UK emergency planning and general pandemic resilience *anticipate* disproportionately high death rates of Black, Asian and Minority Ethnic healthcare workers and community? If so, how was this evident and reflected in decision making?
    b) Was the UK emergency planning and general pandemic resilience built to respond to disproportionately high death rates among Black, Asian and Minority Ethnic people? If so, how was this evident and reflected in decision making, particularly during the early stages of the pandemic?
    c) Were there any specific measures taken by the government to address the disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic communities and healthcare workers, beyond those applied to the general population? If so, what were they and were they taken in a timely manner?
    d) Were there any specific financial or resource allocations made to address the impact of COVID-19 on Black, Asian and Minority Ethnic communities and healthcare workers, beyond those applied to the general population? If yes, what were they?
    e) How did the government communicate with Black, Asian and Minority Ethnic communities and healthcare workers about the particular risks to them of COVID-19 and the measures being taken to mitigate those risks, and was this communication culturally appropriate and effective?

f) Did the government allocate sufficient resources and funding to address health inequalities and the heightened risks faced by Black, Asian and Minority Ethnic communities and healthcare workers during the pandemic, and were these resources effectively deployed?

g) To what extent did political considerations influence the government's pandemic decision-making and planning, and did this impact the health outcomes of Black, Asian and Minority Ethnic communities and healthcare workers?

Data architecture in public health

10. It is important to establish whether UK laboratory, field modelling and case studies at the onset of covid included references to race and/or ethnicity and if not, why not. This is critical because the first public notice that there were disproportionate deaths from Black, Asian and Minority Ethnic communities appears to have been anecdotal, escalated only through campaigners and news reports, rather than from agencies of government.[3] [4] The Inquiry must seek answers in the following lines of enquiry:

    a) Was there any unified national system of data capture that could apprehend rates of infectivity or death rates based on race/ethnicity?

    b) If no such system existed, why was this so?

    c) What barriers if any, exist(ed) to capturing data on race and ethnicity in public health systems, and what measures (if any) were taken to overcome them?

    d) Were there any efforts made to develop or improve data collection on race and ethnicity during the pandemic, and if so, what were they?

    e) How did the lack of comprehensive data on race and ethnicity impact the ability of public health officials to respond to the pandemic effectively, particularly in terms of addressing health inequalities?

    f) How did the lack of comprehensive data on race and ethnicity affect the ability of public health officials to effectively respond to COVID-19 outbreaks in communities of colour?

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[3] See Guardian article dated 25 May 2020, which stated in its headline: *Six in 10 UK health workers killed by Covid-19 are BAME* - https://www.theguardian.com/world/2020/may/25/six-in-10-uk-health-workers-killed-by-covid-19-are-bame. In discussing methodology, the article said: "*The information on health workers has been sourced from news reports, submissions from friends and families, news agencies and a list collated by nursing platform Nursing Notes. In cases where the cause of death was unclear it has been verified with the person's employer. The dataset includes all staff working in hospitals, including pharmacists, porters, cleaners and other roles, as well as healthcare professionals working outside hospitals, including staff working in GP surgeries and medical staff working in care homes. Some workers were categorised as BAME but their ethnicity could not be identified.*"

[4] See British Vogue article dated 8 June 2020: "*Why Are So Many Health Workers from BAME Backgrounds Dying of Covid-19*" https://www.vogue.co.uk/arts-and-lifestyle/article/bame-key-workers-dying-of-covid-19

g) Were there any efforts made to retroactively collect data on the racial and ethnic disparities in COVID-19 outcomes once it became clear that they existed? If not, why not?

h) Did public health officials and policymakers make any specific policy decisions based on the limited data on racial and ethnic disparities in COVID-19 outcomes that were available early in the pandemic? If not, why not?

i) To what extent did the lack of comprehensive data on race and ethnicity in public health reporting reflect a broader failure of government agencies to address issues of structural racism and inequality in healthcare?

j) What lessons can be learned from the shortcomings of the UK's data architecture in responding to COVID-19, and how can these lessons be applied to improve future pandemic preparedness and response efforts?

Contemporaneous response to disproportionate death rate in Black, Asian and Minority Ethnic communities

11. When it became clear in early 2020 that there was a disproportionately high rate of deaths among Black, Asian and Minority Ethnic healthcare workers and in their communities, it is important for this Inquiry to interrogate what, if any, steps were taken to address this and when. This is an area that will, we trust, be explored within the remit of Module 3, however the following lines of enquiry must be pursued in the context of Module 2:

    a) Was there a coordinated national response to the disproportionately high number of deaths in Black, Asian and Minority Ethnic community and/or among Black, Asian and Minority Ethnic healthcare workers?

    b) If there was no coordinated national response, what was the rationale for the failure to act?

    c) How did the government engage with and involve Black, Asian and Minority Ethnic communities and healthcare workers in the pandemic response, particularly in decision-making processes and communication strategies? If there was engagement, state when and how?

    d) Were any specific policies or interventions implemented to address the disproportionate impact of COVID-19 on Black, Asian, and Minority Ethnic communities and healthcare workers, and were these effective in mitigating the impact? What were those policies? If no policies were implemented why not?

e) Was there any consideration given to the intersectional identities of Black, Asian, and Minority Ethnic healthcare workers and communities, such as gender or socioeconomic status, in the response to the high death rates?

f) How did the response to the high death rates among Black, Asian, and Minority Ethnic healthcare workers and communities compare to the response to the pandemic overall, in terms of funding, resources, and decision-making?

III. Issues raised from CTI's notes

12. FEMHO makes the following observations CTI's notes on the second preliminary inquiry:

Rule 9 requests

13. We note the summaries of the rule 9 requests that have been provided to date, along with the updates and indication of further requests that will be sent shortly and to whom. FEMHO still maintains that there is value in the disclosure of the requests themselves to CPs on the basis that it will allow CPs to scrutinise and identify any potential gaps in the evidence requested. We do not anticipate that such disclosure to CPs will invite substantial "*edits*" nor create a significant added layer of work for the inquiry team, so as to make it disproportionate to do so. With the current process, there is a risk that any gaps in the rule 9 requests will not be readily apparent and identifiable until all disclosure has been released to the CPs. This is likely to become a problem at a time too close to the hearings, leaving little opportunity for matters to be addressed, and resulting in missing information or even last-minute delays in timetabling.

Disclosure

14. On the matter of disclosure, we say:

a) Redactions – We note the Inquiry's widening approach on redactions and plans to use auto redaction technology with the intention of speeding up the process. In this approach and the removal of individual judgment, however, there is a real risk that the process may lose important information.

b) Disclosure Platform – We join the calls requesting that CPs be afforded the use of a more user-friendly platform. It is our view that the functionality offered by the alternative platform proposed would streamline disclosure review and hearing preparation in a considerably more efficient way in the long run, thereby more than

recouping the value from any potential additional costs that the change would result in.

c) Timeliness – We acknowledge the newly proposed dates for Module 2 hearings and trust the Inquiry will ensure that there will be sufficient time for disclosure review and preparation before hearings.

Hearings duration

15. Whilst we are of course conscious of the need for efficiency, we have some reservations about whether the current allotment of eight weeks for Module 2 hearings is a realistic one. It is difficult to make a confident assessment at this point but judging from the lines of enquiry that are being urged as necessary for the Inquiry to pursue, it seems more than likely that more time will be needed for a full and effective investigation. We trust the Inquiry will keep the planned duration of the module under review.

Experts

16. We wish to once again renew our request for disclosure of expert instructions that were served on the proposed experts. At the very least, FEMHO seeks confirmation from the Inquiry that the data expert, Mr. Gavin Freeguard, will be addressing the issues we have raised of available data in respect of race and ethnicity.

Parliamentary Privilege

17. We note the Inquiry's observations on the scope of parliamentary privilege and its implications on the inquiry's investigations. We welcome the indication that the Inquiry will take all practical steps to work around any limitations arising from parliamentary privilege, and the issue should not impact on disclosure of Parliamentary material to CPs. This is especially welcomed in respect of findings and conclusions of select committee reports, as discussed in para [38] of CTI's note, which we are grateful the Inquiry will still be disclosing to CPs to provide context. We anticipate that such reports will be implicated in the central issues under enquiry for the investigation in Module 2.

18. To be clear, we say nothing at this stage about the Inquiry's stated opinion on the scope of parliamentary privilege and its application to the Inquiry's investigation which we understand to be untested in case law. Should any issues arise in relation to this issue, we look forward to the opportunity to make further submissions as soon as practicable.

Evidence proposal

19. We welcome the evidence proposal scheme by CTI [45-48] and especially commend the opportunity for informal discussions with the CTI to discuss and seek to persuade the Inquiry team on central matters for CPs arising from the witness evidence. It is difficult at this early stage and without sight of the witness list or hearing timetable, however, to know whether the time frames envisaged will be workable. We would only seek at this stage therefore to encourage the Inquiry to ensure that as a practical matter, the process is maintained within the hurly-burly of scheduling and that this avenue for dialogue and communication is maintained throughout Module 2.

Listening exercise – Every Story Matters

20. We note the Inquiry's approach to the listening exercise and welcome its commitment to hearing the human impact 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-face in the early stages of the pandemic and which have suffered disproportionately and sustained disadvantage throughout.

21. FEMHO have a significant interest in, and first-hand experience and knowledge directly relevant to, the key areas identified for investigation. 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.

22. 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 interest, what areas of expertise any appointed suppliers possess, and details as to how this exercise will operate and meaningfully feed into the modular investigations in practice.

Inquiry panel

23. Whilst not a point directly addressed in CTI's note, FEMHO is conscious that indications have been given previously that Baroness Hallett will be assisted by panel members to "*make sure the Inquiry has access to the full range of expertise needed to complete its important work*".[5] FEMHO remains of the view that this is a sensible and beneficial proposal and would be grateful for an update on this matter.

IV. Conclusion

24. FEMHO invites the Chair to adapt the approach and lines of enquiry proposed in section (ii) and consider and, where relevant, adopt our comments and suggestions made in section (iii).

24 February 2023

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[5] See Prime Minister's announcement of the Inquiry Chair: https://www.gov.uk/government/news/prime-minister-announces-covid-19-inquiry-chair