Witness Name: Ade Adeyemi
Statement No.: 1
Exhibits: 20
Dated: 20 April 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ADE ADEYEMI MBE

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1. i, Ade Adeyemi, will say as follows: -

Background: overview of history, aims and legal status

2. As a black healthcare professional, who has spent most of his career working in policy within the NHS, one of the most maddening obsessions in discussions about pandemic resilience, is the fear of the NHS being overwhelmed. It is not that the NHS has infinite amount of bed space. Yes, years of austerity have certainly made the direction of resources – especially allocation for the NHS - a vexed annual question in discussions about the national budget and dealing with winter pressure. The trouble when the subject turns to pandemic resilience – and indeed, preparedness and emergency planning – is how much structural problems, such as health inequality, are repeatedly ignored. Deep rooted structural problems are never seen as proximate enough, in urgent conversations about emergency planning. The Covid-19 pandemic, of course, has proven this thinking to be deadly wrong.

3. We, black health and social care workers in the UK, both in our personal and professional lives, understand how different societal factors – political, economic or other – may combine to result in adverse personal health outcomes. The first alarming sub-plot of the Covid-19 pandemic in the UK in 2020, was the disproportionate death rates among our numbers. This created the motivation for focused advocacy, to literally, save our own lives.

4. FEMHO was conceived as a federation to bring together Ethnic Minority health organisations representing our shared interests and goals to form a united voice. Our

initial focus was to ensure that the disproportionate impact of the Covid-19 pandemic is addressed in the Inquiry, with the long-term aim of eliminating systemic and underlying inequalities faced by our members and communities. We are not a charity, or a legal entity. Instead, we are a forum or consortium of over 50,000 ethnic minority clinicians, health and social care workers, researchers and support staff.

5. A majority of our members worked in places and come from communities that were at the front and centre in the early stages of the pandemic. Within the health and social care workforce, FEMHO members number highly among the lower paid end, with less professional autonomy and more frontline exposure to patients and the wider public. One big failure in preparedness and emergency planning for our members was the issue of risk assessments. Risk assessments, designed to address risks for those working in high-risk settings, failed to take account of ethnicity as a relevant factor. One of our member organisations, BAPIO (British Association of Physicians of Indian Origin), devised its own risk assessment model to address these failings which met with some success as it was rolled out in Wales as well as parts of England [AA/1.1 - INQ000147870] [AA/1.2 – INQ000120827]

6. By way of further example, the failure to appreciate the risks of airborne transmission of SARS-Cov-2, the virus that causes Covid-19, resulted in increased casualties as there was no early and appropriate PPE in place to meet the risk of airborne transmission and the obvious risks to frontline staff. In fact, 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), went against the available science and affected the levels of exposure of our members.

7. As workers within the health and social care sector from economically deprived communities, most of our members have had to perform their professional duties with comparatively more burdens from covid disruption in their personal lives. Our members mostly did not have the option of working from home as their roles were, by and large, patient facing. Using public transportation to and from work, where there was no personal means to do so, carried heighted risks of infection. FEMHO members felt and experienced the direct correlation between government's apparent indifference to the risks of certain groups to a respiratory virus; and the later disproportionate death rates which resulted within our communities.

8. For some FEMHO members, they were not given public health information in languages other than English, which created difficulties and barriers in accessing the guidance that impacted on their lives. Some FEMHO members, along with other voluntary and community sector organisations and faith leaders, were forced to provide leadership to engage with those from ethnic minority groups and ensure that important public health messaging and information was communicated in culturally sensitive and language appropriate ways. This voluntary effort was pursued on top of our already high workloads and with little to no formal support from the system. Our communities were often referred to, in both in policy and the press, as "*hard to reach.*"

9. Our senior FEMHO members, who are also trusted people within Black, Asian and Minority Ethnic communities, played a critical role in infusing public health messaging with trust, in order that it was embraced and faithfully followed. Some of these members also used media to increase public health education and fill gaps that existed in government public health education and messaging in Black, Asian and Minority Ethnic communities. Even now, our members have continued to play a significant role in campaigning, including for example in petitioning for protective action to address the disparate impact on ethnic minority communities and for an independent investigation into them. One of our founder members, Senior Consultant Psychiatrist, Greater Manchester Mental Health NHS Trust and Former Chair of BAPIO, Professor JS Bamrah CBE, was appointed by the Government to assist in the formation of a distinguished group, examining BAME covid deaths[1].

10. Importantly, FEMHO organised itself as a consortium with the objective of using this Inquiry as a means to investigate its core issues of concern. A fundamental question for FEMHO is: *Did the UK preparedness, emergency planning and general pandemic resilience anticipate disproportionately high death rates of Black, Asian and Minority Ethnic healthcare workers and community*? It seems obvious to our members that building pandemic resilience and proper emergency planning required an appreciation of health inequality, structural racism and institutional racism. A critical piece for developing this understanding is consultation and engagement with communities of colour and ethnic minority healthcare workers. Only then could any targeted policies or guidelines be developed in order to address the vulnerabilities within our communities, conduct emergency planning and build pandemic resilience.

[1] The BAME Clinical Advisory Group

Position on UK's pandemic planning, preparedness and resilience

11. FEMHO is firmly of the view that the UK government pandemic resilience and emergency pre-planning should have *anticipated* high percentage of Covid-19 infectivity within BAME groups. It is well known that there are high levels of certain illnesses within particular ethnic and racial groups, which heighten vulnerabilities to respiratory illnesses. In addition, it is also well known that a high percentage of Black, Asian and Minority Ethnic staff have public facing roles that were likely to be put at higher risk of exposure to SARS-CoV-2 and other respiratory viruses. An appreciation of this background, clearly envisages that health inequality – *occasioned by structural racism and wider issues such as austerity* – would result in disproportionately adverse health outcomes for communities of colour in the Covid-19 pandemic.

12. We identified structural racism as being an important consideration for understanding pandemic planning, preparedness and resilience. Structural racism has been defined in the Du Bois Review, an academic journal, as: *"'the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups.' For example, historical experiences of minority ethnic groups and long-term discrimination may lead to a higher proportion working in lower paid jobs on insecure contracts without sickness benefits and in public-facing occupations, living in crowded housing conditions, and having fewer resources for health (e.g., education, income)"* [AA/2 - INQ000120833] Such understanding – *or even anticipation* – is necessary to apprehend the manifestations of health inequality that were triggered by the pandemic; and appreciate how disproportionate deaths and poor health outcomes would likely result within ethnic minority health care workers and their wider communities.

13. FEMHO is also of the view that the agenda for addressing health inequality has suffered from an unsustainably hodgepodge approach. A pattern of infrequent and short term-funding for healthcare strategies targeted at supporting those from ethnic minority backgrounds may have harmed emergency planning for the pandemic. The Kings Fund (2022) have supported this view, suggesting that for work on inequalities to endure, there must be a shift in the way baseline funding is spent [AA/3 - INQ000120834]. This means treating inequalities spending as part of the mainstream and not as short-term funding, which has not been shown across many years of funding before the Covid-19 pandemic.

14. FEMHO also has deep concerns about how economic planning factored in the disparities between demographic groups within the UK, and in particular, deprivation levels across communities. Geography and socioeconomic factors such as deprivation and occupation are evidenced to have driven the excess Covid-19 deaths seen in all ethnic minority populations. Their impact has been greatest among Bangladeshi, Pakistani, Black Caribbean, and Black African people, who are over-represented among the most deprived communities in England (Raleigh 2022) [AA/4 - INQ000120835].

15. As a result of these structural issues of inequality, FEMHO believes that planning, forecasting and preparatory work for a high-consequence infectious diseases such as Covid-19, did not properly consider the context of a multicultural UK and a global diverse health and care workforce. UK laboratory, field modelling and case studies prior to Covid-19 did not include references to race and/or ethnicity. The *absence* of a national system of data capture regarding race and ethnicity may well be one of the biggest system failures in emergency planning, from the Covid-19 pandemic.

16. We have no doubt that in preparing for a high consequence infectious disease, the UK Government would have benefited from pre-established relationships of focused voluntary, community and social enterprise (VCSE) organizations, analysing demographic data of the health and social care workforce. There would also have been enormous value from ensuring that all levels of the health workforce, including senior management, across both clinical and administrative functions, were represented by those from ethnic minority backgrounds. This conceivably might have made a difference in discussions around preparedness and emergency planning. There was a patent absence of representation and diversity at the most senior management levels in discussions on these topics before the pandemic. Indeed, NHS Trust Boards that are more representative of the local communities they serve, and of the workforce, have been shown to consistently deliver better healthcare services (NHS Leadership Academy, 2012) [AA/5 - INQ000120836]. There is also robust evidence that a diverse workforce across different levels of a healthcare organisation in which all staff members' contributions are valued results in better patient care (West 2012, Dawson 2009) [AA/6 - INQ000120837].

17. It is also important to note that Public Health England were commissioned to provide a report and recommendations at the early stage of the pandemic. However, the review conducted by Professor Kevin Fenton has largely been disregarded after publication

[AA/7.1 – INQ000120838; AA/7.2 - INQ000120839]. FEMHO would like the Inquiry to determine why this was the case and also establish what impact the recommendations would have had in reducing the disproportionate mortality in the ethnic community. FEMHO member, Dr Ananta Dave, Chief Medical Officer for NHS Black Country Integrated Care Board (ICB) and President of the British Indian Psychiatric Association notes: "*There was a lack of planning around risks to vulnerable groups such as BAME and older adults in care homes. It was a combination of ignorance and apathy… the government should have been gathering this data. Because the awareness would have been there about the impact on vulnerable and the planning about the early stages.*"

Assessment of UK government pre-planning

18. FEMHO welcomes the creation of the NHS Race and Health Observatory, which has the aim of '*protecting the vulnerable, including the impact of COVID-19 on ethnic minority communities and the health and care workforce, as well as health conditions and issues that impact ethnic minority communities'* [AA/8 – INQ000147878] [AA/9 – INQ000147879] [AA/10 – INQ000147871. This Observatory may prove critical in protecting ethnic minority populations in the UK in the event of another pandemic. However, the glaring absence of such a body within public health services as part of the preparedness for Covid-19, is an area of concern for FEMHO and we commend this for the Inquiry's investigation.

19. For FEMHO, we are clear that mitigation of health inequality and structural racism should have been a critical component of UK emergency planning and building of pandemic resilience. There was an obvious need for a national system of data capture based on race and ethnicity within healthcare. This was critical for modelling and tracking of the disease, as well as for laboratory and case studies in epidemiological study. Without such a system, there was never going to be scope for targeted and coordinated responses, either at the national or local level.

20. We are also of the view that the voices of our communities needed to have been heard in the discussions about emergency planning and pandemic resilience. Institutions are much more likely to be alive to the concerns of communities when there is representation within senior leadership. Such diversity often ensures cultural competency and imbues public health messaging with trust and authenticity. These are areas for which the NHS was sadly lacking in the Covid-19 pandemic.

21. As i pointed out before, a big problem in emergency planning was the fact that issues of health inequality and structural racism were not sufficiently appreciated as clear and present risks. As an example, the NHSE will send strict clinical guidelines on how to manage clinical presentations of Covid-19, and there will be an expectation that clinicians will abide by them. But where matters of race and ethnic origin are potentially integral, they are often not included in the guidelines or directions – and instead, addressed in memos and newsletters. This may be a reflection of institutional diffidence about how the NHS deals with race/ethnicity and risk; or frankly, may indicate a lack of conviction about the importance of these issues. In any event, these are matters that ought properly to have been addressed in emergency planning. The demonstrable failure to do so should be a matter of huge interest to this Inquiry in Module 1.

Advocacy, press and engagement with government

22. Our members have pursued much activism, both individually and as part of a collective, around issues related to pandemic resilience, preparedness and emergency planning.

23. We refer the Inquiry to the Annex to the statement, which is intended to be updated with further additions once more documentation is received and considered.

24. Perhaps the most germane to the Inquiry's Module 1 investigation, is the robust repudiation of the Commission on Race and Ethnic Disparities (CRED) findings, dated March 31, 2021, that was chaired by Dr Tony Sewell CBE [AA/11 – INQ000120841]. Many of our members, joined other health professionals in appending their signature to a response, which expressed dismay at the findings that downplayed the presence of racism and disparities in health outcomes based on race.

25. It is not an overstatement to make the claim that FEMHO played a key, if not leading role, in the adjustment of the terms of reference that place "*possible inequalities*" at the "*forefront*" of its investigation; and which seeks to "*consider any disparities evident in the impact of the pandemic on different categories of people*…" This has always been the central part of FEMHO's contention for a public inquiry [AA/12 – INQ000147872]; as well as representing our foundational considerations for the investigation of pandemic resilience, preparedness and emergency planning. Using a letter publication to the Guardian in February 2022, we not only welcomed the latest report of the NHS Race and Health Observatory but called on the Inquiry Chair to make "*health inequality*

experienced in terms of race and ethnic origin" as a central part of the Inquiry's investigation." [AA/13 – INQ000147873]

26. From as far back as May 2020, when the spectre of disproportionate deaths in our ranks and within our communities was just becoming noticeable, our members called on then Prime Minister Boris Johnson to launch a public inquiry into the disproportionate impact of Covid-19 on Black Asian and Minoritised Ethnic communities [AA/14 – INQ000147874] [AA/15 – INQ000147875] [AA/16 – INQ000147876]. It is also fair to say that our members, who were not then convened as FEMHO, played a key role in making the spectre of these deaths a matter of public concern, and no longer, merely a matter of anecdotal reference.

27. FEMHO sought to engage with the inquiry team very early in the day and sought to galvanise public support in these interventions. The forum received strong early support from a cross party collection of MPs, who have recognised and championed our central mission and, by extension, our key areas of concern for Module 1. For example: (i) a number of parliamentarians have written personally to Baroness Hallett and/or the Prime Minister in support of FEMHO and its representations on the need for the inquiry to examine the impact of racial health inequalities throughout the inquiry; (ii) an early day motion was tabled and signed by 20 cross-party MPs urging the Prime Minister to accept the Chair's recommendation on FEMHO's central request that inequalities be at the forefront throughout the inquiry and calling for FEMHO to be given CP status [AA/17 – INQ000147877]); and (iii) FEMHO was invited to hold its inaugural meeting at the Houses of Parliament by Bell Riberio-Addy MP, who co-hosted and facilitated a multidisciplinary discussion around the lessons that could be extrapolated from Covid-19 outcomes of Ethnic Minority healthcare workers in the future or in another pandemic.

Hindsight and lessons to be learnt

28. FEMHO is firmly of the view that there should have been greater government outreach towards Black Asian and Minority Ethnic communities. An investment in such community engagement would have provided valuable insights about risk and preparation to address those in a pandemic. One of our members, Dr Ananta Dave, Chief Medical Officer for NHS Black Country Integrated Care Board (ICB) and President of the British Indian Psychiatric Association, opined: "*The most vulnerable*

people should have been protected first. Science tells us if you get it right for the vulnerable then you get it right for everybody."

29. Another of our members, Dr Hina Shahid states: "*Health inequalities data on ethnic minorities is poor and needs to be disaggregated at a local level and this is key to pandemic preparedness. Need better surveillance over community health*". There needed to have been proper investment and action in respect of underlying socio-economic and health inequalities that have been known for decades but have been left unaddressed despite multiple reports and recommendations [AA/18 – INQ000120840]. It is clear to us that the findings of Professor Marmot report on health inequality in the UK, needs to be joined up with our learning on structural racism within the healthcare context. Pandemic emergency planning needed to have had as a priority, the impetus to mitigate the unequal impact of Covid-19 on ethnic minority communities from social and economic inequalities, racism, discrimination and stigma and occupational risk. There was also need to appreciate vulnerabilities from the prevalence of conditions that increase the severity of Covid-19, including obesity, diabetes, CVD and asthma.

30. The NHS needed to have been more inclusive at the rank of senior leadership. Such leadership not only provides access to what is described as "*hard to reach*" communities, but it also imbues public health messages with an element of trust and authenticity. Trust takes time to develop and quick to destroy. Bad political decision-making and behaviour undermines public health.

Ade Adeyemi MBE
April 20, 2023

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Personal Data

Signed: ______________________________

Dated: _______20 April 2023_____________

ANNEX

NB: THESE DOCUMENTS ARE SUBMITTED IN SUPPORT OF THE WITNESS STATEMENT BUT ARE NOT EXHIBITED / REFERRED TO IN THE BODY OF THE STATEMENT.

Letters

1. (19 March 2020) Letter from BAPIO to Prof Chris Whitty, CMO [INQ000148470]
2. (27 March 2020) Letter from BAPIO to Matt Hancock MP [INQ000148474]
3. (30 March 2020) Letter from BAPIO to Sir Simon Stevens, CEO NHS England [INQ000148475]
4. (7 April 2020) Letter from BAPIO to Prof Chris Whitty, CMO; et al. [INQ000148476]
5. (7 April 2020) Letter from BAPIO to Prof Chris Whitty, CMO, et al. [INQ000148477]
6. (22 April 2020) Letter from BAPIO to Chief Executives of NHS Trusts (England) et al. [INQ000120826]
7. (30 April 2020) Letter from BAPIO to Caroline Noakes MP [INQ000120828]
8. (10 May 2020) Letter to Prime Minister Boris Johnson MP, various signatories including Prof JS Bamrah, BAPIO [INQ000120823]
9. (1 June 2020) Letter from BAPIO to Prof Stephen Powis, National Medical Director for NHS England [INQ000148465]
10. (7 June 2020) Letter to MPs Matt Hancock and Kemi Badenoch: Response to the 'Disparities in the risk and outcomes of COVID-19 report' – various signatories comprising organisations now represented by FEMHO [INQ000120832]
11. (12 June 2020) Letter from Prerana Issar, NHS Chief People Officer, NHS Improvement and NHS England to BAPIO [INQ000148467]
12. (24 June 2020) Letter from Prerana Issar, NHS Chief People Officer, NHS Improvement and NHS England to NHS Trust Chairs and CEOs, et al. [INQ000148473]

Statements and reports

1. (11 April 2020) Press Release: BAPIO expresses concern about the death of doctors in the line of COVID-19 fire, BAPIO [INQ000148466]
2. (24 April 2020) Press Release: BAPIO COVID-19 survey of over 2000 HCWs reveals BAME background is independent risk factor, BAPIO [INQ000148472]

3. (21 May 2020) Rapid Review of Excess Burden on Muslim Communities from COVID-19, Muslim Doctors Association [INQ000120825]
4. (May 2020) Impact of Covid-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings | assessment and management of risk, Dr Ananta Dave [INQ000120843]

Articles and Journal contributions

1. (23 April 2020) An Online Survey of Healthcare Professionals in the COVID-19 Pandemic in the UK: Perceptions of Risk Factors. I Chakravorty, et al., *Sushrata* 2020 (Jul) 13(2) [INQ000148471]
2. (9 May 2020), Self-reported Occupational Risk for COVID-19 in Hospital Doctors from Black Asian & Minority Ethnic Communities in UK, I Chakravorty, et al., *The Physician,* (2020) 6(1) [INQ000148478]
3. (7 July 2020) Covid-19 and ethnic minority communities – we need better data to protect marginalised groups, Drs Hina Shahid and Salman Waqar, British Medical Journal [INQ000120831]
4. (31 July 2020) The NHS is 72 this year, covid-19 has taught us some tough lessons, Prof JS Bamrah et all, British Medical Journal [INQ000120829]
5. (5 June 2020), UK needs urgent Covid-19 inquiry before we are hit by second wave, Prof JS Bamrah et al, The Guardian [INQ000120830]
6. (16 July 2021) "Freedom Day" is on the horizon, and brings with it the risk of mass covid-19 infection, JS Bamrah and Kailash Chand, British Medical Journal [INQ000148469]
7. (12 October 2021) Covid inquiry: Anger grows after report finds white medics had better access to PPE than black and Asian staff, Independent [INQ000148468]
8. (2022) The Muslim Gaze and the COVID-19 Syndemic, Dr Hina Shahid and Sufyan Abid Dogra, MDPI Open Access Journals, 2022, 13, 780 [INQ000120824]

Other

1. (May 2022) Risk Assessment Tool, Royal College of Psychiatrists [INQ000148479]