THE UK COVID-19 PUBLIC INQUIRY

BEFORE BARONESS HALLETT

MODULE 2 OPENING STATEMENT FROM THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

Introduction

1. The Covid-19 pandemic was more than just a medical challenge. Echoing the sentiments of the recent Guardian article dated 7 August 2023 by health writer Ms Mia Malan, it was a political, social, economic - and most critically - a human rights crisis. According to this thesis, the pandemic was a crisis that was magnified by human-made inequalities, where policy decisions (or the lack thereof) had profound consequences not just on statistics but on actual lives—lives that were changed forever or tragically cut short.

2. FEMHO's primary concern in this module centres around the need for answers regarding the failure of both central and local government decision-making to anticipate, protect against, respond to and/or mitigate against the stark inequalities and disproportionate impacts on minority ethnic HCWs and their communities. FEMHO's commitment has consistently been focused on ensuring that this Inquiry investigates both the decisions made and those that were glaringly *omitted*.

3. Module 2 of this Inquiry was initiated with the stated aim to understand the complex political and administrative governance that influenced the UK's pandemic response. This module proposes to scrutinise initial reactions, centralised decisions, and the performance and dynamics between political entities and civil services. FEMHO has previously stressed the importance of a comprehensive investigation into governmental policies and processes to unveil any systemic failures contributing to these disproportionate impacts. Key considerations, including *structural racism* and *health inequality*, must remain at the forefront of the Inquiry's explorations. Indeed, there is a pressing need for in-depth examination of the

societal factors which combined to cause adverse racialised outcomes. The UK government's duties under Article 2 ECHR, highlighting the state's obligation to safeguard life, and questions surrounding adherence to the Public Sector Equality Duty ("PSED") further underscore the urgency of this examination.

4. In addition, FEMHO seeks to emphasise the importance of inter-sectoral collaboration, as illuminated by the story of South Africa's battle against HIV, which is referenced in Ms Milan's Guardian article. Inclusive co-operation across governmental departments and the affected communities themselves, can be pivotal in effecting change and challenging existing norms. The Inquiry must, therefore, explore the depth of the UK's inter-sectoral cooperation, understanding its potential strengths and inevitable weaknesses. By reflecting on the relationships between central government, devolved administrations, local sectors, and voluntary groups like FEMHO, we can understand the impact that results from the application of decisions such as non-pharmaceutical measures. Delving into these dynamics, we submit, is critical in assessing the factors that bolstered or impeded their effectiveness and therefore identifying where positive change can be made in future.

5. In these submissions, FEMHO contends that to truly appreciate the full import of pandemic decision making, it is crucial to grasp the societal framework underpinning them. In Module 2, FEMHO again renews its call for heightened scrutiny in three pivotal areas:

   i) The implementation of pre-pandemic government planning;

   ii) The existing public health data architecture; and

   iii) The real-time response to the alarming death rate disparities in Black, Asian, and Minority Ethnic communities.

Implementation of pre-pandemic planning

6. FEMHO's expectation was that in this Inquiry, Module 1 would have provided the predicate of evidence and insights required for a proper examination of the role of structural racism and health inequality in fuelling the pandemic. Indeed, our concerns relating to these issues were raised before our exclusion to participate as a core participant in this module; and we note the

remarkable absence of non-governmental bodies that were designated to participate as core participants in this Module 1.

7. Despite our inability to participate in Module 1, and our disappointment that several key issues of relevance were either not raised at all or not dealt with in as much detail as we consider necessary and appropriate, FEMHO notes the following key points that were brought to light during the course of the evidence. These failures in planning, we say, directly impacted on decision-making and must therefore be kept in the forefront of minds as importance context during Module 2.

   a) Professors Marmot and Bambra's evidence on health inequalities, and the lack of consideration given to them or the resulting vulnerabilities they cause in emergency planning, including that: "*the UK entered the pandemic with its public services depleted, health improvement stalled, health inequalities increased and health among the poorest people in a state of decline*";

   b) Clara Swinson's apparent acceptance that there was a failure in planning to consider and plan for PPE that would fit a wide range of face shapes and sizes ("standard" PPE being modelled on a white male face type which was unsuitable and therefore ineffective at reducing exposure for many, particularly those from ethnic minority communities);

   c) Sir Christopher Wormald's confirmation that PPE that fitted Black staff better was purchased in "*much smaller*" quantities (despite the overrepresentation of Black and Minority Ethnic staff on the frontline) and his apparent acceptance that there was no consideration in any of the emergency planning exercises about possible impacts on vulnerable people or ethnic minorities beyond direct clinical factors;

   d) Sir Patrick Vallance's apparent acceptance that matters of inequality "*needs to be built into the thinking, the thought process, right at the outset*";

   e) Dr Kevin Fenton's agreement with our, FEMHO's, view as expressed in Ade Adeyemi's witness statement on behalf of the group that: "*FEMHO believes that planning, forecasting and preparatory work, for a high-consequence infectious disease 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.*"

f) Dr Kevin Fenton's evidence highlighting the importance of leadership at all levels of government addressing inequalities, investing in ensuring cultural competence and community engagement to deliver programmes effectively and ensuring quality data sets allowing for proper understanding of inequalities and his comment that: "*for a number of the inequalities that we observed, the experience of our communities on poor trust, stigma, discrimination, including structural racism has repeatedly come up as a huge issue that our communities need us to confront and address, and ... i believe that organisations working in health and care have a responsibility to visibly state and to visibly act on these inequalities in a much more comprehensive way*";

g) David Cameron's apparent acceptance that the fact that whole-system catastrophic shocks would likely impact lower socioeconomic groups and minority ethnic groups more was well known; and

h) The evidence of Professor Philip Banfield of the BMA, Dr Richard Horton of the Lancet and Rosemary Gallagher MBE of the RCN all of whom gave evidence that attested to the existence of structural discrimination and racism within the health and social care systems in the UK.

8. Our position is that the Inquiry must closely examine the capacity of both central and local government to make decisions that anticipate and address the consequences which inevitably flowed from health inequality and structural racism during the pandemic. Government emergency planning and work in building pandemic resilience should have anticipated that health inequality – *occasioned by structural racism and wider issues such as austerity* – would exacerbate vulnerabilities and result in disproportionately adverse health outcomes within communities of colour. 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 Covid-19 and other respiratory viruses, it is reasonable to expect that government decision making would reflect the need for focused considerations of race and ethnicity during a pandemic.

9. The response of the Health Foundation to the Covid-19 Inquiry's Module 2 Impact Questionnaire [INQ000099710, pp.7-8] appears to support FEMHO's contention. In sharing its view on "lessons learned", they stated the following:

"*The policymaking process during pandemic should have placed far more emphasis on pre-existing health inequalities, underpinned by greater awareness and understanding of how pre-existing differences in health were likely to be impacted by the virus and by the policy response."*

10. A report from the Department of Health and Social care, titled "The Government's response to the Health and Social Care Committee and Science and Technology Committee Joint Report: lessons learned to date", dated 17 June 2022, tends to accept the Health Foundation's proposition. This report accepts that the government should ensure that its "levelling up" agenda includes specific policies to reduce health inequalities, with a particular focus on ensuring that certain groups, including people from Black, Asian and Minority Ethnic backgrounds, do not continue to face unequal health outcome. It said as follows:

"It is essential that in any future crisis, NHS staff from black, Asian and minority ethnic backgrounds are included in emergency planning and decision-making structures. NHS England should accelerate efforts to ensure that NHS leadership in every trust, foundation trust and clinical commissioning group is representative of the overall black, Asian and ethnic minority workforce."

[INQ000075352, p.10]

11. The imminent need for policy interventions to have been informed by knowledge of pre-existing health inequality, was brought to the fore in the early stages of the pandemic. In a briefing of 21 March 2020, CMO Sir Chris Whitty said the following:

"There is a strong correlation between economic disadvantage and ill-health and in the long-term any prolonged increase in poverty due to our countermeasures will feed through to poor physical and mental health outcomes."

[INQ000048167, p.1]

12. To address the disproportionate impact of the pandemic, a range of policy intervention tools were required. Professor Dame Anne Johnson, from the Environmental Modelling Group of

SAGE, envisaged this tool kit to include prioritisation of those with greatest need; ensuring messaging and communication are appropriate; and ensuring access to prevention and care is available to all [INQ000056516]. At the heart of these measures is the overarching aim of ensuring that the Inquiry should consider how public health systems work to reduce inequality.

13. Indeed, in the early days of the pandemic, public health messaging and the media disseminated and encouraged an unhelpful focus in public discussion about genetic predisposition towards the disease and lifestyle choices rather than the deep rooted structural socio-economic and health inequalities embedded in society. This created stigma and discrimination which exacerbated anxiety and uncertainty about the disease amongst the communities most affected.

14. FEMHO is keen for Module 2 to address the following key question:

Were there any specific measures taken by the government which anticipated and/or reacted to the disproportionate impact of Covid-19 on Black, Asian and Minority Ethnic communities and healthcare workers? If so, what were they and were they taken in a timely manner? If none were taken, what was the reason for this failure to act?

Data architecture in public health

15. Much has been said in the evidence we have seen about the shockingly unprepared state of the UK's data and surveillance systems at the outset of the pandemic, the impact this had on the quality and speed of research and advice possible in the critical early stages of the pandemic and consequently the knock-on impact on decision-making.

16. We consider it vital for this Inquiry to not only investigate this, but also specifically 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 purely anecdotal, escalated only through campaigners and news reports, rather than from agencies of government. The fundamental question for the Inquiry here is:

Was there any unified national system of data capture that could apprehend rates of infectivity or death rates based on race/ethnicity? If no such system existed, how was this data pursued and obtained?

17. FEMHO notes the Inquiry's acceptance of the critical importance of this issue when considering disproportionate deaths among Black, Asian and Minority Ethnic healthcare workers and their communities, in the early days of the pandemic. We were heartened by the appointment of an expert Mr Gavin Freeguard, to examine this subject generally, and note his constructive the amendments made to his final report dealing with issues relating to data on ethnicity, following on from our observations on the same.

18. FEMHO contends that a significant data indication regarding the high vulnerability of people of colour during the pandemic, was the increased infectivity among those with certain underlying conditions. Social scientists have posited that the high levels of such underlying conditions – for e.g. hypertension, heart disease and diabetes – were a reflection of structural racism. For a close examination of this subject, it is therefore important for the Inquiry to explore whether data disaggregated in terms of race and ethnicity, was available regarding diseases associated with heightened vulnerability to Covid-19. What data was available for analysis that connected certain diseases with Covid-19 vulnerability? Did senior political leaders have access to this type of data analysis and if so, is there evidence of any engagement with it in political decision making?

19. In a Rule 9 questionnaire response to this Inquiry, Dr Rob Challen of the Scientific Pandemic Influenza Group on Modelling (SPI-M-O) expressed his frustration at the heterogeneity of data from different nations of the UK [INQ000056439]. Even at the level of key reference data such as geographical boundary data, or population data, there are multiple platforms for distributing data which use inconsistent terminology. Covid data was delivered in different formats and via different technical platforms with differing degrees of detail for each of the 4 nations of the UK.

20. There appears to have been government acknowledgement of the serious deficiency in data capture. In the Public Administration and Constitutional Affairs Committee Report on Government transparency and accountability during Covid (15/03/21) the following was recorded:

"We must highlight one important gap in the data. The Committee has been told by numerous contributors to this Inquiry that there is insufficient evidence to understand the disproportionate impact of Covid-19 on people from Black, Asian and Minority Ethnic groups. Currently the death registration and certification process does not record ethnicity, which means there is not a good flow of data on Covid-19 related mortality by ethnicity."

[INQ000075383, p.9]

21. The absence of a reasonable system of data capture for race and ethnicity during the pandemic, cannot therefore be understated. This serious gap existed in the context a system that was described by the chief political advisor Mr Dominic Cummings, in a manner that was hugely concerning. In Mr Freeguard's report, he quotes Mr Cumming's description of the data system to Parliament in 2021, as follows:

"In all sorts of ways it did not exist. The data system on Monday 16 March was the following. It was me wheeling in that whiteboard you have seen from the photo and Simon Stevens reading out, from scraps of paper, numbers from the ICUs. I would write them down on the left side, and I would get my iPhone out and go x2, x2, x2. Then I would write another column and say, So, if its doubling every five days, these are the numbers we're going to be looking at." Everyone would look at the whiteboard and go, "Jesus – can that possibly be correct?" There was no functioning data system, and that was connected with there being no proper testing data. Because we did not have testing, all we could really do was look at people arriving in hospital. So the whole thing, therefore, is weeks and weeks out of date. Once you are looking at ICU numbers as your leading indicator, you know that you are in a world of trouble."

[INQ000260629, p.40]

22. The evidence of Professor Graham Medley, an expert on mathematical modelling in infectious diseases, will further highlight concerns about data architecture. There is an understanding that infectious disease modelling does not rely on certainty. Put roughly, computational work need only be sufficiently robust in order to assist decision makers to make the right strategic interventions. The precautionary principle, in medical risk, invites reasonable interventions on the basis of probable risk and not certainty. The evidence so far appears to be that there was a paucity of data in relation to race and ethnicity, which logically, must have affected the capacity to conduct robust modelling, especially in the pre-testing, early stages of the pandemic. Professor Medley may hopefully assist the Inquiry to understand the work he was able to pursue in respect of race and ethnicity in the early stages of the pandemic; and importantly,

what type of policy intervention did any such work on race and ethnicity tend to invite of policy makers.

23. The Inquiry's examination of the data architecture in Module 2 raises two important overarching questions: a) transparency and openness; and b) accountability. Already, this Inquiry has been mired at the preliminary stages with issues of transparency and openness. But at a substantive level in Module 2, there are significant issues on this topic to be investigated, including:

    a) *What data or data analysis was available to senior decision makers during the early stages of the pandemic about disproportionate deaths of Black, Asian and Minority Ethnic people?*

    b) *Was there a failure to make the appropriate policy interventions, in the light of an unfolding crisis about disproportionate death rates among Black, Asian and Minority Ethnic people?*

    The question that follows is one of accountability: *who is accountable for any failure to act in these circumstances?*

24. The proposed evidence hearing of Lord Gus O'Donnell presents an opportunity for focused attention to what avenues existed in government for these issues related to data architecture and responsibility for it to be addressed. FEMHO submits that Lord Gus O'Donnell's oral evidence should not be an anodyne examination of the role of the civil service in a pandemic in a generic sense, but instead, an opportunity for a focused exploration of these particular themes which arguably are, or should be, at the heart of the investigation in Module 2.

Contemporaneous response to disproportionate death rates

25. FEMHO urges the Inquiry to closely examine the contemporaneous response by decision-makers to disproportionate death rate in Black, Asian and Minority Ethnic healthcare workers and their communities, during what is referred to as the early stages of the pandemic. This period roughly spans the first half of 2020. It is a notorious fact that from early 2020, there was a disproportionately high rate of deaths among Black, Asian and Minority Ethnic healthcare workers and in their communities. This Inquiry must interrogate:

a) *Whether this disparate impact was anticipated and what, if any, steps were taken to address this and when?*

b) *How did decision-makers at all levels consult or otherwise engage with and involve Black, Asian and Minority Ethnic communities and healthcare workers in response, particularly in decision-making processes, the development of policy and communication strategies?*

c) *Was there a coordinated national response to the disproportionately high number of deaths in Black, Asian and Minority Ethnic communities and healthcare workers? If not, what was the rationale for the failure to act?*

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

26. The Inquiry will have well-noted issues regarding the existence of high-quality data on race and ethnicity in the first stage of the pandemic. FEMHO commends the evidence of Professor Khunti as an inflection point in the government's capacity to respond to the unfolding disaster of disproportionate death rates within Black, Asian and Minority Ethnic community. In any narrative or chronology that is produced by the Inquiry about engagement on this issue during that crucial time, Professor Khunti's communication of his concerns to CMO Sir Chris Whitty on 4th April 2020 [INQ000236611], will be significant. In their brief email exchange, Professor Khunti flags his concerns about disproportionate death rates from Covid-19 among Black, Asian and Minority Ethnic people. He later developed his thoughts on these matters in an article in the British Medical Journal in June 2020 [INQ000223047].

27. It appears that Professor Khunti had access to sufficient data and data analysis to raise an alarm during this crucial period. The Inquiry must give focused attention to Professor Khunti's observations during this period (the earliest stage of the pandemic) – and seek to understand the basis for the Professor's authoritative intervention during this time. Did senior advisors and leaders have access to the same data and data analysis? Moreso, did the unfolding situation require any kind of targeted intervention either at a local or central government level? And what was government's response to the concerns or "*signals*" that had been identified about these disproportionate deaths in Black, Asian and Minority Ethnic community? Professor

Khunti can provide an important focal point in the contemporaneous account of the first stage of the pandemic. Significantly, he can provide assistance to the Inquiry in the investigation of:

a) *What government ought to have known about these events; and*

b) *Whether there was a failure by government to act on this issue?*

28. A select number of "dashboard" reports disclosed in this Inquiry illustrate the growing state of knowledge about the unfolding disaster for Black, Asian and Minority Ethnic people that was being wrought by the pandemic:

Situation Report and Dashboard by Departmental Operations Centre (Home Office) titled Situation Report and Dashboard #118, dated 07/05/2020.

On page 26 in the "HO Staffing" section, there is recognition of the "*impacts on Black, Asian and Minority Ethnic staff*" and the fact that "*Black, Asian and Minority Ethnic Colleagues have expressed concern about the latest ONS analysis on the impacts of Covid-19 for the Black, Asian and Minority Ethnic community."* This section notes the review which had already been launched by the government and the fact that there may be a number of factors at play: *"This must be considered at civil-service wide level and once we have more scientific advice, we can issue further advice. We understand that Black, Asian and Minority Ethnic colleagues are anxious and have provided guidance that they should speak to their line managers about their concerns."*

[INQ000053264]

Situation Report and Dashboard by Departmental Operations Centre (Home Office) titled Situation Report and Dashboard #119, dated 08/05/2020.

On page 5 dedicated to SAGE advice, with summaries of meeting minutes, it is noted that SAGE advised the government to maintain focus on reducing transmission in healthcare settings. This also repeats the exact concerns expressed in above document regarding the disproportionate impact on Black, Asian and Minority Ethnic staff.

[INQ000053265]

Situation Report and Dashboard by Departmental Operations Centre (Home Office) titled Situation Report and Dashboard #129, dated 18/05/2020.

On page 15, there is a mention of articles referencing the impact of Covid on Black, Asian and Minority Ethnic doctors – "*The Guardian, Times and Telegraph report that more than three-quarters of Black, Asian and Minority Ethnic doctors worried about contracting coronavirus in the course of their work, according to a survey that highlights the ongoing lack of protection for frontline NHS staff."*

[INQ000053311]

Situation Report and Dashboard by Departmental Operations Centre (Home Office) titled Situation Report and Dashboard #145, dated 10/06/2020.

On page 5 of the situation report it notes: "*There is an increased risk from Covid-19 to Black, Asian and Minority Ethnic groups, which should be urgently investigated through social science research and biomedical research and mitigated by policy makers."* SAGE advised the government to investigate the risk to Black, Asian and Minority Ethnic groups at this time.

[INQ000053446]

29. Despite this awareness, it seemed that little effort was made at a central government level to convene health system leaders to discuss and tackle the causative issues. This meant that there was an unhelpful ambiguity on how best to protect ethnic minority healthcare staff. It was not until July 2020 that NHS Employers provided updated guidance on prioritisation and management of risk (including risk to ethnic minority staff).

30. A report from Public Health England entitled "Beyond the data: Understanding the impact of Covid-19 on Black, Asian and Minority Ethnic groups", dated June 2020, also provided an authoritative picture and analysis for the state of affairs.

"The literature review and stakeholder feedback indicate that risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of Black, Asian and Minority Ethnic groups. The most recent research from the UK suggests that both ethnicity and income inequality are independently associated with COVID-19 mortality. Individuals from Black, Asian and Minority Ethnic groups are more likely to work in occupations with a higher risk of COVID-19 exposure. They are more likely to use public transportation to travel to their essential work. Historic racism

and poorer experiences of healthcare or at work may mean that individuals in Black, Asian and Minority Ethnic groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risk."

[...]

"It is clear from discussions with stakeholders that COVID-19 in their view did not create health inequalities, but rather the pandemic exposed and exacerbated longstanding inequalities affecting Black, Asian and Minority Ethnic groups in the UK."

[INQ000106482]

The report included a recommendation to "*accelereate the development of culturally competent occupational risk assessment tools*" yet FEMHO members saw minimal and inconsistent changes on the ground to support HCWs. In light of the lack of action, voluntary groups and networks had to take it upon themselves to devise tools to protect their members and colleagues; for example BAPIO (a FEMHO member) developed a risk assessment tool.

31. The decision to downgrade Covid-19 from High Consequence Infectious Disease (HCID) status, thereby permitting use of Personal Protective Equipment (PPE) and not Respiratory Protective Equipment (RPE), also went against the available science and affected the levels of exposure of FEMHO members.

32. To date, there is not much that we have identified from the disclosure, in the way of substantive government response to these issues during the relevant period. In a Report from the Secretary of State for Health and Social Care, titled "The Government's Response to Covid-19: Human Rights Implications" dated December 2020, there is report of an initiative:

"DHSC and NHS England and NHS Improvement (NHSEI) have sought to learn from the experience of Black, Asian and Minority Ethnic staff during the pandemic, with one example being FFP3 masks which do not fit different face shapes. Subsequently, in June, NHSEI launched the FFP3 fit-testing project, led by the Deputy Chief Nursing Officer, to investigate if characteristics such as age, gender, ethnicity, facial profile and other features (e.g. the impact of head coverings on FFP3 mask fit).

We are also ensuring that NHS trusts are receiving their choice of masks, minimising the need for new fit-testing and ensuring staff on the frontline can access masks they have successfully fit-tested to. With this

system, each NHS trust then selects the percentage of each mask that they'd like to receive, based on which masks best suit their staff. They also have the option to order some specifically for the purpose of fit testing."

[INQ000075347]

33. Public health communications and guidance during this time were not consistently provided in accessible formats. Crucially for ethnic minority groups, they were not always provided in languages other than English which created difficulties and barriers in accessing the guidance that impacted on individual lives. 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.

34. As well as engaging with their communities and networks, FEMHO members held a vast array of webinars to discuss, raise awareness and educate the public, government and senior management within the health system on the critical issues they were facing. Alongside this, and their professional commitments, many were also actively campaigning and lobbying ministers, senior officials and management within trusts to draw attention to issues such as the lack of appropriate PPE, exposure risks and disproportionate impacts being seen and felt amongst ethnic minority HCWs. Whilst these efforts resulted in some successes, overall our members feel that the lack of meaningful engagement was a crucial missed opportunity. NHS trusts, for example, could and we say should have engaged more with their BAME staff networks; this would have resulted in improved communication, trust and input into decision-making processes and outcomes to protect and support staff. Similarly, better representation at decision-making level would have enabled direct input and influence to promote effective consideration of the issues being faced and how they might be actively addressed.

35. Within the examination of the early stages of the pandemic, the Inquiry must also investigate whether there was 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. There are serious questions to be answered about whether, in effect, public emergency measures had been put in place in the earliest months of the pandemic - and whether there had been a suspension of regard for the

statutory obligation under PSED. In particular, FEMHO urges the Inquiry to investigate the following key questions:

a) *To what extent was PSED effectively discharged in key decision-making and policy?*

b) *Did Government get the balance right in decision-making in the face of foreseen disparate outcomes of its decisions?*

c) *Should / could decision-makers have taken more steps to mitigate disparate impacts?*

36. In a document showing a "Briefing and agenda for a meeting between Cabinet Office and Home Secretary from Covid-19 Directorate, to the Home Secretary," dated 29 September 2020, there appears almost to be an exhortation to have regard to PSED (presumably, after a period of no such consideration):

> *"In line with the Public Sector Equality Duty, we must ensure that we consider the second order impacts of any new or additional measures we put in place. Doing so will help us to ensure equalities and consistency across all sectors, so we do not inadvertently amplify disadvantage."*
>
> *[…]*
>
> *"Public Health England (PHE) published a report in May, which set out that certain demographic groups were more likely than others to be disproportionately impacted by Covid-19 than others. This included those from ethnic minority backgrounds. The Cabinet office has been leading the work to understand and mitigate impacts on ethnic minority groups as well as other vulnerable groups. A package of £29.5m has been recommended to help mitigate this."*
>
> [INQ000053857, p.3 + p.12]

Conclusion

37. In conclusion, FEMHO calls for particular focus on the government's role in the strikingly disproportionate impact of Covid-19 on minority ethnic HCWs and their communities – especially in the aforementioned three key areas that we have suggested for heightened scrutiny. 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.

38. As a general and overarching principle, the Inquiry must not shy away from a robust investigation of how *structural racism* and *health inequality* are reflected in decision-making (or lack of it) which is under investigation in this module. A thorough and fearless exploration of these issues is essential for the Inquiry to fulfil its mandate and to restore public trust in the government's response to the pandemic.

39. FEMHO is also confident that through engagement with our consortium, the Inquiry will develop its acuity around these issues. We look forward to lines of enquiry, through questioning of witnesses, which reflect the core concerns that have been expressed by FEMHO herein, and in previous submissions.

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