Witness Name: Ade Adeyemi
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF ADE ADEYEMI MBE ON BEHALF OF THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS

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i, Ade Adeyemi, will say as follows: -

1. I am a Black healthcare professional with over 14 years' experience working in the NHS. I started as a ward clerk in Goodmayes Hospital and have worked in different settings since, including NHS England. I am currently a civil servant at the Department of Health and Social Care. I make this witness statement in my capacity as joint-secretary of FEMHO.

2. I am authorised by the membership of The Federation of Ethnic Minority Healthcare Organisations ("FEMHO") to make this statement on behalf of the organisation. I make this statement in response to the Inquiry's letter dated 18 August 2023, inviting one individual from FEMHO to produce a statement about the impact of COVID-19 on our members.

3. In this statement I set out: (1) a description of FEMHO and how and why the organisation was established; (2) an overview of the impact of the Government's decision-making on our members; (3) a summary of representations FEMHO made during the pandemic to core political and administrative decision-makers to influence decision making; and (4) individual summaries as illustrative examples of the types of experiences FEMHO members had that are relevant to the scope of Module 2.

4. To the extent possible, the information contained within this witness statement is based on my own knowledge. Otherwise, it is based on the collective experiences of my colleagues within

FEMHO. I would be happy to clarify or amplify the points addressed in this statement should that be of assistance to the Inquiry.

I. FEMHO: AN OVERVIEW

5. FEMHO is a voluntary multi-disciplinary consortium comprising of over 55,000 individual members belonging to over 40 organisations and networks.[1] We are a consortium, bringing together existing voluntary organisations with shared interests and goals to form a united voice to advocate on behalf of Black, Asian, and Minority Ethnic Health Care Workers ("HCWs") at all levels within the health and social care sectors. 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.

6. FEMHO was designed to be inclusive and all-encompassing such that its membership would be fully representative across the sector. We represent a huge variety of roles and at all levels of seniority within the UK health and social care system 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.

7. FEMHO believes minority ethnic communities should be able to equitably benefit from the level of care that the UK provides to all of its citizens. Unfortunately, inequality and a lack of access and diversity means that communities are missing out on the care they have the right to access. What FEMHO aims to do is close the gap between minority ethnic health and social care organisations and minority ethnic communities to deliver care in an improved way. In doing so we hope that we will be able to achieve better outcomes through the implementation of improved policies, as well as better informed regulators and commissioners both locally and nationally.

[1] Please see Annex 1 for the list of organisations represented by FEMHO.

II. IMPACT OF GOVERNMENT DECISION MAKING ON OUR MEMBERS: AN OVERVIEW

8. FEMHO's central contention is that government decision-making – and its inability to receive input from those of us on the frontline – played a direct and compelling role in the disproportionate rates of infection, death and adverse health outcomes felt among Black, Asian and Minority Ethnic HCWs and our communities. Indeed, this lack of meaningful engagement is a systemic issue felt not just at central government level but throughout UK societal structures, systems and settings. I'm sure I speak not just for myself but for many other of my fellow FEMHO members when I share that this was experienced by us in a manner that is personal and anecdotal but simultaneously harrowing and frustrating, because of the government's lack of preparedness and sometimes, ill-judged responses to the unfolding pandemic.

Context: austerity

9. The UK entered the pandemic after a decade of austerity policies. The impact of these policies cannot be underestimated. Professor Sir Michael Bambra, in his report on health inequalities prepared for Module 1 of this Inquiry but adduced as evidence in Module 2 also, describes the picture of health in the UK as *"stalling life expectancy, increased regional and deprivation-based health inequalities, and worsening health for the poorest in society."*[2] Plausible explanations for this downward trend are cited to be a combination of changes in social determinants of health associated with austerity policies, substantial cuts to local authority, NHS and social care budgets, and cuts to welfare and benefits.

10. Thus, the UK was on a weakened footing when the pandemic arrived, with a depleted NHS which was ill-prepared and equipped for a pandemic. By 2015, £1 billion had been cut from healthcare and £6.3 billion from social care.[3] Understaffed with overworked HCWs, and injured by the effects of mismanagement by successive austerity Governments, in my view, when faced with an incompetent and uncaring pandemic response from central Government, the NHS was doomed to struggle.

[2] Report on health inequalities: Professor Sir Michael Marmot and Professor Clare Bambra [INQ000195843]
[3] Pearson, R., Elson, D., 2015. Transcending the Impact of the Financial Crisis in the United Kingdom: Towards Plan F-a Feminist Economic Strategy. Fem. Rev. 109, 8-30. – https://doi.org/10.1093/sp/jxi021

Disproportionate deaths: lack of Government response and lack of representation

11. It was very apparent to us at an early stage of the pandemic that something was wrong. The first ten doctors to die from coronavirus were from Black, Asian and Minority Ethnic backgrounds.[4] Figures from March – April 2020 highlight the disproportionate impact of COVID-19 on minority ethnic HCWs.
    a. 21% of all HCWs are from minority ethnic backgrounds, yet those groups accounted for 63% of deaths of HCWs.
    b. 20% of nursing staff are minority ethnic, yet 64% of nurses who died during this period were minority ethnic.
    c. 44% of medical staff are minority ethnic, yet 95% of doctors who died during this period were minority ethnic.[5]

12. From early on, ministers and senior NHS leaders were being petitioned by interested groups – many of whom are now a part of FEMHO – highlighting concerns, imploring them to act, and even offering their advisory services.[6] The scale of the disproportionate impact was soon widely reported in a number of mainstream articles and reports; as the stark statistics became unavoidable and obvious.

13. The trends quickly became apparent. As time went by, more minority ethnic HCWs died in larger numbers still. Despite the tragedy unravelling before us all, little effort was made at a central government level to convene health system leaders or take action to halt it. Numerous delays in highlighting and addressing this problem at a central level led to continued ambiguity concerning how best to protect staff of minority ethnic backgrounds. Delays in the provision of national guidelines and policy led to inconsistencies between hospital trusts as to how vulnerable staff are to be protected from the occupational risk of COVID-19. NHS Employers did not provide updated guidance for employers on prioritisation and management of risk, including ethnicity, until July of 2020.[7]

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[4] UK Government urged to investigate coronavirus deaths of BAME doctors, The Guardian, 20 April 2020 – https://www.theguardian.com/society/2020/apr/10/uk-coronavirus-deaths-bame-doctors-bma
[5] Written evidence submitted by the APPG for Africa, the Royal African Society, and AFFORD-UK to the Women and Equalities Committee, Jul 2020 - https://committees.parliament.uk/writtenevidence/8542/html/ - original report from the British Medical Association (COVID-19: the risk to BAME doctors) cannot be accessed
[6] Coronavirus: BAME people make up 72% of all NHS and carer deaths with COVID-19, Sky News, 22 April 2020 – https://news.sky.com/story/coronavirus-bame-people-make-up-72-off-all-nhs-and-carer-deaths-with-covid-19-11977263
[7] Original source (NHS Employers, Risk Assessments for Staff, July 2020 – https://www.nhsemployers.org/articles/risk-assessments-staff) cannot be accessed

14. The Chief Medical Officer commissioned a report on the disproportionate impact of COVID-19 in June 2020.[8] However, little progress was made on acting upon the report's recommendations that would have seen minority ethnic health workers better supported, and after publication the report was largely forgotten. One such recommendation was to "accelerate the development of culturally competent occupational risk assessment tools", but this translated into minimal and inconsistent changes on the ground to better support minority ethnic HCWs. Sadly, this is hardly surprising because barely any representation of individuals of minority ethnic backgrounds are found at senior system leadership levels in the NHS. If more people from our communities were in more leadership positions, they could have used their influence and expertise to ensure the recommendations were implemented and done so effectively.

15. There are a multitude of minority ethnic staff networks across the NHS and the health and care system as a whole. FEMHO represents a great number of professional associations of this kind. In the absence of proper and proportionate representation at senior leadership levels, efforts to engage with these networks at both a hospital Trust level and a national level should have provided an opportunity for minority ethnic HCWs to inform leaders as to relevant considerations to account for when making decisions that affected minority ethnic HCWs, thereby effecting influence over those decisions. According to many of our members, however, little was done to engage them in any meaningful way. Earlier involvement of minority ethnic HCWs, particularly senior clinical leaders, would have resulted in improved communication and trust in decision making processes and outcomes concerning guidelines to support members of staff.

> *A healthcare worker in a hospital Trust, who wishes to remain anonymous, tells of the psychological burden of what they saw unfold in the early stages of the pandemic: "Every day I had people I knew who were dying. I still had to come in [to hospital] and be strong, and I was also supporting my family at home during a lockdown."*
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> *A senior clinician and administrator from a hospital Trusts explains: "one of the first doctors to die was my friend. I knew him for years."*

16. Majority white professional networks and institutions within the field of healthcare enjoy informal relationships with the NHS leadership, through which the attention of decision makers can be

[8] PHE Report: Beyond the data: Understanding the impact of COVID-19 on BAME groups – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

caught. For many of our members, the opposite is true. There is a clear structural imbalance within medical and healthcare networks that disadvantages our members: we do not benefit from those relationships enjoyed by majority white groupings, and this often prevents us from calling on senior leaders to engage with us in the same way that many other groups readily can. We are very lucky when we have the ear of somebody in a senior position. We have to organise, mobilise and campaign for our needs to be addressed at a distance, which can be less effective and rarely lasts for long. The system relies on minority ethnic HCWs to perform unremunerated labour to try and ensure their conditions are improved, in their own time, and without formal systemic support or recognition. During the pandemic, this took the form of petitioning ministers and health leaders and delivering webinars and talks to our communities to disseminate information on how to stay safe.

17. The appalling lack of diversity at senior levels of the NHS is one of the most important systemic issues that contributed to the impact of COVID-19 on minority ethnic HCWs and minority ethnic communities in the United Kingdom as a whole. BAME workers are overrepresented in lower levels of the NHS grade hierarchy[9] while senior NHS management is almost exclusively white. It follows that we are overrepresented in frontline, public-facing roles in both the NHS and other areas of health and social care. Minority ethnic HCWs make up around 20 percent of the overall NHS workforce but just 6.5 percent of senior managers.[10] Further, in London, almost half of NHS employees are minority ethnic but 80 percent of NHS Trust board members are white.[11] The lack of diversity does not provide an environment where minority ethnic staff feel empowered to speak of their concerns to senior managers, further compounding the problem.

18. Further, consultancy firms like Deloitte and McKinsey were a key part of the decision-making apparatus during the pandemic. There was little diversity in the staffing of these firms and no meaningful involvement of minority ethnic HCWs in discussions leading to decisions that would ultimately affect them.

> *One of our members, particularly disturbed by the lack of minority ethnic representation at decision maker level, had this to say: "Decision makers were removed from people on*

[9] This is reflected in many publicly available articles and reports, see, for example: The King's Fund, "Ethnic minority deaths and Covid-19, what are we to do?", 30 April 2020 – https://www.kingsfund.org.uk/blog/2020/04/ethnic-minority-deaths-covid-19
[10] NHS workforce Race Equality Standard, 2019 – https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf
[11] Gov.UK NHS ethnicity facts and figures, 13 April 2023 – https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest

the ground and vulnerabilities that people faced in this disaster. There should have been something around figuring out how to involve the right people that have that diversity in representation in decision making, to give them a voice around the table."

A senior doctor in a London NHS hospital Trust explains: "any recommendation relating to Black and Minority Ethnic staff has to be mandatory or it won't happen. The NHS is stretched, and if [NHS decision makers] see something they don't understand they won't do it unless it is mandatory. There needed to be consultation and engagement from the beginning. You could have planned it. If you were interested in the subject of inequalities, you would know that these people would be targeted by infection."

19. Minority ethnic HCWs were disproportionately hit by the virus and were dying en masse. I have already said that it was obvious this was happening. Instead of doing more to actively intervene against the disproportionate impact of the virus on our members and their communities, the Government chose to do nothing, and we were left to watch helplessly as our colleagues, friends and relatives died alone. It angers and saddens us to know that so many more lives could have been saved if, on seeing the early stark figures, the Government acted to address the problem. Health leaders and relevant ministers should have immediately been convened and made to act. Guidance on risk that included ethnicity should have been produced without delay. When late action was taken to investigate the problem, recommendations should have been implemented, not ignored. Representatives from our networks should have been brought into the leadership fold or at the very least, contacted for guidance. We should not have been left to fend for ourselves.

20. Through the lack of Government response set out above, and in the sections of this statement that follow, I describe an environment of structural and institutional racism. The MacPherson report published in February 1999 following the inquiry into the death of Stephen Lawrence applied a conceptualisation of institutional racism: *"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in the processes, attitudes and behaviour which amount to discrimination […] It persists 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."* To my mind, the failure referred to in the report was

present in the Government's response to this pandemic, seen in both the decisions made and the lack thereof. It is clear to me that since the report's publication, the Government has failed to recognise and take action to eliminate racism within their procedures. Prior to the onset of the pandemic, time and again, the Government failed to implement recommendations from a range of investigations to combat racism within itself and in society.

Aggravation of COVID-19 by decision making and Government conduct

21. When decisions were made, they were often unhelpful and actively harmful to our members.

22. One example of this is the decision to pursue the Eat out to Help Out scheme during August 2020. The then Chancellor, Rishi Sunak MP, launched the scheme as a way to boost the catering industry following the lockdown implemented in the spring of that year. It sought to mitigate the public's concerns around infection and aversion to social mixing at the time, by encouraging eating out in restaurants through a Government subsidised discount on food.

23. It has since been suggested that the scheme drove up Covid-19 infections in England at the time. The scheme had a *"significant causal impact on new cases, accelerating the subsequent second COVID-19 wave."*[12] It was of course known at the time that our communities were being disproportionately affected by the virus. It was also known at the time that our communities were disproportionately represented in public facing roles, including in catering. The scheme subsidised around 160 million meals during the period it ran, driving an influx of hospitality customers, and a concomitant increase demand for shifts in the catering industry. It is thus reasonable to suggest that more minority ethnic workers in the industry would have been infected as a result. Those minority ethnic workers would have been more likely to suffer serious disease after infection, with an increased likelihood of hospital admission, putting our already more vulnerable minority ethnic HCWs at greater risk still. The aggressive second wave of COVID-19, accelerated by the scheme, had a deleterious impact on the health and wellbeing of our members and their communities. Not only did this result from further infection and death, but through renewed psychological burnout from which many of our members had not recovered after the first wave.

[12] Fetzer, T., 2022. Subsidising the spread of COVID-19: Evidence from the UK's Eat-Out-to-Help-Out Scheme. The Economic Journal, Vol. 132, Issue 643, 1200 - 1217 – https://doi.org/10.1093/ej/ueab074

24. Our members suffered, and continue to suffer, devastating personal costs, bereavements and mental health problems as a result of the conditions we have been required to work in. This mental strain was not addressed at a central or systemic level, with no discrete or bespoke mental health support being offered to minority ethnic HCWs. Given the sobering death rate figures for minority ethnic HCWs and minority ethnic people at large, the extreme failures in providing safe working conditions in healthcare settings, significant mental health inequalities for minority ethnic groups already existing before the onset of the pandemic and an increased risk for minority ethnic populations of mental illness including neuropsychiatric disorder as a result of COVID-19 infection[13], the lack of such support seems absurd. Against this backdrop, I am angered and moved to hear reports of bullying by managers and a fear of raising concerns. This Inquiry should explore whether the other avenues through which minority ethnic staff could raise issues, for example the NHS Freedom to Speak Up Guardian, were publicised effectively and whether enough positive impact was felt when they were used.

> *One of our members says: "Promoting a culture of psychological safety is good leadership. If you are making decisions and asking people to risk themselves in line of duty, support them, validate their distress and make sure their risks are understood and make sure they are OK, and value people's lives."*

25. Additionally, the Government's delays in ordering lockdowns were damaging. In the absence of other means to stop the virus ripping through hospitals and society at large, such as a functioning test and trace system or the ability to isolate individual cases, the lockdowns seen in other countries suffering with COVID-19 at the time should have been adopted sooner. It is no secret that when they were adopted, both in the early days and later on over the winter of 2020/2021, the rules around what people could and could not do were vague, confusing, and came across as half cooked. My hope is for this Inquiry to examine with rigour whether these communications hindered the effectiveness of lockdown measures.

26. Further, it should come as no surprise to the Inquiry that I and many FEMHO members are disgusted by the personal conduct of a few Government officials during the pandemic. In the national media, stories repeatedly emerge with new details of rule breaking at the heart of Government at a time when frontline workers were dying, frightened and alone yet continuing to

[13] Smith, K., Bhui, K., Cipriani, A., 2020. COVID-19, mental health and ethnic minorities. BMJ Ment Health, 23, 89 – 90 – http://dx.doi.org/10.1136/ebmental-2020-300174

put themselves at risk day in day out to work to support and care for others. I won't rehearse what our members already know, aside from to say that the Whitehall lockdown parties and the falsehoods advanced after the fact to cover them up made many feel that our leaders see us with nothing but contempt; as others before have put it: "it was one rule for them and another for us".

Social distancing, self-isolation, and infecting others

27. Many of our members had to perform their professional duties in the workplace, as opposed to from home. By their nature, many of our members' roles are patient facing. Public transportation often had to be taken to and from work, especially for those of our membership who are low paid, which carried a heightened risk of infection. Inadequate PPE was provided or, in many cases, especially early in the pandemic, not provided at all. It is common among many minority ethnic communities that the elder generations would cohabit with the younger members of the family, and as such, it was more likely that clinically vulnerable people would be living in the same household as key workers with increased exposure risk. It was difficult and often impossible in these circumstances for many of our members to adhere to the Government's guidance on social distancing and self-isolation.

> *A HCW who wishes to remain anonymous explains how, in the discharge of their patient-facing role in hospital, their tiny office was unable to accommodate any kind of social distancing: "The office itself – it's a tiny little thing. I have never seen anything like it. You can fit in two desks, and even then it's really tight. The length of it fits three workstations. We have windows but they are just on one side of the room. Your chairs are back-to-back. It was anxiety provoking: the office was not fit for the pandemic. You couldn't keep two metres away from each other […] We saw patients who were referred to us. In the room where we worked there was no window – this was really something else considering we had to see them face to face."*

28. Many of our members were on the frontlines in disproportionate numbers compared to their white colleagues. They knew this and could see it for themselves. Knowing that you are being treated worse because of your ethnicity is an exhausting and insidious feeling. Pair this with watching your colleagues die one after the other with nothing done to help them, and the fear of being infected yourself with poor or no PPE for protection, and the emotional toll becomes overwhelming. Further, on watching their minority ethnic colleagues die in great numbers, many

of our members were terrified of taking the virus home to their elderly dependents. The thought of passing a deadly virus to those you love, and for whom it was clear the risks were heightened, was extremely distressing for many on the frontlines. Often, minority ethnic HCWs are paid less than white workers. Our members lives were made more difficult still by having to pay for hotel rooms out of their own pockets so they didn't infect their families at home. Of course, little economic support was provided from the NHS or from Government to soften the blow. An Independent SAGE report published in July 2020 recommended that *"People from […] black and ethnic communities are more likely to live in […] overcrowded and multigenerational housing. Temporary housing availability (e.g., hotels and community shelters) should be made available to facilitate self-isolation for symptomatic individuals. […] employers will need to ensure that those isolating are paid during isolation and do not suffer financial hardship."*[14]

Data

29. Despite the risks to ethnic minority HCWs in contracting coronavirus and the subsequent disproportionate impact of COVID-19 being obvious to many of us, there were apparent delays around the collecting, collating and analysis of relevant data in real time. This reduced the ability to accurately predict and identify effective responses. As an example, one of our member organisations, the Filipino Nurses Association, began collating data from different sources on Filipino nurses who had died and began submitting them to the Chief Nursing Officer because no Government body was doing it. The Independent SAGE report from July 2020 called for action to address this as one of the most urgent issues in the pandemic in the UK.[15]

30. Consequently, there was an over-reliance on informal and anecdotal evidence in the early stages of the pandemic as a result of this failure to collect and analyse data surrounding minority ethnic HCW infection and deaths. Without detailed data being collected and studied, how could the problem be described and quantified accurately? If we don't have a true picture of the problem, how could the appropriate measures to address it be decided? The Government should have mandated the collection and reporting of relevant data and, as the report also suggests, *"all relevant research studies should collect and present disaggregated ethnicity data, national*

[14] 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, July 2020 – https://www.independentsage.org/wp-content/uploads/2020/09/Independent-SAGE-BME-Report_02July_FINAL.pdf
[15] ibid

minimum data sets should include ethnicity data (all existing data sets should be reviewed), and ethnicity should be included in mortality reporting (i.e. death certification)."[16]

31. A FEMHO member touches on the consequences of poor data collection:

> *"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 the vulnerable, and the planning [in] the early stages."*

32. One route through which the collection of data on minority ethnic coronavirus infection and COVID-19 deaths could have been adequate reporting under RIDDOR. There are valid concerns as to the adequacy of the reporting under RIDDOR as a result of how the relevant guidance from the Health and Safety Executive has been interpreted. The Health and Safety Executive has already conceded that there is widespread underreporting, something the Trades Union Congress has described in a recent report as *"an understatement."*[17] This is particularly true of the health sector, where the same report highlights that *"Under-reporting of Covid infections and deaths has been continuously raised by health unions in tripartite meetings with NHS employers and HSE. Health unions report advice issued to employers on RIDDOR reporting results in instances where cases being considered valid only where a mask had become broken or had been pulled off by an agitated or distressed patient. This leaves the instances of cases eligible for reporting very limited."*

PPE and oximeters

33. Minority ethnic HCWs suffered disproportionately from the failures to facilitate adequate personal protective equipment (PPE). Our members were burdened with unavailability and inadequacy of PPE, and fit testing rejection. Our members were more likely than their White British colleagues to find themselves in hazardous work environments without adequate PPE.[18]

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[16] ibid
[17] The Trades Union Congress, RIDDOR, Covid and under-reporting, 2021 – https://www.tuc.org.uk/research-analysis/reports/riddor-covid-and-under-reporting
[18] Equality and Human Rights Commission, Experiences from health and social care: the treatment of lower-paid ethnic minority workers', 2022 – https://equalityhumanrights.com/en/publication-download/experiences-health-and-social-care-treatment-lower-paid-ethnic-minority-workers

34. I was appalled to hear of the evidence given to Module 1 of this Inquiry by Chris Wormald, permanent secretary to the Department of Health and Social Care (DHSC), who confirmed that the department had stocked lower levels of PPE suitable for minority ethnic staff working in healthcare and that little planning had been done to consider the equality of PPE provisions.[19]

35. The PPE that was eventually provided was often poorly fitting and therefore of limited value: little consideration was given to the differences between facial structures between ethnicities.[20] Further, many of our members were not provided with PPE that was compatible with religious and/or cultural dress.[21] When compared with white doctors and nurses, more minority ethnic doctors and nurses reported not having sufficient PPE, and it was reported in evidence submitted to the Women and Equalities Committee that 64% of BAME doctors reported feeling pressured to work in settings with inadequate PPE compared with 33% of white doctors.[22] Some of our members report being forced, through lack of other options, to use bin bags as PPE. Nobody should be made to work in such a dangerous climate. Many of our members were frightened and appalled.

36. Furthermore, the decision to downgrade COVID-19 from High Consequence Infectious Disease ("HCID") status on 19 March 2020, thereby permitting the use of PPE and not Respiratory Protective Equipment, appears to have been a grave error and the impact on lives lost should be examined by this Inquiry. Despite the World Health Organisation waiting over a year since declaring the pandemic to state it was airborne, research suggested much earlier that the virus was airborne,[23] and authorities were implored to acknowledge this reality.

37. Furthermore, in April 2021 concerns were raised about the functionality of oximeters. Oximeters were vital as tools to test oxygen levels in a person's blood and operate through sending light through the body. Research found that oximeter readings for Black and minority ethnic people could be "seriously misleading".[24] The majority of oximeters have been developed based on

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[19] See oral evidence of Chris Wormald given to the UK Covid-19 Inquiry, 19 June 2023.
[20] See, for example, Chopra, J., Abiakam N., Kim, H., et al, 2021. The influence of gender and ethnicity on facemasks and respiratory protective equipment fit: a systemic review and meta-analysis, BMJ Global Health, Nov 6(11), doi: 10.1136/bmjgh-2021-005537
[21] For example, that fitted and were effective with individuals who wear turbans, have beards etc. See, for example, The Telegraph, 1 April 2020, Hospitals inspect doctors for beards and tell those with more than a day's stubble to shave – https://www.telegraph.co.uk/news/2020/04/01/hospitals-inspect-doctors-beards-tell-days-stubble-shave/
[22] Written evidence submitted by the APPG for Africa, the Royal African Society, and AFFORD-UK to the Women and Equalities Committee, Jul 2020 - https://committees.parliament.uk/writtenevidence/8542/html/
[23] Morawska, L., Cao, C., 2020, Airborne transmission of SARS-CoV-2: The world should face the reality. Environment International. 139 - https://doi.org/10.1016/j.envint.2020.105730
[24] NHS Race & Health Observatory, 14 April 2021, Pulse Oximeter Bias Highlighted in Rapid Review – https://www.nhsrho.org/publications/pulse-oximeter-bias-highlighted-in-rapid-review/#:~:text=The%20accuracy%20of%20Pulse%20Oximeter,pandemic%2C%20and%20need%20further%20assessment.

studies measuring oxygen levels in white and light-skinned individuals, but research revealed inaccurate and ambiguous readings for those with darker pigmentation and skin tones. The product guidance for oximeters was found to use terms such as 'pale' and 'blotchy skin', or skin or lips 'going blue', to describe an indication that a patient's blood oxygen level was too low. Reliance on this guidance put Black and darker skinned patients at risk of delayed treatment, as typically, those physical symptoms would only be seen in Caucasians or patients with lighter skin. The decision to use such equipment was made without the protection of our members' lives in mind.

Risk assessments

38. Risk assessments designed to address risks for those working in high-risk settings were delayed and when they were conducted, failed to take account of ethnicity at a factor. This is despite the government being subject to the Public Sector Equality Duty ("PSED"), which obliges due regard to the need to eliminate unlawful discrimination and advance equality of opportunity between those who have a protected characteristic and those who do not, with the aim of removing or minimising disadvantages suffered by people due to their protected characteristic, and taking steps to meet the needs of people from protected groups if different from the needs of other groups.[25] One way in which the PSED can be discharged is through performing risk assessments in situations like this.

39. As I have mentioned in this statement, many of our members have frontline, patient facing roles with exposure to the wider public with increased risk of infection. Most of our members did not have any risk assessment caried out until later in the pandemic and were not assessed for risks arising from the known disparities in infection and mortality for minority ethnic HCWs. Outsourced or agency workers were often not given any risk assessments. A June 2020 study into risk assessments for minority ethnic HCWs found that 65% of doctors said they had not yet been given a risk assessment.[26] When risk assessments began to become more routine in or around June 2020, there was inconsistency between NHS Trusts as to whether ethnicity was included as a risk factor. There were rarely any positive decisions arising from risk assessment. No data was shared with our member organisations on how risk assessment was being carried out, how many people were found to be high risk, and what and how many resultant decisions

[25] Section 149, Equality Act 2010
[26] BBC News, 13 June 2020, Coronavirus: BAME doctors feel 'let down' over risk checks - https://www.bbc.co.uk/news/health-53021628

were made. Risk assessments were often made at peer level and not by managers who had the authority to make reasonable adjustments.

Guidance and communication

40. The communication coming out of Government during the pandemic, including the adequacy and availability of the various pieces of guidance, was generally poor and confusing for everybody but the impact of this on our members was disproportionately high. The ever-changing, unclear, confusing guidance given to HCWs and the public in already challenging circumstances caused stress and concern for our members and our communities.

41. Government guidance needed to be accessible and clear to everybody so that they could stay informed and keep safe. Sadly, the guidance was not culturally competent:[27] publication of translated guidance was slow and less accessible than English language versions; and there were few community-specific awareness raising campaigns or materials distributed by local or central government. Slogans often translated poorly across languages. Our communities were referred to in both policy and the press as "hard to reach", in an apparent attempt to rationalise the fact our communities were less responsive to Government messaging, while removing accountability for the laziness and ineffectiveness of the message.

42. Our members report that there was very little guidance on the needs of COVID-19 patients from minority ethnic backgrounds, which together with poor communication with our communities, made for confusion, reduced understanding, stigmatisation and thus higher risk of infection and death.

43. Some of our member organisations – along with community organisations and faith groups – stepped in to fill the gaps left by government in order to try and mitigate the impact of the poor communication. The British Islamic Medical Association ("BIMA") produced several statements and pieces of guidance aimed at the Muslim community, including "myth busters" around the virus and vaccine, advocated for the suspension of Muslim congregational activity well before the first lockdown by writing to community leaders. Our members delivered talks on COVID-19 to community and faith groups, issued their own guidance, raised money to bereaved families,

[27] For example, in PHE Report: Beyond the data: Understanding the impact of COVID-19 on BAME groups – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

produced risk assessment tools, and provided counselling. Our members provided leadership where government decision making failed to take account of our communities' needs, and they did this on top of high workloads and with little to no systemic support.

One of our members, a prominent practising GP, says: "There has still not been any effort to reach out to communities to say we know your communities have been disproportionately affected, what can we do to change that?"

Summary points

44. Minority ethnic HCWs, but also minority ethnic communities generally, were inadequately supported owing to the failure to adopt and implement strategies that accounted for wider determinants of health. The report commissioned by the Chief Medical Officer of June 2020 highlighted how the disproportionate impact of COVID-19 on those of minority ethnic backgrounds was due to an interplay of structural inequalities[28], however, the failure to address this at a governmental level through the promotion of recovery strategies that promote long-term sustainable change is further evidence for the inadequate support of this group.

45. The pandemic exposed the systemic problem that senior leaders within central government and public health policy circles didn't understand the workforce they controlled. Consultation with our communities on their needs would have been critical for this understanding. Targeted policies and guidelines could then have been developed and decisions made by government to address the vulnerabilities within our communities.

III. SUMMARY OF FEMHO'S REPRESENTATIONS TO DECISION MAKERS

46. Members of FEMHO made numerous attempts to raise concerns about the level of consideration given to the amount of support and protection for ethnic minority health workers. Concerns were largely made through the form of petitions, campaigns and correspondence to decision makers in the NHS and in central Government, including the Chief Medical Officer, Chief Executives of NHS Trusts and General Medical Council, Medical Directors at NHS England, the Chief Executive Officer for the UK Health Security Agency, the then Health Secretary and various

[28] PHE Report: Beyond the data: Understanding the impact of COVID-19 on BAME groups – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

MPs. One result of these efforts was that an early day motion was tabled in Parliament[29] and a cross-party letter coordinated and signed by 39 MPs was sent in support of our aims calling on Government to provide for thorough investigation of the disproportionate impacts of the pandemic on minoritised communities and HCWs.

47. Whilst the opportunity to have direct meetings with decision makers would have been thoroughly welcomed, the lack of such is consistent with our stance that inadequate representation of ethnic minority leaders at a senior level resulted in minimal emphasis being placed on this issue.

48. Our representations to Government are numerous, and I do not seek to rehearse each instance of the same, however, the following examples provide a summary of some relevant examples.

British Association of Physicians of Indian Origin ("BAPIO")

49. On 7 April 2020 one of our member organisations, BAPIO, raised "serious concerns" to NHS England and Public Health England about mortality rates in minority ethnic HCWs which continued to rise at the time. 24 healthcare workers were at the time reported to have died, most of whom were from minority ethnic backgrounds. Also highlighted was the stark disproportionality shown in the latest data on intensive care admissions: 33% were from minority ethnic backgrounds, against 14% of the whole population being of minority ethnic background. It is said: *"A matter of concern to our members and our wider communities is whether race and ethnicity are linked directly or indirectly to the disproportionate morbidity and mortality."* BAPIO pressed for a comprehensive risk assessment be performed for HCWs so that those on the frontline are not put in harm's way, and emphasised the importance of detailed statistical analyses to understand disproportionate death rates in minority ethnic HCWs.[30]

50. On 30 April 2020, BAPIO wrote to Caroline Nokes MP in her role on the Women and Equalities Committee. It stated the impact on minority ethnic communities was disproportionate, and expressed concern about confidential reports from its members and their colleague regarding the lack of PPE, the inability to maintain social distancing, inability to comply with self-isolation rules, and on the reports of rising levels of anxiety and stress among its members relating to the

[29] Early Day Motions: Covid-19 and Black, Asian and minority ethnic communities deaths, 11 February 2021 [EDM 1500] – https://edm.parliament.uk/early-day-motion/58113/covid19-and-black-asian-and-minority-ethnic-communities-deaths
[30] [INQ000148476]

risk of harm to themselves and their families. It is said: *"We are of the view that no HCW should die from contracting COVID whilst treating and caring for their patients, and we would like to see this as being the underlying principle that defines the aims and objectives of your inquiry."* Recommendations are given to the effect that no deaths of HCWs from COVID-19 should occur; research in ethnic disparities is pursued; the rollout of an appropriate risk stratification tool incorporating ethnicity; and oversight panels within organisations improve their diversity.[31]

51. On 22 April 2020, BAPIO wrote to the Chief Executives of NHS Trusts in England, of Health and Social Care Trusts in Northern Ireland, of the Health Boards in Scotland, and to the Chairs of the Clinical Commissioning Boards in England to express concern for the disproportionate mortality rates suffered by minority ethnic HCWs in the United Kingdom. It is said: *"There is palpable worry, upset and at time anger amongst* [minority ethnic NHS staff and doctors] *that the matter is not being addressed with sufficient urgency."* Adjustments to policy are recommended to mitigate the impact while the review is underway:

    a. Employers must observe their legal duty to provide a safe working environment for their employees and to perform comprehensive risk assessment, given the health risks of COVID-19. On the basis of existing data, ethnicity is identified as a major determinant of mortality from COVID-19.
    b. Employers must carry out urgent stratified risk assessments on HCWs, and highlights the moral imperative to do so.
    c. If HCWs are found to be at heightened risk of COVID-19, they are redeployed in non-COVID areas.
    d. Appropriate PPE must be given to all frontline staff, and specifies what appropriate PPE should be.[32]

52. On 27 March 2020, BAPIO writes to the then Health Secretary, Matt Hancock MP, to express its grave concerns about the disbursement of PPE and the lack of testing for frontline workers in many NHS Trusts. A number of serious anecdotal reports are advanced to Mr Hancock such as Trusts refusing to provide PPE at all on the basis of guidance from Public Health England that PPE should only be given to staff treating COVID-19 positive patients, despite evidence already having emerged by this point that many patients present asymptomatic. It is urged that

[31] [INQ000120828]
[32] [INQ000120826]

the Health Secretary sends instruction to NHS Trusts that PPE should be made available to all staff treating any patient in a hospital and HCWs deemed at high risk be tested.[33]

53. In July 2020, BAPIO devised its own risk assessment model in lieu of Government intervention. This was met with some success and was rolled out in Wales as well as some parts of England.[34]

British Islamic Medical Association ("BIMA")

54. On 20 May 2020, another of our member organisations, BIMA, wrote to Professor Kevin Fenton at Public Health England to express its alarm at the disproportionate mortality rate of minority ethnic HCWs during the pandemic and noted a significant proportion of the deaths come from the Muslim faith. It is said: *"… we must focus on structural issues […] and remain cautious of giving credibility to narratives that seek to 'otherise' minority communities."* In performing its review of the disproportionate impact on minority ethnic communities (mentioned previously in this statement), Public Health England is urged to consider the perspectives of cultural, religious and professional sources in order to maintain the trust of minority ethnic communities. It is also urged to acknowledge the *"considerable intersection of faith, race and even gender inequalities [that] are being played out every day in the NHS, affecting both patients and staff."* Attention is drawn to how minority ethnic individuals are unrepresented in leadership roles, failures in the public communications from government, and the initial exclusion of ethnicity from data around COVID-19 deaths, and the overlooking of minority ethnic communities in clinical research and policy consideration.

Consortium

55. On 31 January 2021, BIMA, BAPIO and a number of other organisations now a part of FEMHO, at the time united as a *consortium of UK based ethnic minority healthcare organisations,* wrote to the then Health Secretary Matt Hancock MP, and the Minister for Covid Vaccine Deployment, Nadhim Zahawi MP, to express its concern that minority ethnic communities (including minority ethnic HCWs who felt vulnerable and exposed) were not being prioritised in the vaccine rollout by the Joint Committee on Vaccines and Immunisation.

[33] [INQ000148474]
[34] BAPIO, BAPIO Releases an Interactive COVID-19 Risk Assessment Web App, July 2020 – https://www.bapio.co.uk/bapio-releases-an-interactive-covid-19-risk-assessment-web-app/

a. It was said that this is unjustified given the sufficient evidence showing minority ethnic people have a higher risk of infection and death from COVID-19. This is placed in the context of the United Kingdom having one of the highest HCW death rates in the world, with minority ethnic people being overrepresented. A recommendation is made that minority ethnic people are prioritised.
b. BIMA asks for community and faith groups to be given funding to carry out information dissemination work on the vaccine rollout: it was mentioned earlier in this statement that the Government's messaging had failed to effectively translate to many minority ethnic communities. Community and faith groups were, at this stage, being asked to do this work on a voluntary basis.
c. It is made clear that media narratives are perpetuating mistrust and stigmatising minority ethnic communities. A recommendation is made for better standards and regulation of the media is instilled.
d. It is asked that data is collected and published weekly on vaccine uptake by disaggregated ethnic groups and faith groups to monitor inequalities and evaluate interventions.
e. The lack of inclusion of community leaders in the decision-making process relating to vaccine rollout is criticised, and improved inclusion is recommended.
f. The Government is asked to engage in constructive dialogue with HCWs to understand their concerns with Government policy, and not to maintain a culture of censorship, which had been seen up to this point.[35]

56. Our concerns did not seem to be recognised and were not addressed.

IV. FINAL THOUGHTS

57. One of our members said the following about the Government's response to this pandemic: *"People were used. Nobody cared whether they lived or died."* I am moved to agree with her and couldn't have put it better myself.

58. Throughout the course of this pandemic, the disheartening experiences of minority ethnic HCWs have underscored systemic oversights and lapses in our health and governance systems. The

[35] Letter from "Consortium of UK-based ethnic minority healthcare organisations", accessed through BIMA website – https://britishima.org/wp-content/uploads/2021/12/Combined-group-letter_vaccination-Jan-2021.pdf

poignant accounts of our members, and the stark data supporting them, reflect not just individual tragedies, but an overarching narrative of neglect.

59. As this Inquiry progresses, it is my fervent hope and that of FEMHO that our testimonies ignite a deeper understanding and tangible action. We seek a formal acknowledgment of these disparities, targeted and funded strategies to address the root causes, and a commitment woven into the culture of the NHS ensuring that such oversights never re-occur. As we navigate forward, our collective aim should be an inclusive, compassionate, and responsive system where no community ever feels as forsaken as ours did during these trying times.

60. We know that British institutions have mobilised to respond to great and tragic events in the past. The NHS proposing Martha's Rule, the introduction of Harpers Law and the recent launch of an inquiry on a statutory footing into the circumstances around Lucy Letby's crimes to name but a few. FEMHO hopes that the issues and costs ethnic minority staff across health and social care settings in the UK have faced during the pandemic will be treated with equally dynamic and meaningful responsive action.

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.

Signed: Personal Data

Dated: 22/09/2023

ANNEX 1

List of FEMHO member organisations

1. African Caribbean Medical Mentors (ACMM)
2. Asian Professionals National Alliance NHS (APNA NHS)
3. AskDoc
4. Association of Afghan Healthcare Professionals-UK (AAHPUK)
5. Association of Pakistani Physicians and Surgeons UK (APPS UK)
6. Association of Pakistani Physicians of Northern Europe (APPNE)
7. Bangladesh Medical Association UK (BMAUK)
8. Bangladeshi Doctors in the UK (BD Doc UK)
9. Better Health 4 Africa (BH4A)
10. Black Women in Health (BWIH)
11. British Association for Physicians of Indian Origin (BAPIO)
12. British Caribbean Doctors and Dentists (BCDD)
13. British Egyptian Medical Association (BEMA)
14. British Indian Nursing Association (BINA)
15. British Indian Psychiatrists Association (BIPA)
16. British International Doctors Association (BIDA)
17. British Islamic Medical Association (BIMA)
18. British Pakistani Psychiatrists Association (BPPA)
19. British Sikh Doctors Organisation (BSDO)
20. British Sikh Nurses (BSN)

21. British Somali Medical Association (BSMA)
22. Cameroon Doctors UK (CamDocUK)
23. Filipino Nurses Association UK (FNA UK)
24. Ghanian Doctors and Dentists Association UK (GDDA-UK)
25. Medical Association of Nigerians Across Great Britain (MANSAG)
26. Melanin Medics
27. Midlands Egyptian Society (MES (Medical))
28. Muslim Doctors Association (MDA)
29. Nepalese Doctors Association (NDA UK)
30. Nigerian Nurses Charity Association UK (NNCAUK)
31. PalMed UK
32. Seacole Group
33. Sikh Doctors and Dentists Association UK (SDDA(UK))
34. Sri Lankan Psychiatrists Association UK (SLPA(UK))
35. Sudan Doctors Union UK (SDU-UK)
36. Syrian British Medical Society (SBMS)
37. Uganda Nurses and Midwives Association UK (UNMA-UK)
38. UK Black Pharmacists Association (UKBPA)
39. UK Ugandan Medical Doctors Association (UK UMDA)
40. United Iraqi Medical Association (UIMA)
41. Zimbabwe Doctors Association UK (ZDA-UK)
42. Zimbabwean Allied Medical Professional Association (ZAMPA UK)
43. Society of African Caribbean midwives UK (SoAC)