Witness Name: M3/W3
Statement No.: 1
Exhibits: 0
Dated: 17 July 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF M3/W3 ON BEHALF OF THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS (FEMHO)

I, M3/W3 will say as follows: -

1. I am I&S

   I&S

   I & S which is a FEMHO member organisation. I make this statement in my personal capacity as a representative member of FEMHO to provide evidence to the Inquiry on the impact of the pandemic on me as an ethnic minority nurse.

2. In this statement I will set out a summary of my experiences as an ethnic minority healthcare worker during the pandemic in relation to: (1) my role and responsibilities; (2) infection prevention and control ("IPC") measures and guidance; (3) PPE; (4) risk assessment; (5) test, trace and isolate; (6) vaccination as a proposed condition of deployment ("VCOD"); and (7) mental health and wellbeing.

3. The information contained in this witness statement is based on my own knowledge and experiences save for where I have expressly stated otherwise, for example where I have referred to experiences of my colleagues. I would be happy to clarify or amplify the points addressed in this statement should that be of assistance to the inquiry.

Background

4. After I qualified, I worked initially on a medium secure unit for around 10 years before moving more into the community and into A&E hospital settings. I rose through the ranks and over the years have held a number of roles and titles including team leader, out of

hours site manager, duty shift coordinator and deputy ward manager. I moved for a while into the community to be a crisis coordinator, which involved both seeing patients in A&E and also supporting individuals with mental health issues in the community.

5. In my current role as I&S I work in a hospital setting. I see the patients who come into A&E. The team I work in is sub-divided in two parts, with one sub-team like me working with patients coming into A&E and the other working with inpatients. Mine is a largely autonomous role for which day-to-day there is very minimal supervision. My main responsibilities are to assess incoming patients where mental health issues are suspected or known to be present and to manage their risk, making sure there is a robust care plan in place, arranging referrals where necessary and ensuring that those who are not safe to be discharged are admitted safely and get the care they need. Sometimes I need to liaise with community teams regarding patient care and information sharing, and where patients are detained and brought in by the police I will also liaise with the approved mental health professional ("AMHP") service as appropriate regarding my assessment of the patient. It is a busy role and I operate an open-door policy so very often Doctors, Nurses and other healthcare staff come in and ask my advice on mental health issues affecting their patients. I also conduct some teaching sessions and mentor student nurses.

I. IMPACT OF THE PANDEMIC ON MY ROLE AND RESPONSIBILITIES

6. The impact of the pandemic on ethnic minority people is an issue very close to my heart. We as ethnic minority healthcare workers ("HCWs") were more affected than others though it was a very difficult time for everyone in the health sector.

7. I started my current job in early I & S 2020, in the throes of the early pandemic when it was gaining force in the UK and at which point the disproportionate outcomes and impact on ethnic minorities was becoming scarily obvious. Prior to this I was working in a similar role I & S in a different hospital. I had started that job in I & S 2016. I wasn't working a lot between mid-I & S and early-I & S because I took some annual leave and then I was in hospital after I & S a health problem myself. Before I left my old role the pandemic hadn't really taken off and it wasn't really clear how much we were going to be affected. I didn't really see that much change because of the pandemic as a consequence; the real changes came when I started my new job.

8. Because of the pandemic I didn't have an induction like you normally would get. Usually you would meet the key senior staff, your team and wider department, and people would

talk you through how the team and the department work, how your role fits in, and what the job was going to look like etc. You would also normally be introduced around to everyone, receive some face-to-face training and be shown where everything is in the hospital as each one is different and has a different layout and set up.

9. I would normally have expected to spend time during my induction with the different teams and on the wards getting to know how the teams operated and worked together. Because of the pandemic I was told the teams were not mixing and this couldn't happen so I was just verbally given a short introduction. At the time this was quite confusing and overwhelming, particularly as this was also a step up to my first **I & S** role, and I do remember that I was really scared that I wouldn't know who or where to go to if I needed things etc. I didn't have the normal training, I just had an e-learning course which wasn't the same as face-to-face. It was really challenging and meant that it took much longer for me to settle in.

10. My line of work is mostly verbal; I talk to patients to assess them and then triage with other services where needed to ensure they get the help they need. I don't carry out any physical examinations or procedures. As far as I see it, all this could have been done over the phone or a video-call, and I could have worked from home, but we were not allowed to do it that way. Instead, we had to keep coming in and seeing patients face-to-face no matter how bad things got.

11. I remember asking some of my colleagues when I joined the team about this and they said they had raised it and discussed, for example, using tablets to speak with, see and assess patients remotely but it was rejected due to initially not being aware of the extent of the risks of the pandemic. Strictly speaking for most people (unless they didn't have access to a phone or the technology needed), I think that it would have been better for everyone if we had seen patients remotely; it definitely would have been safer. I didn't really feel able to say anything though because I was told it had been raised and rejected before my time and, being new to the team and the job and trying to build relationships, I didn't feel I could come in and demand that they do things differently. Ultimately though, whether there was a risk of Covid or not we were told we had to keep seeing the patients face-to-face.

12. Our team is split into two sub-teams with some working with inpatients and others with patients coming into A&E. My team is small in number; usually there are two of us in my sub-team on shift at a time. This means that when I or colleagues are sick sometimes you are left alone as the only person from the team available for the whole of A&E. In my previous role, which was very similar in nature just at a different hospital, there were more

of us – usually at least four assessors on shift at a time with three consultants on hand and a manager. We can never predict what patients might come in from one day to the next but it is generally a very demanding role with long shifts and a lot to manage. Our manager may or may not be around day to day. I should explain that the inpatient team at my hospital works slightly differently and more traditionally. There, they mostly have standard day shift pattern where there will be four or five nurses working together with the consultants. There are no night shifts in the inpatient team and we cover them out-of-hours.

13. We did become very short staffed at times during the pandemic where I worked, and there were some delays to patient treatment due to staff absences and redeployment. Luckily there weren't as many patients coming in because of the lockdown and not as many were being referred to A&E for mental health at the time. This was in some ways just as well because we could only see 1 patient at a time so with the usual flows of patients we would not have been able to cope. The longer-term impacts I think will be less good given the delay on patients' onward care which they needed; the patients won't have disappeared during the pandemic and they will probably still need our help. Some will probably have gotten worse because they haven't been supported. It is hard for me to gauge the full impact or emerging signs of this in my role as my interaction with patients is temporary in nature assessing them when they present at A&E; I do not have any ongoing interaction with them.

14. I myself, as far as I know, was never at risk of being redeployed. This is partially because there are so few of us in the role that I do but also because we were essentially external workers commissioned by the mental health trust to work at the hospital. I did hear about other people being redeployed and that Black people were always the ones being chosen to be moved but it didn't happen to me personally. I have also become aware since then that many people felt they were not being treated in the same way because of their race or colour. For example, some told stories about things like shifts and overtime not being distributed fairly. There was then a bit of a backlash from our White counterparts who I understand said they felt discriminated against too, though I don't know the specifics of why. It was all very difficult. More has come out since the pandemic about these sorts of issues; in the early stages it wasn't very well known and I don't think people were really speaking out as much.

II. INFECTION PREVENTION & CONTROL MEASURES AND GUIDANCE

15. I feel like infection risks weren't really catered for, particularly in regard to PPE which I will come on to discuss. From the beginning of the pandemic, as soon as I got into the office I would open the windows; I wasn't told to do this but it was almost an instinct. It was common sense; I knew that if I let fresh air in, it would also get rid of whatever else was there in the air. Other people at this time though were still questioning the danger of Covid and were unclear on infection prevention. On one occasion that I recall, my manager said sarcastically to me when I was opening the window: "*Do you think if you open the window Covid will go away?*". I think it later became a recommendation to let air in as much as you can. At the time it felt like it was better than nothing and I had to try and do everything I could to protect myself.

16. Thinking back to our working conditions; our office itself was a tiny little thing that used to be a cupboard. I have never seen anything like it. It was incredibly narrow and you could just fit the workstations, which are fixed against the wall on both sides back to back, plus a board with the patient information on it and even then it was really tight. There was no major space, there are two computers on one side and another on the other side so our chairs had to be next to each other or back-to-back. It was impossible to socially distance or keep more than 2m away from colleagues especially as others would often come in and use our office too; it was not fit for the pandemic. Though the office upstairs for the other sub-team was much larger the manager for that team refused to let me work there.

17. In the room where we saw patients there was no window. Considering we had no option but to see patients face-to-face this really was something else and far from ideal. During handover meetings our sub-teams would meet up. The managers were keen for this to be face-to-face but it was confusing with the every changing Covid guidelines on when it was safe to be in one room together. There was also no division of areas in the A&E department or "safe passages" put in place. Even though I was only seeing mental health patients and had a separate assessment room I was constantly having to walk through the main areas. I knew there were Covid patients around, and my patients also could have been carrying Covid, but there was no procedure in place that seemed to keep suspected positive cases separated.

18. There is only one **gendered** **I & S** staff toilet for the whole of A&E where I work despite a lot of **gender** working in the department. As a result there is usually a queue to use it. It is also often blocked and **Irrelevant & Sensitive** You can just imagine the infection control concerns.

19. Considering that the information and guidance coming from the higher powers in government were neither here nor there it was not easy to get clarity from our managers. They could only guide as much as they could I guess; it wasn't the easiest thing. I mostly had to rely on what I heard and saw on social media and occasionally I would check that with what the guidelines were saying in our Trust. I didn't want to do anything I wasn't comfortable doing and I was worried more things were going to come where I would be asked to do things that put me at risk. I don't know if I would have felt comfortable in raising concerns or trying to push back if that had happened. It was another constant worry given what I was hearing about things around the hospital and through colleagues in the I&S

20. I have noticed that as we have returned to more "normal" times the hospital has really filled up. We seem to have had lots of corridor care and patients who are left in narrow corridors unprotected, coughing everywhere etc. You can't blame the patients as it isn't their fault they are unwell but there doesn't seem to be anything being done about infection risk or hygiene, let alone the volume of patients and wait times to be assessed. It isn't good for the patients and is unpleasant, and potentially dangerous if they are infectious, for us staff to have to walk through and around them in the corridors to get to where we need to go. Infection prevention and control hasn't been resolved it all just seems to be getting worse if anything.

21. One final thing I would say is I didn't understand why we kept having face-to-face staff meetings. Management said they thought they were more effective but in terms of the risk I would have preferred to have online meetings and not to have to face being exposed with lots of staff gathered together in close proximity when it could have easily been avoided.

III. PPE

22. During the pandemic we were told to wear scrubs and to wear masks when seeing patients. For the most part, and particularly through the early stages of the pandemic, we were only provided with the blue surgical masks though, not more protective ones like FFP2 or FFP3 masks, despite working in the A&E department. There did come a time much later on in the pandemic where I heard that FFP masks were being offered to staff if you got a fit test done. By the time it became available I didn't think it was so necessary for me because testing was more widely available, and I was taking my own precautions very seriously.

23. I always had access to a surgical mask when seeing patients but unless you were on a ward there wasn't access to aprons and gloves. Masks also made my role really difficult as it made it really hard to communicate with patients which is essential when working in

mental health. Sometimes, depending on the patient's condition, the masks exacerbated things and made them more distressed. It was really hard to build a rapport and communicate effectively when half your face is blocked from view and I found this really frustrating and conflicting as I needed the mask to try and keep myself safe but also I wanted to do the best I could to care for my patients. I have since heard of clear masks being used in some mental health settings but I don't remember there ever being an option to have that where I was working; there was no alternative and no workaround.

24. Some mental health patients would say they were exempt from wearing a mask but I wasn't sure if that was true or not. I would try and encourage them and/or say sorry but please put a mask on when I had to be face-to-face with them but some did not and refused and I found this really difficult. We weren't really told how to handle this and there was no one else to say to them that they had to put it on. It was really anxiety provoking because we still needed to treat people but at the same time people were dying around us and it seemed to be killing black people more than anything so I wanted as much protection as possible. Nobody ever had a panic attack after putting one on even if they had said they couldn't wear one because of anxieties. It is my job to make patients with anxiety feel that they are in a safe environment and this was a matter of life and death as far as I was concerned. As we say in healthcare, we prioritise life and safety; safety is paramount about everything else.

25. Even now, though most people are acting like the pandemic is over, Covid is still here and people are still dying. Not that long ago I found out that there was a Covid positive patient in A&E and they were allowed to just be walking around like there was no problem. Some of us still use masks, and I notice this is particularly people of colour. I think it is a noble thing to do but some people make fun of us and try to make us feel bad; I shouldn't have to justify protecting myself to anyone.

26. Aside from wearing masks, we were also supposed to wipe down our workstations and clean everything ourselves to make sure it was sanitised regularly. We used workstations and you really should wipe them down every time somebody changes seat or finishes shift but this was not kept on top of at all. I personally would try and wipe everything – my seat, my computer, my keyboard – everything; but it was hard to do so properly. Even for wiping down desks and computers and the like that we shared with colleagues we just had ordinary wipes most of the time, not the proper antibacterial wipes, which weren't so effective.

27. As I didn't carry out physical examinations or procedures on patients I didn't get given any other PPE apart from the surgical mask. I am aware though that there were issues for others who needed things like aprons and gloves and that there were often shortages so people had to improvise or bring their own. I am also aware that lots of ethnic minority staff failed the fit tests for the more protective masks because they were designed on a White male face shape. Although it didn't affect me directly I was hearing about it through I&S and know the anxiety and distress this caused; it is yet another area where we have not been thought of and where we suffer and are worse off as a result.

IV. RISK ASSESSMENT

28. Risk assessments were not carried out immediately. I cannot remember exactly when I had mine but it was definitely after the time that people were talking a lot about ethnic minorities being affected more and many people had died. They seemed to be realising there was an issue and that I was at more risk myself so ethnicity was something that was, I think, supposed to be taken into consideration. Initially I thought it was a good thing; I thought "*at least they are doing something about it*"; it was something that I felt would reduce my anxiety.

29. The actual process however was not very good and I don't think it was working effectively. I had the assessment with one of my managers who followed a questionnaire asking me the questions and recording my answers. I remember they asked about underlying issues and as I understood it part of this was to work out who should be shielding or needed other measures. I remember discussing what might happen if I was asked to go into resus, for example, if a patient was seriously unwell. It was like a review of your health data but in my view it wasn't effective and I was not happy with the assessment I had.

30. Shortly before I started the job during the pandemic I had ended up in hospital myself due to a health condition I&S I&S The doctors never worked out what was causing this but given it was so recent, and the risks associated with Covid and (health condition) I&S I thought I would be better supported. I do not think it was considered to be a risk; certainly not one that was thought to require any adjustments or additional protection for me. This troubled me, and felt wrong, but I didn't feel like I could do anything about it.

31. I don't even think I was sent a final copy of the form after we had the meeting and there wasn't any outcome or recommendation or anything. There was no follow up; I have no idea if my assessment is still in place now or not but as far as I know it has not been reviewed.

V. TEST, TRACE & ISOLATE

32. When we were first given the test kits nobody explained how to use them or any detail about the process or how our samples and the results would be used; we were just issued them and expected to take them home and do them without question. My manager kept asking me whether I was going to test and I felt pressured to say yes even though I didn't really understand what I was committing to. There were so many rumours going around and it all seemed to happen very suddenly so I was feeling a bit sceptical about it, but I never outwardly said to my manager I wouldn't do it.

33. One day, my manager sent a message in our group chat telling me to give back my test kit. It felt like it was done in quite a hostile manner; I don't know why they felt the need to do it in the group chat rather than messaging me privately, and there was no reason explained as to why I had to bring it back nor did they try and talk to me about it. I was shocked and felt ambushed – where was the respect and dignity I asked myself? By this time I was scared that I was becoming a target and was being seen as troublesome so I didn't want to make a fuss about it and decided I would just have to do what they had asked me to do so I took it back.

34. After this had happened my manager called me to a room for a surprise meeting with them and their manager. It immediately felt like a very serious meeting and I had no warning about it or time to prepare. They started to say I might have to be redeployed because I "*didn't want to have the test*". Some of what they were saying wasn't right so I corrected them and explained I was not refusing but was taking my time to do some research as I wanted to understand what they were asking of us and how it all worked as very little had been explained to us; it seemed from the conversation that my manager had told their superior that I had point blank refused to test myself which was just wrong.

35. Even after I corrected my manager they then continued to act quite passive-aggressively. Instead of talking to me after the meeting they just left a test kit on my desk with my name on it. As it turned out after someone else explained it all to me I felt okay about doing the test, but my manager's approach had been not to explain but just to chase whether or not we were doing it.

36. The TTI app came later and caused many issues. I remember getting loads of messages and notifications from it which was anxiety provoking. I'm not sure where the message originated from, I assume from management, but I remember there came a time when we were getting so many notifications that people at work started saying they'd been told to turn it off or to delete the app. Obviously working in a hospital the app would pick up lots

of exposure risks and it became a nightmare. I remember hearing about people who were in the middle of a shift and got an exposure notification and instructions to isolate. It was a nightmare for staffing. No one seemed to know what we were meant to do.

VI. VACCINATION AS A PROPOSED CONDITION OF DEPLOYMENT

37. The vaccine caused a lot of difficulty; lots of people were unhappy about how it was handled. I myself didn't want to get the vaccine. There were so many theories about it when it first came out and a lot of hesitation and speculation in the media. As mentioned before, it had not been long since I collapsed and ended up in hospital because I had large (health condition) I&S and nobody had been able to figure out why that had happened. There were rumours about people getting (health condition) I&S from the vaccine quite early on and then it became established it was true that this was happening to some people. Given that I was getting (health condition) I&S before Covid and no one knew why this really put me off and made me afraid to get the vaccine. It was one of the main reasons why I was cautious about everything I was doing and why I was hesitant to get a new vaccine that seemed to have risks of (health condition) I&S associated with it when I already seemed to be having issues with (health condition) I&S for whatever reason.

38. When people in my department started to talk about being told to get the jab I said I didn't want it. I hadn't caught Covid at that point even though people around me had been going down with it. Then came the announcement that it was going to become a requirement for healthcare workers as a condition of our deployment. The managers and senior people in the trust kept saying we needed to have it to protect the patients and I thought I didn't have a choice about it. I messaged my managers (who were aware from my risk assessment that I had had issues with I&S not long ago) asking whether I had to have it but nobody replied to me. This made me nervous as I thought maybe it was a set up. It was only after I had voiced my concerns about getting the vaccine that I was called into the meeting I mentioned above about potentially being redeployed. I felt like I was being targeted and started to think to myself "*oh god, what's going to happen if...*" I was torn between the risk of getting the vaccine and something going wrong, possibly getting (health condition) I&S again or worse, and the risk of losing my job and my ability to provide for me and my family as I am a solo parent and responsible breadwinner. The nature of my role and the way I was employed meant that I don't think there was anywhere I would have been redeployed to so I was worried I would simply lose my job one way or another. It was impossibly stressful.

39. As time went on and the deadline they had given staff to get vaccinated approached I started to get more and more worried that I was going to lose my job if I didn't get the

vaccine so I booked myself in and got the first vaccination and booster right at the tail end of the deadline even though I didn't want to. It was still unclear where I could be redeployed to without being vaccinated and VCOD seemed to be firmly going ahead at this point so I was anxious and scared about losing my job. It felt like I had no option but to get the vaccine, regardless of the risk. I felt pretty shortchanged to be honest when they announced very shortly after I had got the vaccine that we didn't have to have it after all. The U-turn on the decision came too late for me. This is still a bitter regret and something I feel very strongly about given my personal risks.

VII. IMPACT ON MENTAL HEALTH AND WELLBEING

40. The pandemic as a whole was a very anxiety provoking situation. Every day there were people I knew dying. It was so close to my heart because working in healthcare you're always just one step away from where Covid was. There were so many unknowns; it was like this huge fear that came upon me, but I still had to come in and be strong and that's what I did. At the same time I was trying to support my family as well. They were all having lots of anxieties about the pandemic and so every day I would speak with them and encourage them to talk things through as it was so important to ventilate and talk about what was happening and what we were experiencing. My siblings in particular were really affected and were struggling so I would call them to check in regularly.

41. There was no support really at work; I think some people were signposted to a wellbeing team but I didn't get the opportunity to access that support because of the way our system and team worked. Lots of things at work were increasing my anxieties during this time; as well as the risks and challenges brought by the pandemic there was also the fact that I was very new and hadn't had a normal induction to settle in. There were also the difficulties I was having with my manager who was very hostile to me, and in the office the atmosphere wasn't very good, and I had situations where I was being jeered at and made fun of for trying to take precautions against Covid. First impressions last and I felt like I had been brushed aside from the outset.

42. The only support I really got during this time was from I&S an ethnic minority network. It is hard looking back to remember when and how I first found out about the group but I think it was through a colleague in late 2020 or early 2021. I was hoping to find a group who I could identify with as I didn't know anyone at my hospital when I moved for the role and the role itself was quite isolated due to the pandemic so I wanted somewhere I could go to and get support without being judged; I joined immediately.

43. Within a short time after I got support for myself I also started to help others and became part of the leadership. We did a lot of work to support staff and organisations, including sharing information and coming together to discuss issues we were facing to do with things like risk assessment and vaccination. Social media was causing a lot of issues because people were sharing all sorts of things and nobody knew what was true and what wasn't. I remember we had to work together to try and help people know the truth and to provide advice and information. Many others, like me, were asking their managers questions but receiving no response so there was a gap that had to be filled. We had dedicated people who members could go to speak to about different issues. We also had some communication with senior personnel within the health service trying to get their support and help too.

44. It was hard at times to manage all this extra work, support my family, keep going at work and manage my own anxieties; it was a lot. I think something that made it harder as well was that my patients are, by the nature of my speciality, vulnerable individuals. I wanted to do the best I could to care for them but it felt like there was so much standing in the way of that. We all did our best, and put ourselves at risk to continue to work and care for people, but it has come at a high cost. It feels to me that lots of things could have been done differently and better; it didn't have to be as hard as it was.

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: ________________________________

M3/W3

Dated: 17 July 2024