IN THE MATTER OF THE UK COVID-19 PUBLIC INQUIRY

BEFORE BARONESS HALLETT

MODULE 7: WRITTEN CLOSING SUBMISSIONS FROM THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS (FEMHO)

Introduction

1. The evidence heard in this module has laid bare the deeply unequal experience of the Test, Trace, and Isolate (TTI) system as it operated during the Covid-19 pandemic. FEMHO appears in this Inquiry to speak on behalf of its members, Black, Asian and Minority Ethnic health and social care workers. FEMHO's concern has never been simply that the system was imperfect or made under pressure, but rather that it was shaped and deployed in ways that ignored, excluded, and in some cases actively disadvantaged those who were already structurally marginalised.

2. FEMHO's position is simple, but stark: the TTI system as it was conceived and implemented failed Black, Asian and Minority Ethnic communities. It failed to account for known pre-existing inequalities and the structural conditions in which these communities lived. Rather than acting as an instrument of public health, TTI became a mirror held up to entrenched inequality. It exposed the extent to which minority communities were treated not as partners in health protection, but as an afterthought in policymaking. As Ade Adeyemi, joint-secretary of FEMHO, put it: *"We felt at best overlooked, and at worst abandoned in the development and rollout of the TTI scheme, leading to a devastating loss of trust."*[1]

3. Those are not words spoken in hindsight from a position of comfort. They are the words of a healthcare worker who, along with countless others, bore the emotional and physical weight of a public health system that did not see or hear them. It is a statement of deep disillusionment from those who showed up to do their duty, but who were left without the protections, data, consultation or support needed to do that work safely or effectively.

[1] [INQ000587648_0023].

4. The TTI system did not arise in a vacuum. It was built within a society already marked by inequality. But what we have learned through this Inquiry is that key decision-makers failed to adequately consider that context when designing the TTI policies. The system was built around assumptions on access to space, digital connectivity, economic stability and trust in policing and government, which were not true for many minority communities.

5. FEMHO submits that what was needed was a system that recognised how health, housing, employment, and inequality are intertwined. That such a system was not even attempted reflects a broader institutional failure to take seriously the lives, voices, and needs of Black, Asian and Minority Ethnic people. That failure had consequences; it undermined public health and it caused real and enduring harm.

6. These final written submissions seek to highlight our interventions and learning throughout this module within the following categories: i) structural inequalities and foreseeability; ii) barriers to testing; iii) financial support for isolation: a key failure; iv) lack of data and its consequences; v) (dis)trust, cultural competency and messaging; vi) missed opportunity in community engagement; vii) disproportionate enforcement; viii) recommendations for future preparedness; and ix) conclusion.

7. FEMHO echoes and supports, but does not seek to rehearse, submissions made by the bereaved family groups and the Trades Union Congress (TUC) on wider TTI failings including the impact of the lack of planning and infrastructure for testing, consequent delays in the roll out of testing, the delayed recognition of asymptomatic transmission and the overall inadequacy of support for isolation.

Structural Inequalities and Foreseeability

8. At the heart of FEMHO's submissions is a proposition that should not be controversial: structural inequality and systemic racism were a known context before the pandemic began. These are longstanding, well-evidenced realities embedded in British health outcomes, housing, employment, and policing. The disproportionate impact of TTI on Black, Asian and Minority Ethnic communities was not just predictable, it was *predicted*, flagged repeatedly, and acknowledged at the highest levels of government. And yet, the Inquiry has heard compelling evidence that little to nothing was done to meaningfully accommodate or mitigate this reality in the design, delivery, or oversight of the TTI system.

9. When asked whether disaggregated data might have enabled a better pandemic response, Vaughan Gething, the former Welsh Minister for Health and Social Services,

replied: *"I'm not sure it would have made much difference, though, with respect. And that's because the inequalities that we talk about are not a secret. They're not unknown."*[2]

10. This was a frank admission that the government did not lack knowledge, it lacked will. As Dr Mian (the Senior Responsible Officer for Disproportionately Impacted Groups) put it, there was a lack of ambition to deal with the underlying issues which meant that proposals "*didn't really go anywhere*". He spoke of the ebb and flow of interest in addressing issues of inequality at government level, admitting that they did not get the right systematic attention throughout.[3]

11. The inequalities were known; the disproportionate risk to minority ethnic communities was evident. Yet the TTI system was conceived and executed as though these facts were peripheral. If better data would not have made a difference, it is because the decision-making framework itself was not designed to centre equality. Minister Gething's testimony is less an account of oversight than a confession of inertia.

12. Moreover, foreseeability was not just retrospective, it was *actively voiced* during the pandemic. The SPI-B subgroup of SAGE published numerous papers and advices, one of which was as early as July 2020, warning that TTI messaging was failing to reach minority ethnic communities and that existing disparities were at risk of being deepened.[4] Despite these attempts and those of others including FEMHO members, no coherent, nationally led response emerged. The system carried on as though universality was equality and centralisation was competence.

13. The failure to engage with cultural nuance, language needs, housing conditions, and employment precarity, factors disproportionately affecting minority ethnic communities, in spite of warnings and advice, was a structural blind spot; the product of governance that saw minority communities as statistical outliers rather than as integral participants in public health. Lord Bethell testified that the government's communications approach was *"targeted more at the Waitrose classes"* and acknowledged the failure to reach poorer and more diverse communities.[5] Baroness Harding lamented that the National Testing Programme had prioritised headline numbers over reaching the most vulnerable, despite data from the Joint Biosecurity Centre consistently showed higher infection rates among

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[2] [6/167/20 – 6/169/18].
[3] [3/181/8-3/183/25; 3/190/24-3/192/16].
[4] [INQ000311897]; [INQ000311892]; [INQ000061561].
[5] [8/158-159].

non-White groups and deprived areas.[6] The imbalance was evident. The tools existed. The need was urgent. Still, the structural inertia of the system prevailed.

14. The framework created by the Public Sector Equality Duty (PSED), as enshrined in the Equality Act 2010, provided government with the opportunity to act on the foreseeable risks posed by TTI to minority ethnic communities. Equality Impact Assessments (EIA's) carried out in relation to different aspects of TTI highlighted risks posed to minority ethnic communities by the different policies. Whilst these documents again highlight that these risks were foreseeable in real time, they also highlight the lack of action taken to mitigate these identified risks. If a given policy was to be implemented, despite known possible risks to minority ethnic communities, concrete action needed to be taken to mitigate the possible harms caused. So often it wasn't. The result is that the many of the EIA's completed during this period amounted to mere "tick box" exercises and did not discharge the governments' PSED duties.

15. The Inquiry must grapple with this uncomfortable but inescapable truth: the unequal impact of TTI was not an accident; it was the logical consequence of ignoring known risks. Foreseeability without mitigation is negligence in legal and policy terms. Foreseeability creates a duty to respond. That duty was not discharged. The TTI system, as built and enforced, compounded historic harms and inflicted new ones, harms that were visible, predictable, and preventable.

Impact of the national testing failures

16. The evidence heard in this module paints a stark picture: the testing infrastructure, in its early and most critical phases, failed generally. We heard extensive evidence about the delays in the roll-out of testing and the impact that these delays had. The impact of those failures was compounded by the structural inequality which was entrenched in the test prioritisation system itself. Professor Spector, for example, described how frontline healthcare workers, particularly those from ethnic minority backgrounds, were both more exposed and less likely to access timely testing. His early data showed UK healthcare workers had dramatically higher infection rates than those in the US, a disparity he traced to systemic failings in PPE and testing availability.[7] Former Health Secretary, Matt Hancock, confirmed that these workers, including cleaners, porters and domestic staff,

[6] [INQ000587322_0029, §5.33].
[7] [5/5/21–5/6/19].

were not prioritised in early eligibility criteria, despite their disproportionate vulnerability being later acknowledged.[8]

17. Baroness Harding accepted that had the national testing programme been started in January 2020, marginalised communities could have been better protected. She stated unequivocally that designing for the disadvantaged from the outset would have led to testing centres in the right places and services built for those most affected, not those most visible.[9] Yet this mindset shift did not occur. Instead, as her own correspondence reveals, concerns about low-paid and migrant workers' reluctance to test, due to fear of self-isolation, were known but not acted upon at scale. Despite recognising that isolation support was key, this insight was not translated into operational change.[10]

18. As Professor Buchan explained in his oral evidence, both financial and digital poverty posed serious obstacles to accessing community testing, while self-testing, the approach most suited to disadvantaged communities, was not prioritised early enough.[11] At this point in the pandemic, the issue was not simply one of availability, but of accessibility and equity.

Financial Support for Isolation: A Key Failure

19. A critical failure of the TTI system was that it placed the burden of compliance on individuals without putting in place the financial support necessary to make compliance feasible for many. The evidence before the Inquiry confirms that without adequate and accessible financial support, self-isolation was often unattainable for large sections of the population, particularly those in precarious employment, low-income occupations, or insecure housing, where Black, Asian and minority ethnic communities are overrepresented.[12] For many in precarious employment or overcrowded housing, testing was not simply a health act but a financial gamble.

20. A consistent theme in the evidence is the recognition that financial constraints directly undermined adherence to isolation requirements. As Professor Arden explained, the feasibility of self-isolation is highly stratified across the socioeconomic spectrum: "*For some people, self-isolating may simply mean working from home, possibly in a comfortable house with access to a garden… However, for others, especially those in*

[8] [8/79/11–8/80/12].
[9] [10/77/24–10/80/17].
[10] [10/77/24–10/80/17].
[11] [3/7/10–16].
[12] See, for example, [INQ000575999]; [INQ000287604_0050-51]; [INQ000587569_0015]; [INQ000215036_0089].

precarious employment, overcrowded housing… self-isolation is incredibly challenging… they may understandably avoid testing altogether."[13]

21. Professor McKee was one of several witnesses who identified the inadequacy of the £500 self-isolation payment in England, as well as issues with the system's accessibility.[14] He argued that the UK was "*miserly*" in its approach to financial support for isolation.[15] The inadequacy of the financial support was compounded by the fact that those from minority ethnic communities disproportionately worked in insecure jobs (with zero-hour contracts) and so were more likely to receive no Statutory Sick Pay (SSP). Professor Machin noted that 2 million of the UK's lowest-paid workers were ineligible for SSP, a group disproportionately composed of ethnic minority individuals.[16] Meanwhile, as Professor McKee identified, the level of SSP in the UK is "*right at the bottom in Europe*".[17]

22. Studies have since confirmed that the policy of isolation was both disproportionately difficult for those from minority ethnic communities to practically comply with and, when they were able to comply, also had a disproportionate financial impact on those communities.[18] In her oral evidence, Professor Arden explained that it was those from disadvantaged communities that that were disproportionately required to isolate. She said:

"Disadvantaged groups, especially those in key worker roles, were often more exposed to infection simply by the nature of their jobs — they couldn't work from home and were interacting with others daily. As a result, they were also asked to self-isolate more frequently, and I don't think that's been adequately acknowledged. This wasn't just a one-time request — for many, it was a repeated expectation throughout the pandemic. Maintaining adherence to self-isolation over time — often without sufficient financial or practical support — became increasingly difficult. This recurring burden disproportionately affected those already facing hardship, and I think we need to recognise that expecting sustained compliance without addressing the underlying inequalities was a major limitation in the public health response."[19]

23. This systemic parsimony was not only inequitable, it was counterproductive. Lord Bethell unequivocally said: "*There's pretty much no point in doing testing, tracing and isolating if*

[13] [11/152/10-11/153/5].
[14] [2/70/2–17].
[15] [2/70/2-17].
[16] [12/28/1-12/29/19].
[17] [2/70/2-17].
[18] [INQ000287604_0050-51].
[19] [11/156/9-11/157/1].

you don't create the circumstances where people can actually isolate."[20] Communities were not unwilling to test, they were unable to test safely, securely and without disproportionate risk to their livelihood.

Government Knew the Risks and Chose Not to Act

24. The disproportionate impact of the inadequate financial support was foreseen. SAGE consistently raised the importance of adequate financial support from the start of the pandemic.[21] In a paper dated 16/09/2020, the SPI-B noted with that financial support for isolation needed to be "*developed in partnership with the target population, including local community leaders and the BAME community"* and *"consider separately the needs of different groups within the population including the BAME community, rather than assume a 'one size fits all' approach to support"*[22]. SAGE was explicit in October 2020 that: "*Isolation will not work unless people are supported to enable them to isolate. Self-isolation should be replaced by 'supported isolation' with assistance, if needed, with accommodation, domestic assistance and financial support up to £800…Government should make isolation financially feasible for all cases and contacts. This was not provided until September 28, since when £500 has been provided to properly isolate for 14 days, or £7.14 per hour, substantially below minimum wage and hard to access (and many remain ineligible). For five million workers in the gig economy, this provides little incentive. We recommend £800 as a minimum."*[23]

25. Nearly six months later, in March 2021, a SAGE paper stated: "*Punitive fines and police surveillance are the wrong tactics…The current £500 sum, for which most people have their application rejected, is wholly inadequate and a disincentive to isolate. A minimum sum should be 14 days x £70 or £980*".[24]

26. As early as May and June 2020, senior officials in the Department of Health and Social Care were raising alarm. Ben Dyson gave evidence of repeated efforts by DHSC to persuade HM Treasury that additional financial support for isolation was necessary, particularly for low-income and ethnic minority workers. These representations were repeatedly rejected. As Mr Dyson put it: *"We did try really hard to persuade ministers that this would be a good thing, not just for the individual wellbeing of those disadvantaged*

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[20] [8/98/18–8/99/1].
[21] See, for example, [INQ000475175_0002, §22]; [INQ000249693_0018]; [INQ000553580_0007; 11-12]; [INQ000350433_0005; 19-20]; [INQ000474943]; [INQ000145926]; [INQ000061522]; & [INQ000061560].
[22] [INQ000188943]
[23] [INQ000145926_0001 & 7, §31].
[24] [INQ000535912_0005-6].

people but also economically."[25] Baroness Harding echoed this, stating that she had the budget available to improve self-isolation support, but her proposals were blocked at ministerial level. She described the experience as "*banging your head against a brick wall*".[26]

27. Dan York Smith, giving evidence for HM Treasury, confirmed that financial support for isolation was not prioritised, and the Treasury was more focused on the risk of fraud or "*perverse incentives*" than on ensuring the scheme reached those most in need.[27] Matt Hancock acknowledged that the Treasury's fiscal caution outweighed the clear public health rationale for more generous support.[28] Overall, as Lord Vallance's contemporaneous note of a Prime Ministerial meeting made clear, ministers prioritised "enforcement" over "incentives", and "punishment" over "help".[29]

28. Even when presented with clear evidence that the scheme was not working, no remedial steps were taken to widen eligibility, simplify access, or increase the payment. Indeed, Professor Machin could not find any evidence of how the level of support in the financial support scheme was calculated or if this was ever reviewed after its introduction.[30]

The Result: A System That Disproportionately Penalised Ethnic Minority Workers and simultaneously undermined the public health response

29. The impact of these omissions was disproportionately felt by Black, Asian and other racialised minority groups.

30. The structural flaw in the English system was not only that it failed to provide sufficient support, but that it provided support so poorly targeted, poorly publicised, and poorly designed that it actively discouraged engagement with the TTI regime. As Professor Arden warned: *"If you perceive that you may not have access to that money, then… you're going to be less motivated to [isolate]… even if you qualify."*[31]

31. This failure cannot be characterised as an unfortunate oversight. It was the predictable result of a failure to embed equality duties and behavioural science into financial policy decisions. Professor Machin concludes in his expert report that the: "*Equality Impact*

[25] [10/70/13–10/72/10].
[26] [10/70/13-10/72/10].
[27] [6/47/19–6/49/3].
[28] [8/74/20–8/76/2].
[29] [8/209–210].
[30] [12/48/2-10].
[31] [11/171/1–11/172/3].

Assessment completed in England was inadequate and the evidence it presents is inconsistent with established knowledge on the disproportionate impact of self-isolation on certain groups in society. A clear rationale has not been provided for why there is 'no specific impact' on any group in society. This is not consistent with the research…which outlines the disproportionate impact of the pandemic on, for example, women, minority ethnic groups, and younger people."[32] When asked about this in oral evidence Professor Machin asserted: "*I believe that the evidence shows, particularly in England, there was a lack of consideration of equalities issues, and this, then, feeds into communication plans."*[33]

32. FEMHO's position is clear: the failure to ensure robust, equitable and accessible financial support for isolation fatally undermined the system's effectiveness. As predicated by SAGE and many others, the failure to introduce adequate financial support weakened the TTI system as a whole: people were reluctant to test, reluctant to report contacts, and unable to isolate. The ideological opposition to greater financial support was short-sighted and undermined the government's attempt to stop the spread of the virus. It also constituted a willing abandonment of those most in need.

Lack of Data and its Consequences

33. FEMHO submits that another of the most profound operational failures of the TTI system lay in its failure to collect and apply disaggregated data (including ethnicity) in real time. This was not merely a technical omission, but a policy failure that significantly undermined the system's fairness, responsiveness, and ultimately its effectiveness.

34. Over the course of these hearings, witness after witness has acknowledged that the absence of granular data obstructed targeted intervention and contributed to the disproportionate harm suffered by Black, Asian and Minority Ethnic communities.[34] The implications of this omission are wide-ranging. Without disaggregated data, it was said to be impossible to evidence uptake gaps in real time, to track infection rates in specific communities, or to effectively deploy culturally competent interventions where they were most needed.

35. Throughout each module of this Inquiry, decision-makers have made government's reliance on, and requirement for, having clear quantitative data before taking action

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[32] [INQ000575999].
[33] [12/14/19-12/15/7].
[34] See, for example, [INQ000475070_0043-44]; [INQ000587250_0120, §558]; [7/30/5-7/40/6]; [7/137/16-7/140/10];[7/213/8-7/215/2]; [9/137/8-9/137/22]; [INQ000575986].

abundantly clear. Time and time again it has been the reason proffered for inaction and/or delays to action. The result of ineffective data gathering therefore would have had significant impact on effective and timely intervention, even in the face of issues and qualitative data being raised on an individual and/or campaign level.

36. This was not a localised or incidental oversight, it was a systemic deficiency, confirmed across the UK's nations. In Northern Ireland, Baroness Arlene Foster acknowledged that data capture and modelling during the first phase of the pandemic failed to consider vulnerable groups in light of existing inequalities, and relied too heavily on UK-wide systems without local nuance.[35] Chief Medical Officer Sir Michael McBride admitted that ethnicity was not recorded on testing forms and that routine data flows did not allow for identifying trends in infection among ethnic groups. He candidly called this a "*gap*" and an "*important learning point*".[36] Similarly, Robin Swann, the then Health Minister, acknowledged that the absence of ethnicity data impaired policymaking, stating that it "*made it challenging for us to do that*".[37] These testimonies, similarly echoed by Dr Robin Howe for Wales and senior figures in Scotland such as Caroline Lamb, demonstrate the nationwide consequences of not embedding ethnicity data collection into the TTI system's architecture.

37. Even when community-specific needs and vulnerabilities were apparent and obvious, such as overcrowded or multigenerational housing or occupational exposure, the system seemingly failed to act. A lack of analytical visibility and an overreliance on empirical evidence, it appears, resulted in a failure of the system to respond effectively even to issues right in front of it. Data systems ought to have been in place to facilitate timely and accurate reporting capable of disaggregation; it ought to have been available as a tool to be used as an active driver of equity and progress. Its absence, however, does not in our submission excuse inaction or inertia.

38. The failure to collect and operationalise ethnicity data must be viewed in the broader context of public health equity and preexisting structural inadequacies. That the UK had poor data capturing, storing and sharing systems in place was yet another "known" issue prior to the pandemic that had been left unaddressed. Successive governments' failure to act on known weaknesses left us vulnerable and scrambling in the midst of a public

[35] [7/39/5–7/40/6].
[36] [7/137/16–7/140/10].
[37] [7/213/8–7/215/2].

emergency. It is crucial that weak spots such as this are acted on to strengthen our resilience and capacity to respond to future incidents.

39. Effective public health responses require not only that systems function technically, but that they are guided by principles of fairness, representation, and inclusion. Without disaggregated data, there can be no detailed analysis of disproportionately impacted groups, nor monitoring of the effectiveness of interventions and/or unequal outcomes across population variables. Without disaggregated data, and in a system that will only act on empirical evidence and data, marginalised groups remained to some extent invisible it seems to policymakers who pressed ahead with one-size-fits-all approaches.

40. The failure was not solely one of collection, but of utilisation. Some witnesses have spoken proudly of the improvements made during the pandemic to data collation. Even when data was gathered, however, the evidence indicates that it was limited, often patchy and rarely used effectively to inform strategy. Witnesses described how feedback from local authorities and community partners, many of whom had early warning signs about disparities, was not integrated into central decision-making. So too, qualitative data in the form of experiences raised by individuals and campaign groups was seemingly ignored across the board for the most part, along with their offers to engage and assist in tackling the issues being raised. This reflected a deeper institutional mistrust and/or reluctance to treat the lived experiences of marginalised communities as legitimate sources of knowledge.

41. Moreover, the inability to track the reach and impact of TTI initiatives among Black, Asian and Minority Ethnic groups, combined with a lack of engagement with these groups to hear their experiences and needs first-hand, meant that the system lacked the very tools needed to course-correct. Public health is not static; it requires adaptation. Yet the system's blindness to difference meant it could not evolve in response to need.

42. FEMHO submits that a failure to prioritise disaggregated data is, in effect, a failure to prioritise those whose experiences differ from the imagined norm. It is a form of systemic erasure that leaves communities under-served and over-exposed. Going forward, the collection, analysis, and use of disaggregated data must not be an afterthought. It must be embedded as a foundational pillar of pandemic preparedness, not only as a means of enhancing operational efficiency, but as a matter of justice.

43. The experience of this pandemic has shown what happens when data fails to see difference. In the next crisis, we must build systems that see clearly, act fairly, and serve all.

(Dis-) Trust, Cultural Competence, and Messaging

44. FEMHO submits that the government's failure to engage with minority ethnic communities, through culturally competent communication and meaningful dialogue, critically undermined an already fragile relationship of trust and, as a result, the effectiveness of TTI.

45. This failure was not peripheral to the public health strategy; it should have, but largely did not, sit at its very centre. Public health depends not only on operational infrastructure and technical capacity, but on public confidence, credibility, and clear channels of communication. As FEMHO's Ade Adeyemi explains it: "*The success of a TTI system will always fundamentally depend on adherence. Trust is critical in every aspect of the scheme; it is essential if compliance is to be achieved for there to be trust in the system, and yet also the system itself is predicated on trust that the population will abide by it.*"[38]

46. Trust is never a given, it must be cultivated through genuine inclusion, clear and consistent messaging, and a willingness to listen before acting. Unfortunately, the government's communications strategy did not reflect these values and so compounded a pre-existing lack of trust among minority ethnic communities.

47. Government frequently prioritised centralised control and speed over accuracy, local nuance, and/or cultural relevance. This resulted in messaging that was often contradictory, alienating, and ultimately ineffective in securing voluntary compliance. Professor McKee, for example, described how the shifting public health advice, often untethered from clear scientific rationale, created confusion and suspicion. He noted that policies appeared to be retrofitted to resource constraints, giving the impression of expediency over truth, a perception that deeply undermined public confidence.[39] Professor Arden in turn underscored how rapidly shifting guidance and lack of transparency sowed confusion, while high-profile breaches of the rules by public figures damaged collective morale and trust.[40]

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[38] [INQ000587648_0002, §6].
[39] [2/86/18–24].
[40] [11/159/15–11/160/19].

48. The lack of cultural sensitivity in public messaging further eroded trust among minority ethnic communities. Professor Arden noted that five million people in the UK speak a primary language other than English, yet translated guidance was delayed, oversimplified or inaccessible. The need to co-produce messaging with minoritised groups was well-evidenced but poorly implemented.[41] The government, she said, did not adequately consider "*what different people need*" — a fundamental requirement of culturally competent communication.[42] Guidance was issued predominantly in English and in online formats, without adequate translations or adaptations for those with limited literacy or no access to the internet.

49. As Mark Drakeford powerfully stated, the government could not assume that communication from the state would be received as benign. For some communities, particularly those with traumatic histories of state overreach, a letter from government could provoke fear, not compliance. Trust, he said, required the involvement of intermediaries: doctors in mosques, faith leaders, and community advocates who understood and could interpret the message with credibility and clarity.[43] The evidence in this module and from the experiences of FEMHO members is that important health directives were not sufficiently communicated through community networks, religious institutions, or trusted local figures. As a result, many individuals were left without clear or accessible advice at crucial points during the pandemic.

50. FEMHO contends that the exclusion of minority ethnic voices from the strategic design and communication of public health messaging is one of the most serious failures of the TTI rollout. Evidence from Professor Fenton showed that minority ethnic healthcare professionals were uniquely placed to serve as cultural brokers, trusted sources, and community educators.[44] These professionals could have helped to shape not only the language and format of key messages, but the tone and framing that would make them resonate with specific groups. Indeed, many FEMHO members were actively trying to get a seat at the table and to be involved in these discussions to ensure their community's needs and experiences were heard. Instead, however, their insights were largely sidelined and their communities paid the price.

51. Community leaders, religious institutions, cultural organisations and frontline minority ethnic healthcare workers offered an invaluable and underutilised resource that could have

[41] [11/175/5–11/177/20].
[42] [11/158/9–11/159/14].
[43] [6/193/4–11].
[44] [INQ000587544].

transformed both the design and delivery of the TTI scheme. FEMHO members made considerable efforts to bridge gaps, engage and assist government, but for the most part felt their efforts and contributions were "*underutilised and appreciated*".[45] That this resource was largely ignored represents not just a policy oversight, but a profound failure of imagination and inclusion.

52. As FEMHO submits, effective public health is not only about systems and data; it is also about relationships, dialogue and cultural intelligence. A pandemic response that sidelines those with the deepest insight into community needs, behaviours and vulnerabilities is bound to falter. The lack of engagement and understanding fostered distrust and stigmatisation, with many feeling if they tested positive they would be stigmatised at work, at home and within their communities through no fault of their own. Throughout the rollout of TTI, the absence of proactive, sustained engagement with trusted local actors contributed to widespread confusion, alienation and, ultimately, diminished uptake. This was a failure not simply of communication, but of respect and recognition.

53. Community organisations that understood the specific barriers facing their members, be they linguistic, technological, cultural or economic, were able to tailor responses accordingly. Yet such organisations were not meaningfully involved in the national strategy. There was no clear mechanism to harness their knowledge, no financial support to empower their operations, and no attempt to integrate their insights into broader pandemic planning.

54. The failure to involve Black, Asian and Minority Ethnic healthcare workers in strategic leadership roles during the development of the TTI scheme further undermined its legitimacy and effectiveness. These workers not only understood the science, but the social context. They were uniquely placed to advise on barriers to uptake, community-specific risks, and culturally competent messaging. Yet their involvement was largely ad hoc, informal, or tokenistic. FEMHO submits that their exclusion from formal planning structures contributed directly to the disconnect between national policy and local experience.

55. The government's inadequate support for those hit hardest (physically and financially) by the policy of isolation also eroded trust among minority ethnic communities. There was a perception among some that government either didn't understand the difficulties

[45] [INQ000587648_0012, §35].

associated with isolating, or didn't care enough to provide adequate support. Sir Paul Nurse gave candid testimony when asked what could have been done to ensure the TTI system was culturally competent and equitable, frankly suggesting: "*I think it's having people in charge who care.*"[46]

56. The fragility of the relationship of trust between the state and minority ethnic communities predated the pandemic and was known about prior to the pandemic. Despite this, not enough effort was made by government to bridge the trust gap during the pandemic. Professor McKee asserted that trust, especially among minority communities with historical reasons for scepticism, "*arrives on a tortoise but leaves on a horse.*"[47] Professor Fraser echoed this sentiment, citing data-sharing concerns among communities with previous negative experiences of state surveillance — where trust must be earned through trustworthiness, not assumed.[48]

57. Professor Arden testified that the contact tracing app required levels of personal data sharing and behavioural compliance that were simply incompatible with the low trust many minority ethnic communities had in state-led tech initiatives. This mistrust, she argued, could have been anticipated and mitigated through co-design and user consultation, yet none of that occurred.[49] The app was effectively "all-or-nothing"; many chose nothing.

58. The missed opportunity to engage Black, Asian and Minority Ethnic communities was not due to a lack of warning or expertise. It was foreseeable, repeatedly raised – including by bodies such as SAGE[50], and avoidable.[51] Professor Arden was clear: the importance of co-designing messages with diverse communities was already known prior to the pandemic. She testified that "*we need to speak the languages of the people... and that means co-designing messages with those communities.*"[52]

59. Once again, the inadequate emphasis placed on trust building by government was strategically flawed, as the lack of trust likely undermined the government's attempt to fight the spread of the virus. Lord Bethell described a communications infrastructure that was not only outdated, but ill-suited to reaching the very people most at risk. He recalled being unable to see in government strategy "*the people or the tactics*" needed to bridge the trust

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[46] [4/52/9-4/53/7].
[47] [2/98/1-2].
[48] [2/194/15–22].
[49] [11/184/17–11/188/20].
[50] [INQ000061561, INQ000214050].
[51] [INQ000350433_0017-18].
[52] [11/169/10–11/170/9; 11/173/11–11/175/3].

gap, and said he had to draw on his private-sector experience in music to push for creative alternatives.[53]

60. FEMHO recognises that some attempts were made by the different nation's governments to communicate with minority ethnic community through engagement with the communities themselves. However, the experience of FEMHO's members is that this engagement was largely delayed, ad hoc, sporadic, last minute and lacked proper planning. This module has not been able to determine empirically the extent to which the different programs/ or plans were effective.

61. From the evidence available, it appears as though the Government in Westminster fell most short in its engagement with minority ethnic communities to improve communication and trust. Greg Fell confirmed what community workers already knew: trust cannot be built from a central podium, it must be earned through long-standing local partnerships.[54] Ben Dyson accepted that what worked best was working through faith groups and voluntary sector organisations, but that this was not standardised or embedded.[55]

62. The Outreach Plan devised in Wales, whilst only implemented in October 2020, seems to be an example of good practice. It was implemented after considered thought was given to how best to reach, communicate and engage with minority ethnic communities. In her witness statement, Jo-Anne Daniels describes how outreach workers were funded in each health board to break down barriers, encourage and support compliance and understanding and facilitate a two-way communication between organisations and communities, based on learning from international models such as Barefoot Workers India. Literature was produced in 28 different languages and in various different accessible formats, and a community outreach toolkit was developed: "*to encourage community leaders, third sector organisations and others to understand the key messages and circulate within their communities.*" Both the materials and the process for disseminating messages were developed with advice and input following engagement with a range of Black, Asian and Minority Ethnic stakeholders. [56]

63. It is clear from the advice to ministers which recommended the Outreach Plan[57] that detailed thoughts had gone into this Plan and it was underpinned by a genuine commitment to redressing some of the disproportionate impact of the pandemic and TTI

[53] [8/148/6–8/149/9].
[54] [10/177/11–10/178/16; 10/218/11–10/218/24].
[55] [9/53/25–9/54/24].
[56] [INQ000587349].
[57] [INQ000145029].

on minority ethnic communities. Disappointingly, there is no evidence that the Westminster government (or others) ever sought to learn from the Welsh Outreach Plan.

64. FEMHO urges the Inquiry to conclude that trust, cultural competence, and community engagement must be regarded as core pillars of any future public health response. Messaging should be co-designed with community stakeholders, translated across languages and registers, and delivered through locally respected figures. It should reflect the lived realities of those most affected, rather than assumptions made in Westminster offices. Above all, it must begin with the understanding that people will not act on information they do not understand, do not trust, or do not feel was created with their wellbeing in mind.

65. Without this shift in approach, we risk repeating the very failures that rendered TTI less effective and more harmful than it needed to be. Future preparedness requires not just technical planning, but a deep investment in relationships, respect, and representative leadership.

66. FEMHO urges this Inquiry to understand that trust is not won by accident. It is earned, through deliberate inclusion, clear communication, equitable support, and respect for the dignity of all communities. The pandemic revealed what happens when that trust is absent. The next crisis demands that we do better.

67. FEMHO submits that minority ethnic communities must be treated as co-producers of health policy, not passive recipients. Engagement is not a luxury, it is a precondition of legitimacy and compliance. The failure to embed this from the outset of the TTI system was not simply an administrative oversight. It was a governance failure with predictable and preventable human costs.

68. Looking forward, FEMHO argues that community engagement must no longer be treated as an optional extra. It should be a standing component of pandemic preparedness, with funding, infrastructure, and formal advisory pathways in place long before a crisis begins. The government must invest in relationships with minoritised communities, not just in moments of emergency, but in periods of calm. Only through sustained partnership can it hope to rebuild the trust so severely damaged during this pandemic.

Disproportionate Enforcement

69. The evidence heard in this module confirms a long-standing and painful truth: the enforcement of Covid-19 regulations disproportionately affected Black, Asian and minority ethnic communities. This was not incidental. It was foreseeable, preventable, and yet inadequately addressed.

70. Martin Hewitt, then Chair of the NPCC, acknowledged that disproportionality in policing had been "*a key feature and a key feature of concern*" throughout his career.[58] He testified that he recognised going into the pandemic that every interaction under the TTI enforcement regime would be refracted through the lens of historical over-policing and institutional mistrust.[59] So too, he acknowledged the context created by the murder of George Floyd and the Black Lives Matter movement placed "*the whole policing context… into really stark focus*".[60] It was, he admitted, a time of heightened scrutiny and a test that policing failed.

71. Mr Hewitt further explained how structural inequalities, particularly housing, shaped patterns of enforcement, with those living without private outdoor space facing an increased likelihood of police engagement and enforcement.[61] In other words, the conditions of inequality created the circumstances of criminalisation.

72. Importantly, Mr Hewitt confirmed that concerns about unequal enforcement were raised with government from the outset. The NPCC, he said, regularly liaised with the Home Secretary and policing ministers, and "*raised [the issue] from the very beginning*".[62] Concerns were similarly raised by other interest groups including the Equality and Human Rights Commission.[63] The government was not unaware of the risks. It was warned. It did not act. Nowhere in the evidence does it appear that this foreseeable harm informed the policing strategy for TTI enforcement either. No safeguards were in place. No targeted communication was deployed. No trust-building measures were introduced. Even when data revealed the extent of disproportionate enforcement, and promises were made to address the issue, it persisted.[64] This omission is not just an institutional failure; it is a moral one.

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[58] [3/161/20–21].
[59] [3/161/24–3/163/8; 3/167/16-25].
[60] [3/162/22–25].
[61] [3/170/14–3/171/1].
[62] [3/167/13–15].
[63] [INQ000185311].
[64] [See Mr Hewitt's Module 2 oral evidence at 21/66/13-21/88/13 & INQ000187993].

73. A similar picture emerged in Wales. Vaughan Gething, former Minister for Health and Social Services, gave evidence about the disproportionate use of fixed penalty notices by Dyfed Powys Police.[65] Crucially, Mr Gething rejected any suggestion that this reflected differing levels of criminality. Instead, he identified unconscious bias and the blunt application of blanket measures as the root cause. He stated: "*This just shows that when you apply a blanket measure… it can have a disproportionate impact, and that isn't explained by differing levels of criminality… it's about how the engagement and education approach moves to enforcement.*"[66]

74. These testimonies align with FEMHO's consistent position: that enforcement powers, wielded without sufficient regard to structural inequality or community experience, entrenched mistrust and reinforced existing disparities. Ade Adeyemi of FEMHO reported in his statement that there was: "*a sense amongst our members that they were more likely to be penalised more harshly if they broke any rules. This simply reflected wider societal inequalities and reinforces our thinking that the pandemic exacerbated underlying structural racism.*"[67] The failure was not merely operational; it was a failure to safeguard equity in the design and implementation of public health powers.

75. FEMHO submits that disproportionate enforcement was not an aberration but a structural inevitability once policing was given wide discretion without adequate checks. Communities already over-policed before the pandemic were policed more intensely during it. The results, trauma, alienation, and deepened mistrust have left a lasting scar.

76. As well as enforcement and penalties issued by the police, there was widespread inconsistency in the application and enforcement of TTI policies and strategies in workplaces. For FEMHO members working on the frontline in the heath sector, the complex logistical issues arising were particularly acute.

77. An obvious example is the functionality of the TTI app within hospital settings where the often thin walls and frequent movement of high volumes of people meant that Bluetooth connections were made even where individuals had never come face to face and/or in situations where full PPE had been worn due to known exposure risks. Frequent exposure alerts, delayed results from testing and isolation when household members were infected created further challenges for already overstretched staffing and capacity. All these issues

[65] [6/154/18–6/155/5].
[66] [6/155/15–25].
[67] [INQ000587648_0019, §56].

appear to have been ill thought-through if at all by decision-makers and there was no centralised guidance or policy on dealing with the significant challenges they posed.

78. As FEMHO's witness evidence for this module noted: *"During surge times, it would have been practically (if not completely) impossible for the health service to continue to function had the strict policies been enforced. It seemed that little thought had been given to these inevitable challenges, and so guidance and/or direction was lacking. This resulted in variance in approach, and an additional psychological burden both on those dictating the approach within trusts and teams, as well as on individuals' perception of personal safety at work and for their households."*[68]

79. Furthermore, it seems the impact may not have been felt equally amongst the workforce. FEMHO members have reported alarming instances of discriminatory treatment including individuals having been told TTI policies "did not apply to them", being called into work despite having tested positively and/or being called back in early before their isolation period was due to end and before full recovery; whilst White counterparts were seen to be allowed to isolate, redeploy or work from home in similar circumstances.[69] Minority ethnic staff were already statistically less likely to feel comfortable in speaking out against perceived inequalities and so often felt they had no recourse to object to this type of discriminatory treatment.

80. It is vital that in future there are better safeguards against discriminatory application of TTI policies, and careful thought given as to the implications of policy within different settings, in particular health settings given the inevitable exposure risks.

Conclusion

81. The evidence heard in this module paints a stark picture. The TTI system, one of the core pillars of the United Kingdom's response to Covid-19, was conceived and delivered in a manner that systematically failed Black, Asian and Minority Ethnic communities. The result was a public health approach that prioritised scale over specificity, speed over equity, and uniformity over inclusion.

82. At every stage of the TTI system's design and implementation, there were opportunities to do better. Decision-makers were aware of the profound structural inequalities that shaped people's ability to comply with public health measures. They were warned by experts and

[68] [INQ000587648_0004].
[69] [INQ000587648_0018].

community leaders about the risks posed by TTI policies and yet, these risks went unmitigated in a system that was not built with marginalised communities in mind. It is therefore unsurprising that much of this module's evidence has focused on how shortcomings in data collection, financial support, community engagement and cultural competence failed the most vulnerable.

83. FEMHO does not appear in this Inquiry to assign blame for its own sake. It appears to ensure that the voices and experiences of Black, Asian and Minority Ethnic healthcare workers and communities are properly heard, understood and acted upon. These communities were not passive recipients of state policy, nor "hard-to-reach". They were active participants in the national response, often bearing the highest risks with the lowest protection. And when they called for help, or even just engagement, their voices were too often drowned out or ignored. TTI success was contingent on *trust* and yet their trust was undermined and broken time and again when it mattered most. The lessons of this module must therefore go beyond technical refinement. They must speak to a fundamental shift in how public health is conceptualised and delivered. The goal cannot be to return to business as usual.

84. FEMHO invites this Inquiry to ensure that future preparedness is informed not only by the technical failures of TTI, but by the deeper moral and structural failings that enabled those shortcomings to occur. If we are to protect all communities in the next public health crisis, we must first be willing to learn from those we failed to protect in this one.

Recommendations for Future Preparedness

85. Fundamentally, future pandemic planning must embed equity at its heart. This was the emphatic conclusion drawn by Professor Buchan, who said, "*whatever we do now to consider future pandemic responses needs to consider equity at its core.*"[70] Future public health strategies must be designed from the outset with a detailed understanding of the social determinants of health, including the impact of structural racism, economic precarity, housing inequality, and differential access to healthcare.[71]

86. Emergency preparedness frameworks must contain specific protocols and safeguards to ensure decision-makers effectively assess and address the needs of disadvantaged and marginalised groups. National consistency is important, but so too is local relevance. Local

[70] [3/43/21–23; 3/44/14–3/45/3].

[71] We echo Prof Fraser's recommendations in this area – see [2/193/18–2/195/1; 2/196/25–2/197/11].

authorities, NHS trusts, and community-based organisations must be resourced and empowered to adapt national strategies to local contexts. A one-size-fits-all model will always struggle in a society marked by deep regional, cultural and socio-economic diversity. This requires not only high-level commitments, but clear mechanisms for implementation, monitoring and accountability.

87. To ensure that these mechanisms can be created, individuals, organisations and in some cases healthcare workers, from minority ethnic communities must participate in their design and implementation. Future preparedness must begin with humility: a recognition that the state cannot protect communities it does not listen to. Building resilience against future health emergencies requires trust, which can only be earned through sustained, inclusive and respectful collaboration. Trust is not an accessory to health policy. It is its foundation. Without trust, even the best-designed systems will falter. Professor Buchan was right when he urged the co-creation of preparedness measures with people who have lived experience of the barriers posed by isolation, testing, and digital exclusion. Individuals and organisations from minority ethnic communities must be treated as strategic partners and present at every table where decisions are made.[72]

88. This engagement must be professionalised and structurally integrated into pandemic preparedness. It cannot be episodic, voluntary or symbolic. FEMHO proposes the creation of funded advisory panels comprising minority ethnic health professionals and community leaders, with a standing remit to inform public health strategy and emergency planning. These panels should have officially recognised status as government advisory panels, in the same way as SAGE. These proposals will ensure that public health messaging is designed with cultural competency, with the flexibility to engage communities.

89. To ensure that equity remains at the core of pandemic planning and response, it is also crucial that the existing PSED framework is properly integrated. It cannot be used as a "tick box" exercise to pay lip service to the issue of equity, it must be treated with the importance that it deserves. The framework, when used properly, can identify equality issues in policy development and then, having done so, design strategies to mitigate those risks identified. To ensure that the PSED is effectively embedded into future pandemic planning and response, FEMHO repeats its proposal to incorporate a race equity decision audit tool (REDA).[73] Such a tool would create an accessible mechanism to effect meaningful engagement with equity considerations in decision making and ensure that the

[72] [2/193/18-2/197/11].
[73] See [INQ000587648_0022; 28-30] & FEMHO Module 3 Closing Statement for full detail of this proposal.

voices of those less often heard, but who nonetheless have valuable insights and ideas to share, are heard and considered.

90. The establishment of robust, accessible and adequately resourced financial support mechanisms is vital to enable individuals to comply with isolation and other public health measures, and thus to the success of any future TTI scheme. The government must adopt a public health framework in which welfare and health protection are not treated as competing priorities, but as mutually reinforcing obligations. In future crises, support payments must be swift, sufficient, and accessible to all, including those in insecure or informal work. Whilst appreciating that the circumstances will be different in a future pandemic, work can and should begin now on researching and testing the appropriate levels of financial support for isolation.

91. FEMHO submits that it is essential that disaggregated data by ethnicity, occupation, and other relevant social indicators is routinely collected, analysed and acted upon from the earliest stages of a public health emergency. This requires that action is taken now to improve the national data landscape, including investment in data infrastructure, training for data collection personnel, and the development of ethical frameworks to ensure that trust in data collection is increased among minority ethnic communities. Data must be transparent, publicly available, and meaningfully incorporated into decision-making at all levels.

92. Finally, FEMHO endorses the warnings provided by both Minister Gething and Professor Arden, namely that without addressing the structural inequities that undermine adherence to emergency public health interventions, future interventions will again falter.[74] It is no easy task, but to ensure that pre-existing societal inequalities are not compounded in times of emergency, the root causes of those inequalities need to be addressed before the next emergency takes place. The pandemic has left deep scars across society. For Black, Asian and Minority Ethnic communities, those scars are not only medical, but institutional and psychological. If we are to move forward, it must be with a public health system that is not only stronger, but fairer.

30 June 2025

Leslie Thomas KC

Philip Dayle

[74] [11/167/12–11/168/5]; [6/158/6–6/159/19].

Una Morris

Elaine Banton

Ifeanyi Odogwu

Saunders Law