Leigh Day

Mr Boris Johnson
The Prime Minister
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Your Ref:
Our Ref: TGY/LCA/00243806/1
Date: 18 June 2020

Dear Mr Johnson,

Introduction

The Claimant

1. We are instructed by The Ubele Initiative, which is an African Diaspora led intergenerational social enterprise founded in 2014. It was established as a result of the founders' concern about the deep systemic social issues which affected their community and the lack of a coherent strategy to tackle those issues. Its primary mission is to help build more sustainable communities across the UK. Ubele in Swahili means 'The Future'.

2. The Ubele Initiative established a #WeNeedAnswers campaign as a result of the disproportionate impact the Covid-19 crisis is having on ethnic minority groups, as well as the shortcoming in the government's response to that disparate impact.

3. As part of that campaign, The Ubele Initiative coordinated an open letter to the Prime Minister, dated 10 May 2020[1] (sent to the Prime Minister on 9 May 2020). The letter called for an independent public inquiry to be established as a result of the severe impact of Covid-19 on ethnic minority groups. The letter has been signed by over 650 individuals, a significant proportion of whom are prominent members of the BAME community. No response to this letter has to date been received from the Prime Minister.

4. The Ubele Initiative wrote a further letter to the Prime Minister, dated 3 June 2010[2]. This letter responds to the Public Health England report 'Disparities in the Risks and Outcomes of Covid 19 into the impact of COVID-19'. The letter points to the report's inadequacies, in particular that the report:

1 https://www.ubele.org/weneedanswers
2 https://www.ubele.org/news/2020/6/4/we-need-answers-second-letter-to-the-prime-minister

4.1. Has produced no recommendations, the purpose of which would be to reduce the impact on ethnic minority groups and/or put protective measure in place;
4.2. Has been stripped of a section which related to the submissions of relevant stakeholders about their concerns;
4.3. Contains no detailed breakdown by heritage of how Covid-19 has impacted particular communities such as Nigerian, Jamaican and Filipino communities; and
4.4. Contains findings which have already been identified and published by other bodies, such as the Office for National Statistics.

5. No response to this letter has to date been received from the Prime Minister.

6. Our client has also initiated a petition calling for an independent public inquiry into the impact of Covid-19 on BAME communities, which to date has been signed by over 32,800 people.[3]

7. Our client remains deeply concerned about the failures of the government's response to the impact of Covid-19 on ethnic minority groups. Those failures have contributed to the death and serious illnesses of members of ethnic minority groups.

8. Our client's position is that these concerns warrant both: (i) an immediate independent inquiry which would investigate the underlying causes of the increased risk that ethnic minority groups face in relation to Covid-19 and produce recommendations which seek to protect ethnic minority groups from the increased risk of death from Covid-19 during a second or subsequent wave of infection; and (ii) a commitment from the government to undertake a more comprehensive, independent public inquiry into the disproportionate impact of Covid-19 on ethnic minority groups, which would investigate both the increased deaths amongst ethnic minority groups, the relevant causes of health disparities between ethnic groups in the UK, and the disproportionate economic impact of lockdown measures on ethnic minority groups.

9. Our client is also concerned by the government's apparent failure to consider the equality impacts of the lockdown-easing measures on ethnic minority groups, including the impact on higher-risk occupations, and seeks an explanation of whether any relevant assessments have been undertaken and disclosure of any such documents.

[3] https://you.38degrees.org.uk/petitions/bame-communities-and-the-disproportionate-incidence-of-covid-19?share=c1c370db-dc62-460e-a89c-e3576037c4e9&source=rawlink&utm_source=rawlink

The Defendant

10. The Rt Hon Boris Johnson MP, Prime Minister. The Prime Minister is proposed as the Defendant in this case, because it is clear that the issues raised require co-ordination at the highest level across various departments of government. If you consider that another party ought to be named as Defendant in the proposed proceedings, please explain why.

Background

11. The government has long been aware of health inequalities amongst ethnic minority communities in the United Kingdom. A 2018 report by Public Health England, 'Local action on health inequalities: understanding and reducing ethnic inequalities in health', recognised the need for *"effective action on ethnic health inequalities".* The report found that *"Progress on ethnic health inequalities has been slow and the need for senior leadership on this agenda has been repeatedly highlighted"* (p 6). It emphasised that *"Across all areas of activity, the meaningful engagement and involvement of minority ethnic communities, patients, clinical staff and people is central to understanding needs and producing appropriate and effective responses or shaping services"* (p 7), and that when taking action to address health inequalities, *"[t]he central role of racism must be acknowledged, understood and addressed"* (p 6).

Data published in April and May 2020 on the disproportionate impact of Covid-19 on ethnic minority groups

12. The Covid-19 pandemic has disproportionately affected ethnic minority communities in the United Kingdom. This became clear early into the outbreak in the UK. Research in early April 2020 from the Intensive Care National Audit and Research Centre (ICNARC) found that 35% of almost 2,000 patients were non-white, despite BAME people making up only 14% of the UK population.[4] Analysis by the Guardian of the 53 NHS Staff who had died in the pandemic by 16 April 2020 found that 68% were BAME.[5]

13. In an article published in the Health Service Journal on 22 April 2020,[6] clinicians analysing the deaths of 119 NHS staff from Covid-19 found that:

    13.1. 71% of deaths of nurses and midwives were from BAME groups, despite BAME people only comprising 20% of the workforce;
    13.2. 56% of deaths of healthcare support workers were from BAME groups, despite BAME people only comprising 17% of the workforce;

[4] ICNARC report on 'Covid-19 in critical care', 4 April 2020, p 4.
[5] https://www.theguardian.com/world/2020/apr/16/inquiry-disproportionate-impact-coronavirus-bame
[6] https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

13.3. 94% of deaths of doctors and dentists were from BAME groups, despite BAME people only comprising 44% of the workforce;
13.4. More than half of health and social care workers who have died were born outside the UK, despite comprising 18% of NHS staff. 36% of deaths of workers born outside the UK were Filipino;
13.5. Members of staff considered at highest risk of viral exposure and transmission are absent from the data set of staff deaths, raising questions about why staff involved in lower risk activities are becoming infected.

14. On 7 May 2020, the ONS published a report entitled 'Coronavirus (Covid-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020'. The ONS found that *"the risk of death involving the coronavirus (COVID-19) among some ethnic groups is significantly higher than that of those of White ethnicity"* (p 2). It found that after taking account of *"age"*, *"other socio-demographic characteristics"* and *"measures of self-reported health and disability at the 2011 Census"*, there remained a raised risk of death amongst some ethnic groups. The *"difference between ethnic groups in COVID-19 mortality"* was found to be *"partly a result of socio-economic disadvantage and other circumstances, but a remaining part of the difference has not been explained"* (p 2; emphasis added).

15. After adjusting for the risks of death from Covid-19 relating to age, the ONS found that *"men and women from all ethnic minority groups (except females with Chinese ethnicity) are at greater risk of dying from COVID-19 compared with those of White Ethnicity. Black males are 4.2 times more likely to die from COVID-19 than White males, while Black females are 4.3 times more likely to die from COVID- 19 than White females. People of Bangladeshi and Pakistani, Indian, and Mixed ethnicities also had statistically significantly raised odds of death compared with those of White ethnicity. For the Chinese ethnic group, we find a raised risk among males but not females"* (p 6).

16. The ONS also carried out an adjustment for *"region, rural and urban classification, area deprivation, household composition, socio-economic position, highest qualification held, household tenure mand health or disability in the 2011 Census".* The fully adjusted results found that *"Black males and females are 1.9 times more likely to die from COVID-19 than the White ethnic group. Males of Bangladeshi and Pakistani ethnicity are 1.8 times more likely to die; for females, odds of death are reduced to 1.6 times more likely. Individuals from the Chinese and Mixed ethnic group have similar risks to those with White ethnicity"* (p 6).

17. The ONS found that socio-economic disadvantage was a relevant factor in explaining the disproportionate impact of Covid-19 on ethnic minority communities. Its report stated that "*Existing evidence indicates that most ethnic minority groups tend to be more disadvantaged than their White counterparts"* (p 5). This includes:

a higher likelihood of living in overcrowded households: *"while only 2% of White British households experienced overcrowding, 30% of Bangladeshi households (the highest percentage), 16% of Pakistani households and 12% of Black households experienced this"*; a higher likelihood of Bangladeshi, Pakistani and Black ethnicities living in deprived neighbourhoods; a higher likelihood of unemployment amongst Black, Bangladeshi and Pakistani populations; and a higher likelihood of low income and child poverty, with persons of Bangladeshi, Pakistani, Chinese, and Black ethnicities twice as likely to be living on a low income and experiencing child poverty, compared with those of White ethnicity (p 8).

18. However, the ONS found that socio-economic factors "*do not explain all of the difference, suggesting other causes are still to be identified"* (p 7, emphasis added).

19. The ONS did not undertake any analysis on two issues recognised to be relevant to the disproportionate impact of Covid-19 on ethnic minority communities: (i) the over-representation of ethnic groups in public-facing occupations which place employees at increased risk of contracting Covid-19, and (ii) the propensity amongst some ethnic groups to suffer co-morbidities associated with worse outcomes from Covid-19. The ONS indicated that further work would be undertaken on these issues although no indication was given of a timeframe for this (p 7).

20. This early evidence of the disproportionate impact of Covid-19 on ethnic minority groups prompted calls for an urgent government inquiry into the issue.

Public Health England's Review

21. In response, the government undertook to conduct a rapid review into the issue. A government news bulletin on 4 May 2020 on the **'**Review into factors impacting health outcomes from Covid-19'[7] explained that Professor Kevin Fenton, Regional Director of Public Health at Public Health England (PHE) was commissioned to lead the review, "*to better understand how different factors such as ethnicity, deprivation, age, gender and obesity could impact on how people are affected by COVID-19"*. Professor Fenton stated that *"PHE is engaging a wide range of external experts and independent advisors, representing diverse constituencies including devolved administrations, faith groups, voluntary and community sector organisations, local government, public health, academic, royal colleges and others. We are committed to hearing voices from a variety of perspectives on the impact of COVID-19 on people of different ethnicities"*.

[7] https://www.gov.uk/government/news/review-into-factors-impacting-health-outcomes-from-covid-19

22. The Terms of Reference for the review[8] specifically stated that one of the review's objectives was to *"suggest recommendations for further action that should be taken to reduce disparities in risk and outcomes from COVID-19 on the population"* (emphasis added). The government promised that *"PHE will work with external experts, independent advisors and stakeholders to consider the results of the review and any suggested recommendations".*

23. However, the scope of the review was limited. The Terms of Reference stated that *"the review will not ascertain root causes of findings that are likely to be driven by complex interactions"*. It was stated that the National Institute for Health Research (NIHR) has been commissioned to *"examine these in more detail".* The NHIR has launched a call for research proposals which *"have the potential to deliver public health impacts within 12 months".* There has been no commitment by the government to undertake a more prompt investigation into the underlying causes of the health disparities.

24. Over 4,000 individuals and organisations representing ethnic minority communities in the UK made submissions and recommendations in response to the PHE review; these have been described by PHE as having *"provided rich qualitative and contextual insight into a range of issues on Covid-19 and BAME groups"*[9]. Written evidence was submitted and discussions were also convened by Professor Fenton.[10] Many of those responses raised the issues of structural racism, poor life chances, stigma, discrimination, and distrust and suggested that these factors contributed to the disproportionately high death rate from Covid-19 in some ethnic groups.[11]

25. The submissions raised issues which are not only relevant to explaining the disproportionate impact of Covid-19 on ethnic minority groups to date, but also to the potential impact of lockdown-easing measures on ethnic minority groups. For example, the Muslim Council of Britain highlighted a number of relevant factors, including:

    25.1. The prevalence of intergenerational households in ethnic minority communities (20% of South Asian households; 50% of Black African or Caribbean households), which *"puts elderly BAME individuals at a higher*

[8] https://khub.net/documents/135939561/287909059/COVID-19+Impact+Review+ToRs.pdf/611bea2c-0cbe-4c71-57fe-abfeccdbf273?t=1588688788954

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf - see p 26.

[10] https://www.wmca.org.uk/news/mayor-hosts-virtual-roundtable-as-part-of-public-health-england-review-into-coronavirus-effect-on-bame-communities/

[11] https://www.channel4.com/news/professor-fenton-speaks-for-the-first-time-since-government-report-into-bame-covid-risk-factors

risk of contracting COVID-19 due to the difficulty to sufficiently self-isolate and the potential for younger generations to bring the infection into their homes" (§6 vii);

25.2. A high rate of overcrowding in BAME households, resulting in self-isolation being impossible (§6ix-x);

25.3. The significantly higher rates of BAME healthcare worker deaths, with analysis indicating *"that these have occurred in roles that are not considered high risk of viral exposure and transmission"* , and that external factors are in play, of which one may be *"discrimination and bullying of BAME and Muslim healthcare staff, and an inability to speak out on key issues because of this"* (§7Vii-viii). Reference is made to a survey of over 2,000 BAME NHS staff which found that respondents felt that BAME staff were unfairly deployed to the most at risk wards, unable to speak out, and that discriminatory behaviour played a role in the high death toll (§7ix);

25.4. The importance of understanding "*why such inequalities exist in the first place, the impact of racism and structural discrimination on different facets of people's lives, and how this has contributed to the disproportionate rate of deaths in BAME communities"* (§6xi).

26. Stakeholders also expressed major concerns about the impact of a second wave of Covid-19 on ethnic minority communities, and the government's preparedness for a second wave (see further, below).

27. In a webinar on 22 May 2020, Professor Fenton stated that the work being undertaken for the review had several components, all of which would be submitted to the government in late May 2020 for release.[12] One of the components of the review was the lived experience and recommendations from the individuals and groups who had engaged with the review.

28. It was reported in the Health Service Journal[13] that an early draft of the review report contained a section, annexed to the report, which included the submissions from the organisations and individuals who supplied evidence to the review.

29. The PHE 'Disparities in the risk and outcomes of Covid-19' review was published on 2 June 2020 ("**the PHE Review**"). The report did not contain any of the responses from the stakeholder and community engagement process.

[12] https://www.hsj.co.uk/coronavirus/exclusive-government-censored-bame-covid-risk-review/7027761.article
[13] Ibid

30. Chapter 4 of the PHE Review addresses 'Ethnicity'. It reports that *"after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 5% higher risk of death when compared to White British"* (§4.1). When looking only at the working-age population (between 20 and 64 years old), people of Bangladeshi ethnicity have an 80% higher risk of death than White British people (§4.5). Working-age people of Black Other and Pakistani ethnicity have a 50% higher risk of death than White British, and people of Black Caribbean ethnicity a 30% higher risk of death (§4.5).

31. The PHE review stated that BAME communities are *"likely to be at increased risk of acquiring the infection"* on account of being more likely to live in urban areas, overcrowded households, deprived areas, have jobs which expose them to higher risk, and be more likely to be born abroad which may result in additional barriers accessing services (§4.2). It stated that BAME communities are *"also likely to be at increased risk of poorer outcomes once they acquire the infection"*, noting that some co-morbidities (e.g. cardiovascular disease, hypertension and type III diabetes) are more common among certain ethnic groups.

32. Chapter 5 of the PHE Review, which looks at 'Occupation', reports a higher infection rate amongst midwives and nursing associates from Asian (3.9%) and 'Other' (3.1%) ethnic groups, than White ethnic groups (1.7%); however the report states that the *"analysis did not look at the possible reasons behind these differences"* (§5.1). The PHE review reported that an analysis of 119 deaths of NHS staff *"showed a disproportionately high number of BAME staff among those who had died"*, but did not contain any further details of the findings (which are set out at §30 above).

33. Like the ONS report published a month earlier, when quantifying the increased risk from Covid-19, the analysis in the PHE Review did not analyse the effect of occupation, co-morbidities, or obesity, notwithstanding that these were factors that the ONS had specifically recognised to be relevant to the higher risk of death amongst certain ethnic groups. The PHE report did not consider the effect of structural racism and discrimination on increasing the risk from Covid-19 to ethnic minority groups, issues which were raised by stakeholders and ethnic minority communities in submissions.

34. The PHE Review did not make any recommendations for action to address the disproportionate impact of Covid-19 on ethnic minority groups, despite this being a stated objective of the review, as set out in the Terms of Reference.

35. Our client is extremely disappointed that the PHE Review simply repeats or summarises information which had already been published in April and May, by the ONS and other organisations, without any further meaningful analysis of the root causes of the increased risk from Covid-19 to ethnic minority groups, or recommendations for concrete action to rectify the underlying causes of the disparities. As set out below, there is a substantial risk of a second wave of infection in the near future, and the government is losing valuable time within which to take steps to mitigate the disproportionate impact of Covid-19 on ethnic minority communities.

36. Following widespread criticism of the PHE Review and calls for the government to publish the missing stakeholder submission and recommendations in full, on 4 June 2020 the Government's Equality Hub announced that the Equalities Minister would be leading on further work on Covid-19 disparities.[14] The Terms of Reference for this work do not contain a commitment to publish or implement any recommendations or actions to address the disproportionate impact of Covid-19 on ethnic minority communities within any particular timeframe. It does nothing to reassure our clients that the government has a robust plan in place to investigate the root causes of the health disparities between ethnic groups, or to protect the lives of people disproportionately affected by Covid-19.

*PHE England report: 'Beyond the data: Understanding the impact of Covid-19 on BAME groups' ("**the Stakeholder Engagement report**")*

37. The BAME stakeholder submissions and recommendations, which had been omitted from the PHE Review, were eventually published on 16 June 2020, following widespread criticism of the government's failure to publish the report, and after it had been leaked to the press[15].

38. The Stakeholder Engagement report found that risks associated with Covid-19 transmission, morbidity and mortality can be exacerbated by challenges BAME community face with regards to housing conditions, household composition, population density, income inequality, over-representation in occupations with a higher risk of Covid-19 exposure, increased use of public transportation to travel to work, historic racism and poorer experiences of healthcare, workplace discrimination, racism and bullying, and a difficulty expressing and addressing concerns in the workplace about risk (p 5-8). The main themes were identified as follows:

    38.1. Longstanding inequalities exacerbated by Covid-19: this includes social and economic factors, which are strongly associated with Covid-19 diagnoses,

[14] https://www.gov.uk/government/news/next-steps-for-work-on-covid-19-disparities-announced
[15] https://www.bbc.co.uk/news/health-53035054

incidence and severe disease, as well as with the prevalence of co-morbidities which increase disease severity.

38.2. Increased risk of exposure to and acquisition of Covid-19: key actions recommended include the provision of adequate protective equipment, occupational risk assessments, targeted education and support for key workers, and tackling workplace bullying, racism and discrimination.

38.3. Increased risk of complications and death from Covid-19: key actions recommended include *"culturally competent strategies"* to support better symptom recognition, early diagnosis and earlier presentation to clinical services.

38.4. Racism, discrimination, stigma, fear and trust: this was identified as affecting communities and specifically BAME key workers *"as a root cause affecting health, and exposure risk and disease progression risk",* as well as a lack of trust in NHS services and health care treatment, which resulted in *"reluctance to seek care on a timely basis and late presentation with disease"*. Strategies to create workplaces which empower BAME staff to raise concerns about occupational risk and safety, and which worked with local communities to rebuild trust in using health services, were considered essential.

39. The report set out a number of stakeholder requests (pp 8-11; 48-51). These include:

39.1. improving data recording of faith and ethnicity;

39.2. increasing community participatory research;

39.3. ensuring that education and prevention campaigns guidance and media are *"culturally appropriate and available in different languages"*;

39.4. accelerating the development of *"culturally competent occupational risk assessment tools"* to reduce the risk of employees' exposure to and acquisition of Covid-19;

39.5. ensuring that Covid-19 recovery strategies actively reduce inequalities caused by the wider determinants of health; and

39.6. reviewing and identifying changes to be made to policy and guidance as lockdown measures are relaxed (including guidance on shielding, PPE, testing, and guidance to employers and employees) in response to the

evidence on the disproportionate impact of COVID-19 on BAME communities.

40. The report emphasises the *"deep concern and anxiety"* expressed that *"if lessons are not learnt from this initial phase of the epidemic, future waves of the disease could again have severe and disproportionate impacts".*

Substantial risk of a second wave of infections, and a need for urgent action

41. There are widespread concerns, as lockdown-easing measures are implemented in the UK, of the risk of an increase in infections and deaths during a second wave in infection later this year. The international scientific community has warned about the substantial risk of a second wave of Covid-19[16] and the WHO has advised that *"There is currently no evidence that people who have recovered from Covid-19 and have antibodies are protected from a second infection"*[17]. Scientific literature suggests that even where immunity develops from exposure to a virus, secondary waves can result in significant mortality amongst those who were not exposed to the primary wave.[18] Scientific data indicates that second and subsequent waves in a viral pandemic have increased severity than primary waves.[19]

42. There have been warnings of a substantial risk of a second wave of Covid-19 following the easing of lockdown over the summer[20], or later in the year, to coincide with the start of flu season[21].

43. There is, accordingly, an urgent need for timely investigation of the underlying causes of the disproportionate impact of Covid-19 on ethnic minorities, and the implementation of concrete actions to protect ethnic minority groups from an increased risk of death in the likely event of a second and subsequent wave of infection later this year.

44. As set out further below, our client seeks a commitment by the government to undertake an urgent inquiry over the next three months to investigate the root causes of the increased risk from Covid-19 to ethnic minority groups, and to ensure that concrete steps are taken promptly to protect ethnic minority groups from an increased risk of death from Covid-19 during a second or subsequent wave of infection.

[16] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30845-X/fulltext
[17] https://www.who.int/news-room/commentaries/detail/immunity-passports-in-the-context-of-Covid-19
[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5907814/
[19] https://www.ncbi.nlm.nih.gov/pubmed/29530388
[20] https://www.thetimes.co.uk/article/britain-must-be-ready-for-second-wave-of-coronavirus-leading-scientist-warns-jsvrlmchq
[21] https://www.washingtonpost.com/health/2020/04/21/coronavirus-secondwave-cdcdirector/

Easing of lockdown

45. Our client is extremely concerned that there has been no consideration of the impact of lockdown-easing measures on ethnic minority communities.

46. On 11 May 2020 the Prime Minister laid before Parliament a guidance document 'Our plan to rebuild: The UK Government's Covid-19 recovery strategy' (**"the Recovery Strategy report")**.[22] The report acknowledged the higher proportion of deaths amongst people from ethnic minority groups, stating that *"It is critical that the Government understands why this is occurring"* and explaining that this was the reason for launching the PHE Review (which, as set out above, has not carried out the investigation required to enable the government to understand the reasons for the disproportionate impact on ethnic minorities).

47. The Recovery Strategy report referred to the government's *"carefully planned timetable for lifting restrictions"*. This has included telling workers who cannot work from home to travel to work from 13 May 2020, with the government recognising that this would result in an increase in the use of public transport; a phased re-opening of schools in England from 1 June 2020; and the re-opening of non-essentials shops from 15 June 2020. There has, however, been no analysis on the impact of lifting lockdown restrictions on ethnic minority groups.

48. It is already known that certain ethnic groups are at increased risk of infection from Covid-19 on account of being over-represented in key worker roles, which carry a higher risk of exposure to the disease.

49. The Institute for Fiscal Studies (IFS) May 2020 report 'Are some ethnic groups more vulnerable to Covid-10 than others'?' reports that Pakistanis, black Africans and black Caribbeans are *"over-represented among key workers overall"* placing them at increased risk of infection (for example, a black African of working-age is 50% more likely to be a keyworker than a white British working-age person, with almost a third of the working age black African population employed in keyworker roles) (p 13).

50. Data available across various industries shows:

    50.1. Health and social care: The IFS reports that one in five black Africans of working age are employed in health and social care, and that black Africans of working-age are nearly three times as likely to be a health and social care worker than a white British working-age person. Black Africans make up 2.2% of the working-age population but account for 7% of nurses. Persons of

[22] https://www.gov.uk/government/publications/our-plan-to-rebuild-the-uk-governments-covid-19-recovery-strategy/our-plan-to-rebuild-the-uk-governments-covid-19-recovery-strategy#the-current-situation

Indian ethnicity make up only 3.2% of the working-age population, but over 14% of doctors (p 13). The PHE Stakeholder Engagement Report found that 40% of doctors, 20% of nurses, and 17% of social care workforce are from BAME groups, and that *"Often, BAME workers are in lower paid roles within the NHS, which mean that these roles cannot be done remotely"*[23]. One of the key findings from the PHE Stakeholder Engagement report was that *"[h]istoric racism"* at work may mean that BAME NHS staff are *"less likely to speak up when they have concerns about PPE or testing"*[24]. Some stakeholders reported that *"BAME front line workers were sometimes given substandard quality or inadequate PPE given the nature of their roles and the risk of exposure"*[25].

50.2. Elementary workers (including security guards, construction workers and cleaners): The ONS' 11 May 2020 report found that men working in "elementary occupations" had the highest rates of death from Covid-19. Of these, security guards and related occupations had the highest death rate, followed by process plant occupations and construction workers. The government's own statistics indicate that persons of Black ethnicity comprise 16% of all workers in this industry; persons of Asian, Indian, Pakistani and Bangladeshi ethnicity are also over-represented.[26] Guidance issued for construction workers on 11 May 2020[27] is, however, silent on ethnicity considerations.

50.3. Caring, leisure and other service occupations (including nursing assistants, care workers and ambulance drivers): the ONS' 11 May 2020 report found that this occupational group had the second highest rate of death for males, and a statistically significantly higher mortality rate for women. The government's statistics indicate that persons of Black ethnicity comprise 18% of all workers in this industry; persons of Asian, Indian, Pakistani and Bangladeshi ethnicity are also over-represented.[28]

50.4. Transport: In a report published on 11 May 2020[29], the ONS found that taxi drivers and chauffeurs, bus and coach drivers had *"raised rates of death*

[23] PHE Stakeholder Engagement report, p 22.
[24] Ibid, p 23.
[25] Ibid, p 33.
[26] https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/employment-by-occupation/latest#by-ethnicity-and-type-of-occupation – published on 15 May 2020
[27] https://assets.publishing.service.gov.uk/media/5eb961bfe90e070834b6675f/working-safely-during-covid-19-construction-outdoors-240520.pdf
[28] https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/employment-by-occupation/latest#by-ethnicity-and-type-of-occupation – published on 15 May 2020
[29] 'Coronavirus (Covid-19) related deaths by occupation, England and Wales: deaths registered up to and including 20 April 2020). The report did not include analysis of ethnicity within occupations.

involving Covid-19". Ethnic minority groups are known to be over-represented in this sector (for example, 30.5% of TfL's workforce identify as being of BAME ethnicity[30]; government figures which aggregate the date for the transport and communication sectors show that Pakistani and Bangladeshi workers comprise 17.8% of the workforce, Indian workers 17.7%, and Asian 16.1%[31]).

50.5. Education: very little research has been conducted into the risk to teachers and school support staff. Some research indicates that whilst children are far less likely to become infected, when they do, they carry as much viral load as an adult and pose a transmission risk.[32] According to a recent publication by UNISON, school support staff *"tend to be older, are disproportionately from the BAME community and come from more disadvantaged backgrounds".*[33]

51. To our client's knowledge, no Equality Impact Assessments have been produced in respect of the various lockdown-easing measures and their impact on ethnic minority groups:

51.1. On ethnic minority communities in general, taking account factors already known to be relevant such as:

51.1.1. overcrowded housing (e.g. in London, 30% of Bangladeshi households, 16% of Black African households, and 18% of Pakistani households have more residents than rooms, compared with only 2% of white British households[34]);

51.1.2. intergenerational housing (Bangladeshi, Indian and Chinese households are particularly likely to have family members over 65 years living with children under 16 years[35]);

51.1.3. deprivation (*"individuals in the most deprived quintiles are nearly twice as likely to be admitted to ICU as the least deprived"*[36]);

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https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/latest

[30] http://content.tfl.gov.uk/tfl-ethnicity-pay-gap-summary-report-2019.pdf

[31] https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/employment-by-sector/latest#by-ethnicity

[32] https://www.theguardian.com/world/2020/may/17/scientists-divided-over-coronavirus-risk-to-children-if-schools-reopen

[33] https://www.unison.org.uk/news/press-release/2020/05/support-staff-little-confidence-government-school-safety-plans-says-unison/

[34] PHE Stakeholder Engagement report, p 21.

[35] Ibid.

[36] Ibid, p 22.

51.1.4. differential economic impact of Covid-19 on financial security: for example PHE found that *"Pakistani and Bangladeshi households were most likely to have men working in a 'shut-down' sector (restaurant work, taxi driving) as well as having a partner not currently in the labour market"* and *"the proportion of Black African and Black Caribbean households with dependent children and lone parents is high when compared to other groups; this may lead to difficulty arranging childcare in order to become economically active"* [37], that *"the measures to control the spread of Covid-19 across the country may have led to further economic or housing instability"*[38], and that adequate financial support is key to ensuring that *"people who should be shielding or isolating for their own and others' health are not forced to work by economic necessity"*[39])

51.1.5. increased use of public transportation to travel to work, resulting in additional routes of exposure[40];

51.1.6. an increased prevalence of Covid co-morbidities (with a *"higher incident of chronic diseases and multiple long-term conditions… occurring at younger ages"*[41]);

51.1.7. prior poor experience of healthcare services and treatment and *"a culturally insensitive health service"*, which *"may mean that they are less likely to seek care when needed"*[42]. The PHE Stakeholder Engagement report reported that *"Some BAME communities feel that they receive different treatment when compared with white patients – this has further exacerbated fear within BAME communities and reluctance to seek medical care"*[43].

51.2. Within specific industries (including those identified above) which carry a high risk of exposure to Covid-19, and in which ethnic minority groups are over-represented.

51.3. With respect to the impact of the government's test and trace strategy, a key safeguard in controlling the pandemic and enabling the easing of lockdown, on ethnic minority communities.

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[37] Ibid.
[38] Ibid, pp 23-24.
[39] Ibid, p 32.
[40] Ibid, p 22; see also p 31.
[41] Ibid, p 7.
[42] Ibid, p 23.
[43] Ibid, p 36.

Legal obligations

Public sector equality duty

52. Section 149 of the Equality Act 2010 sets out the Public Sector Equality Duty ("PSED"). It provides that:

> *(1) A public authority must, in the exercise of its functions, have due regard to the need to –*
> *(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
> *(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
> *(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

53. *"Advancing equality"* means having due regard, in particular, to the need to:

(a) *"remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic"* (s 149(3)(a));
(b) *"take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it"* (s 149(3)(b));
(c) *"encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low"* (s 149(3)(c)).

54. The following well-established principles apply to the PSED:

(i) where a decision affects *"large number of vulnerable people, many of whom fall within one or more of the protected groups… the due regard necessary is very high"* (*R (Hajrula) v London Councils* [2011] EWHC 448 (Admin) §62);

(ii) the duty is on the Minister or the decision-maker personally; *"[w]hat matters is what he or she took into account and what he or she knew"; "the Minister or decision maker cannot be taken to know what his or her officials know or what may have been in the minds of officials in proffering their advice"* (*Bracking v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345 §26(3));

(iii) an *"important evidential element in the demonstration of the discharge of the duty is the recording of the steps taken by the decision maker in seeking to meet the statutory requirements"* (*Bracking* §26(2));

(iv) the PSED imposes a duty to assess the risk and extent of any adverse impact of those affected by a policy and the ways in which such risk might be eliminated or mitigated *before* adopting the policy (*Bracking* §26(4)). The PSED must be complied with *"not as a rearguard action following a concluded decision but as an essential preliminary to any such decision. Inattention to it is both unlawful and bad government"* (*R (BAPIO) v SSHD* [2007] EWCA Civ 1139 §3);

(v) the PSED imposes a duty to inquire properly into and appreciate the full impact of the policy. If the relevant material, required in order for a public authority to be properly informed before taking a decision, is not available, *"there will be a duty to acquire it and this will frequently mean that some further consultation with appropriate groups is required"* (*Bracking* §26(4), 26(8) and *R (Hurley & Moore) v Secretary of State for Business, Innovation and Skills* [2012] EWHC 201 (Admin) §89-90).

55. Compliance with the PSED imposes a number of obligations on decision-makers, which include:

55.1. Investigating the underlying reasons for the disproportionate impact of Covid-19 on ethnic minority communities to date, to ensure that going forward, as lockdown restrictions are lifted, or in the event of a second wave, ethnic minority communities do not continue to suffer at an increased rate;

55.2. Rigorously analysing, <u>prior</u> to the implementation of specific lockdown-easing measures, the potential impact of such measures on the statutory equality objectives.

56. It is clear from the government's handling of the Covid-19 pandemic that there has been little if any regard to the impact on ethnic minority groups or the needs of particularly vulnerable people within ethnic minority communities (e.g. the elderly). For example:

56.1. Most of the government advice issued during the pandemic has not been translated into other languages (notwithstanding the government being aware that a significant proportion of people in certain ethnic minority groups do not speak English well or at all, and that this is much higher amongst elderly

people[44])[45]: e.g. the 'Stay at home: guidance for households with possible or confirmed coronavirus infection' is only available in English, the 'Guidance for households with grandparents, parents and children living together where someone is at increased risk or has possible or confirmed coronavirus infection' is only available in English[46] (notwithstanding that it is known that multi-generational households are common amongst certain ethnic minority groups); the 'Guidance on shielding and protecting people who are clinically extremely vulnerable from Covid-19' is only available in English, as is the 'Guidance for young people and shielding and protecting people most likely to become unwell if they catch coronavirus'[47].

56.2. None of the government's daily media briefings, which have been crucial for informing the public about the government's understanding of the disease, its modes of transmission and progression throughout the country, and what the public should be doing to protect themselves, have been translated into any other languages.

56.3. The PHE review which contains information about the striking disparities in risk from Covid-19 has not been translated into the languages of the communities most affected.

56.4. Employers have not been advised of considerations relating to ethnic minority staff which should be taken into account when implementing return-to-work procedures.

57. The same lack of regard to the impact on ethnic minority communities can be seen with the government's test and trace strategy, which is intended to be a crucial safeguard in controlling the pandemic and enabling the easing of lockdown. For example:

57.1. No provision has been made to provide individuals who have tested positive for Covid-19 and who are required to self-isolate for at least a fortnight, with

[44] https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/english-language-skills/latest#full-page-history

[45] The PHE Stakeholder Engagement Report specifically highlighted that *"Covid-19 communications and their method of cascade were not always appropriate for all BAME groups"*, and of the importance in translating communication materials into different languages as well as improving community participatory engagement *"recognising the central role that faith plays in many BAME groups"* (pp 37-8).

[46] https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance

[47] https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19

alternative accommodation[48], as a means of protecting elderly relatives or others living in overcrowded households.

57.2. No provision has been made for financial support for individuals who are required to self-isolate for a fortnight (either on account of having tested positive for Covid-19, having a member of their household who has tested positive, or having otherwise come into contact with a person who has tested positive). No consideration has been given to the economic consequences for persons unable to work from home, who are in self-employment or on zero-hour contracts, of being required to self-isolate for two weeks, or to the financial impact if an entire family are unable to work on account of being required to self-isolate.

58. This failure by the government to have due regard to the needs of ethnic minority groups during the Covid lockdown has put lives at risk, and will continue to do so going forward as restrictions are lifted unless these issues are properly investigated and lessons learnt.

59. To our knowledge, no Equality Impact Assessments (EIAs) have been undertaken in respect of lockdown easing measures implemented from 13 May 2020 onwards, or in respect of the test and trace programme which is being rolled out, and we consider that the government is in breach of the PSED.

60. Our clients seek an explanation of whether any assessments have been undertaken of the impact of lockdown-easing measures implemented from 13 May 2020 onwards, and on the impact of the test and trace programme, on ethnic minority communities, and disclosure of any such documents.

61. In particular, our clients request disclosure of any EIAs produced to address the impact of lockdown-easing measures on ethnic minority people working specific industries, including in Health and Social Care; Elementary occupations; Caring, Leisure and other service occupations; Transport and Education. As set out above, information already in the public domain indicates both that ethnic minority workers are over-represented in these industries, and at increased risk from Covid-19.

62. Our clients also seek disclosure of any EIAs undertaken in respect of the impact of specific lockdown-easing measures within the government's *"carefully planned timetable for lifting restrictions"* (e.g. the policy to advise workers who cannot work

[48] As per the recommendation of the World Health Organisation in their interim guidance, '*Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts'* dated 17 March 2020: https://apps.who.int/iris/handle/10665/331473, and of Independent Sage in their report '*Towards an Integrated Find, Test, Trace, Isolate, Support (FTTIS) response to the Pandemic'*, dated 9 June 2020: https://www.independentsage.org/wp-content/uploads/2020/06/IndependentSAGE-report-4.pdf

from home to travel to work from 13 May 2020; the phased re-opening of schools in England from 1 June 2020; the re-opening of non-essentials shops from 15 June 2020, etc).

Article 2 ECHR

63. Article 2 ECHR, as well as imposing a negative duty not to take life, also imposes positive duties on the State to protect persons from life-threatening risks. These positive obligations include:

63.1. A systems duty: a duty to devise and apply appropriate systems for the identification of persons in need of protection and the protection of life.

63.2. An operational duty: a duty to take specific steps to protect life when there is a "real and immediate" risk of death or serious injury to an identifiable individual or group of individuals of which the State is or ought to be aware.

63.3. An information duty: a duty to provide accurate and adequate information to persons exposed to particular risks, including occupational risks, to enable them to assess the risks and provide informed consent, or refuse to take those risks.

63.4. An investigative duty: a duty of effective investigation where there is an arguable case that there has been a breach of one or both of the systems or operational duties.

64. The 'arguable' threshold, which triggers the investigative duty, is a low one: it is *"anything more than 'fanciful'"* (R (*Palmer) v HM Coroner for the Count of Worcestershire)* [2011] Med LR 397 §60. It arises not only where death has occurred, but also where serious or life-threatening illness has been suffered.

65. Minimum requirements must be met for an Article 2-compliant investigation (*Palmer* §61):

> *"(a) the authorities must act of their own motion;*
>
> *(b) the investigation must be independent;*
>
> *(c) the investigation must be effective in the sense that it must be conducted in a manner that does not undermine its ability to reach the relevant facts;*
>
> *(d) the investigation must be reasonably prompt;*
>
> *(e) there must be a 'sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well*

as in theory; the degree of public scrutiny required may well vary from case to case'....;

(f) there must be involvement of the next of kin 'to the extent necessary to safeguard his or her legitimate interests'....".

66. The purpose of such an investigation is *"to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others" (R (Amin v SSHD)* [2004] 1 AC 653 (HL) §31).

67. It is submitted that it is at least arguable that the deaths and serious illnesses of a disproportionate number of individuals from ethnic minority communities were contributed to by breaches of the State's substantive Article 2 systems, information or operational duties. Accordingly, the government has a duty to commission an independent investigation in the disproportionate impact of Covid-19 on ethnic minority communities.

68. Our clients recognise that a broad public inquiry which effectively investigates and addresses all of the relevant causes of health disparities between ethnic groups in the UK, and the disproportionate impact of Covid-19 on ethnic minority communities in terms of (i) the increased deaths, (ii) the economic impact of lockdown measures, and (iii) the impact of lockdown-easing measures, may necessitate a longer-term investigation, and that this may sit within a broader public inquiry which addresses all aspects of the government's response to Covid-19.

69. However, given the substantial risk of a second or subsequent wave of the pandemic in the imminent future, it is imperative that prompt action is taken in the short term, which includes identifying the underlying causes of the disproportionate number of deaths of ethnic minority people from Covid-19 so that concrete steps can be taken to prevent further deaths and serious illness. Article 14 ECHR, which prohibits discrimination (read with Article 2 ECHR) requires specific analysis of the disproportionate impact of Covid-19 on ethnic minority communities as part of any broader inquiry.

70. Accordingly, our clients seek the following:

    70.1. A commitment to undertake an urgent, independent inquiry over the next three months to (i) investigate the root causes of the increased risk from Covid-19 to ethnic minority groups, and (ii) to ensure that concrete steps are

taken promptly to protect ethnic minority groups from an increased risk of death from Covid-19 during a second or subsequent wave of infection.

70.2. A commitment from the government to undertake a longer-term, independent public inquiry into the disproportionate impact of Covid-19 on ethnic minority communities, investigating both the increased deaths amongst ethnic minority groups, the relevant causes of health disparities between ethnic groups in the UK, and the disproportionate economic impact of lockdown measures on ethnic minority groups.[49]

Action required

71. As set out in further detail above, our clients seek the following:

71.1. An explanation of whether any EIAs have been undertaken to assess the impact of lockdown-easing measures implemented from 13 May 2020 onwards on ethnic minority communities, and disclosure of any such documents. In particular, our clients request the immediate disclosure of:

71.1.1. all EIAs produced to address the impact of lockdown-easing measures, implemented from 13 May 2020 onwards, on ethnic minority communities;

71.1.2. all EIAs produced to address the impact of the test and trace programme on ethnic minority communities;

71.1.3. all EIAs produced specifically to address the impact of lockdown-easing measures on ethnic minority workers in the following industries:

(i) Health and social care;
(ii) Elementary workers (including security guards, construction workers and cleaners);
(iii) Caring, leisure and other service occupations;
(iv) Transport;
(v) Education.

71.2. A commitment to undertake an urgent, independent inquiry over the next three months to (i) investigate the root causes of the increased risk from

[49] A House of Commons Library briefing paper 'Coronavirus: Impact on the labour market' dated 5 June 2020 (No 8898) found that *"Shut down sectors have a higher than average proportion of workers from a BAME… ethnic background"*, and that certain shut down sectors have an *"especially high" proportion of BAME workers (BAME workers comprising 28% of the vulnerable jobs in the transport sector, and 16% of vulnerable jobs in the accommodation food sector"* (p 12).

Covid-19 to ethnic minority groups, and (ii) to ensure that concrete steps are taken promptly to protect ethnic minority groups from an increased risk of death from Covid-19 during a second or subsequent wave of infection.

71.3. A commitment from the government to undertake a longer-term, independent public inquiry into the disproportionate impact of Covid-19 on ethnic minority communities, investigating both the increased deaths amongst ethnic minority groups, the relevant causes of health disparities between ethnic groups in the UK, and the disproportionate economic impact of lockdown measures on ethnic minority groups.

Timeframe for response

72. We seek a response to this letter by 4pm on Thursday 25 June 2020, failing which our client reserves the right to initiate judicial review proceedings.

73. We consider that a truncated response period is appropriate in the present case, on account of the urgent need to effectively investigate and protect the lives of ethnic minority groups, given the substantial risk of a second wave of infection as lockdown restrictions are lifted. We also consider that a response to our request for disclosure of any Equality Impact Assessments already prepared can reasonably be provided within a 7 day period: either these documents exist, or they do not.

Reference / address for future correspondence

74. Tessa Gregory and Lucy Cadd of Leigh Day. Please respond to this letter using the contact details and reference supplied in the letterhead of this letter.

Yours sincerely,

Leigh Day

Leigh Day