

**West Midlands Inquiry into
COVID-19 Fatalities
in the BAME Community**

August 2020

Taskforce: Terms of Reference

Background

The COVID-19 BAME Evidence Gathering Taskforce was established on 2nd June 2020, to gather the evidence from our community to substantiate our call for a proper public inquiry. Inspired by Cllr Paulette Hamilton and Baroness Lawrence, we aim to gather the evidence that government sought to avoid.

The Taskforce has been led by a number of community leaders who stepped up to help get the job done, gathering witnesses, listening to some of the most harrowing evidence we have heard during our time in public life – and bring together a plan for change. From the agony of loss that our communities have experienced, after all the sacrifice and pain, change must come. We cannot have another report that simply sits on a shelf gathering dust.

The Taskforce members were Khalid Mahmood MP, Taiwo Owetami MP, Councillor Paulette Hamilton, Councillor Aftab Nawaz, Councillor Sandra Samuels OBE, Councillor Mohammed Yaseen, Gurinder Singh Josan CBE and Rt Hon Liam Byrne MP.

Crucially, we want to challenge the government on the actions and lessons it will now draw in the light of our evidence to prevent another tragedy.

While this inquiry has been established by Liam Byrne MP, the Shadow Mayor of the West Midlands and is drawing on the expertise of the BAME leadership within the Labour Party, it is not intended as a party-political activity.

The purpose of the Taskforce is to create a clear picture of the impact on COVID-19 on our BAME communities in our region, to gather testimony about *why* the impact has been disproportionate and to develop recommendations for safeguarding our communities for the future – for both the short and long term. We want both the stories of lived experience, as well as the statistics. In particular our goal is to contribute significantly to the evidence gathering and recommendations of Baroness Doreen Lawrence's review – and substantiate the calls for proper public inquiry.

At the outset, we identified eight key lines of enquiry:

1. Understanding the science of COVID-19's differential impact
2. Inadequate delivery of public services, in general, and preventative public health services in particular
3. The disproportionate impact of austerity on BAME communities
4. Institutional barriers that impair BAME communities access to public services in general, and health services in particular
5. The inadequacy of appropriate data, data collection and measurements for monitoring impact of COVID-19 on BAME communities
6. Risks and protections for frontline workers, working at all levels
7. The inadequacy of risk assessments and monitoring
8. The debt of risks to socio-economic and immense disparities

Taskforce Co-Chairs



Liam Byrne MP
Shadow Mayor for West Mids
MP for Birmingham, Hodge Hill



Cllr Paulette Hamilton
Cabinet Member for Health
and Social Care, Birmingham



Khalid Mahmood MP
Shadow Defence Minister
MP for Birmingham, Perry Barr



Cllr Aftab Nawaz
Leader of the Labour Group
Walsall Council



Taiwo Owatemi MP
MP for Coventry North West
Former NHS pharmacist



Cllr Sandra Samuels OBE
Councillor for Ettingshall,
Wolverhampton Council



Gurinder Singh Josan CBE
Hope not Hate, Council member
of Socialist Health Association



Cllr Mohammed Yaseen
Councillor for Tipton Green,
Sandwell Council

1. Fear

Fear was a deterrent to many asking for help. Fear of inequitable treatment, fear the NHS wouldn't listen, fear of conspiracy theories.

2. Overwhelmed

The BAME community felt overwhelmed by an NHS and care services that were overwhelmed.

4. Voiceless

BAME families weren't heard in the NHS on visiting rights, condition updates and Do Not Resuscitate plans. Many had to "pull strings" to visit dying loved ones

6. Grief

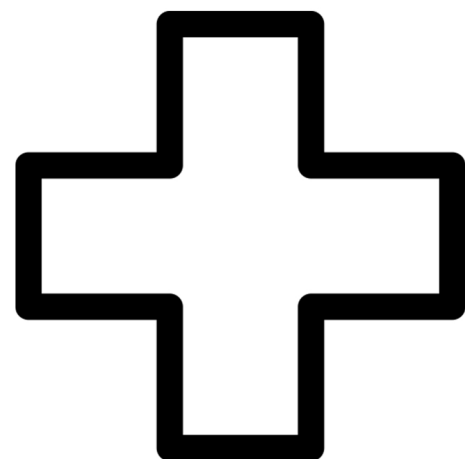
Disruption to traditions for grieving have created significant mental health risks.

8. Data

Data to track the impact of COVID is unavailable, particularly ethnicity coding in death certificates.

9. Strategy

A clear strategy on the impact of COVID on the BAME community has not been communicated.



**"THIS IS
MEDICAL
EMERGENCY"**

Ten key findings

humbled
community experienced
system that was

3. Communication
Public health messages were poorly
communicated to BAME
communities leaving misinformation
to circulate.

3 A
AL
GENCY..."
s from the report

5. Underfunded
Groups working for long term health
conditions have been chronically
underfunded and could have
disseminated health messages.

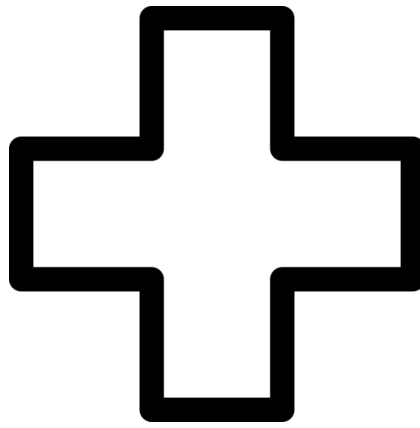
7. PPE
BAME frontline workers reported
inadequate PPE, sometimes
having to make it themselves.

gy
n the impact of
E community has
cated effectively

10. Change
Confidence that change will come
is low to non-existent. That's why
an action plan is vital



Executive Summary



Executive Summary

Our BAME communities were disproportionately hit hardest by the COVID-19 pandemic. Arguably a situation could have been avoided. We therefore agree with the judgement made by our regional NHS Medical Director that the disproportionate impact of COVID-19 on the BAME community 'is not just an equality, diversity and inclusion issue – ***it is an urgent medical emergency***'.

Men and women in the black community have been over four times more likely to die from COVID-19 than white people (4.2 and 4.3 times respectively). Men of Bangladeshi and Pakistani origin were 3.6 times more likely to have a COVID-19 related death, while the figure for women was 3.4 times more likely. As a result, this may now accelerate the trend already identified by Professor Sir Michael Marmot, that in the poorest communities, improvements in life expectancy may now have come to a temporary halt.

A perfect storm of factors meant our BAME community was hit hardest.

Chronic disease unfortunately is higher and stubbornly persistent in our BAME community, exacerbating health inequalities. BAME individuals are less likely to use GP services and therefore more likely to report poor general health than the white British population. The failure to protect key workers exacerbated the risk to the BAME community because they make up a disproportionate number of key workers, especially in the NHS and care sector, care agencies, transport including bus and taxi workers and the hospitality industry. The risk was especially high for BAME health workers with around 6 in 10 UK health workers killed by COVID-19 were from the BAME community. Inequalities in income also exacerbated the risk from COVID-19 still further.

Yet, despite these inequalities, we are working without the data, or the resources we need.

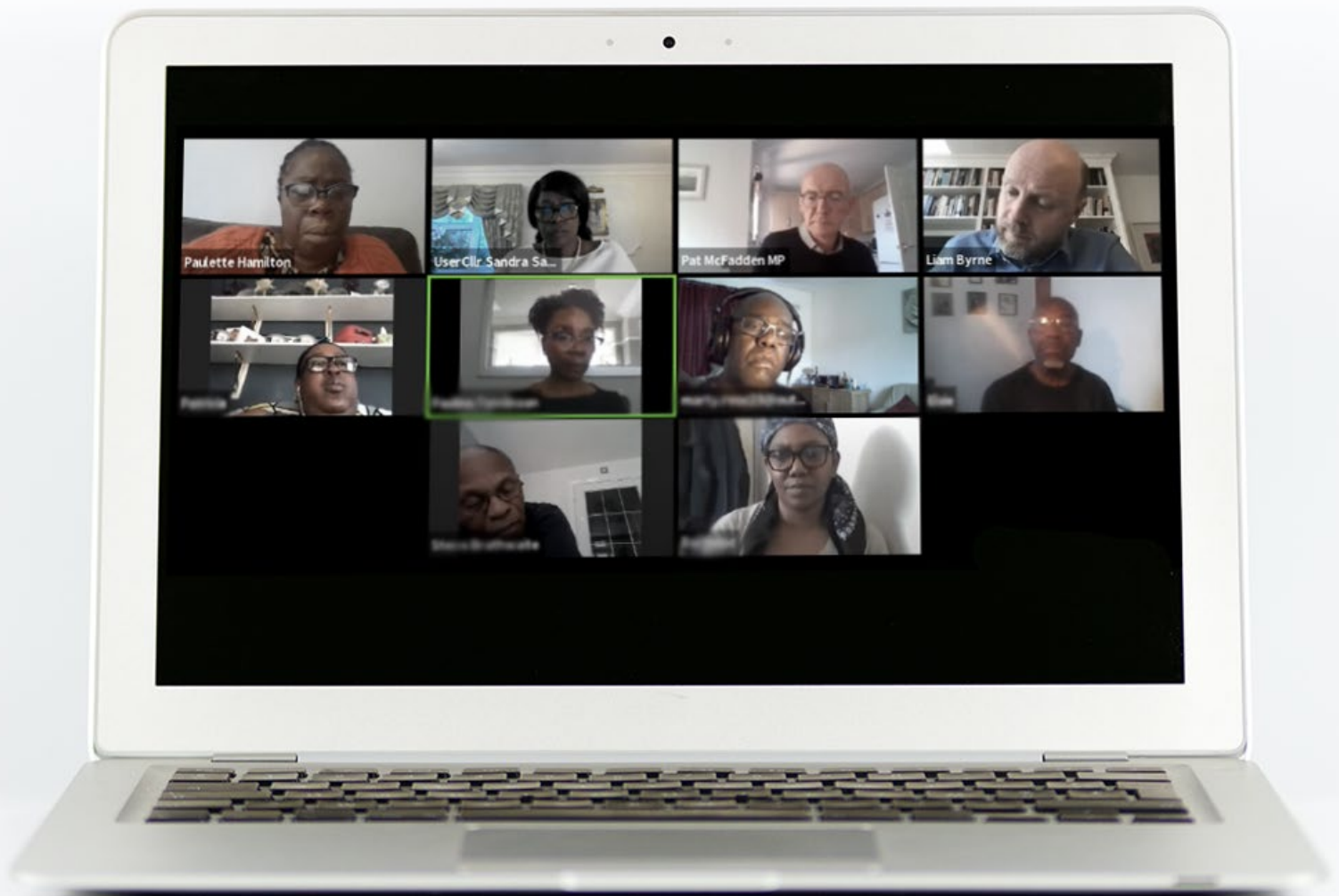
Ethnicity is not collected on death certificates as it has been in Scotland for ten years and the Government's testing strategy has so far failed to mention the increased risk to BAME individuals. The data capture system is inadequate to the extent that one local borough Sandwell, has had to create its own track and trace system.

Worse, across our region the most diverse areas have suffered the biggest cuts in public health funding. The three most diverse boroughs in the West Midlands are Birmingham, Wolverhampton, and Sandwell have suffered cuts to public health budgets in the last five years, of 9%, 8% and 15% respectively. The sheer scale of these cuts is well in excess of the English average cuts to public health budgets of 5%. As one of our Public Health Directors put to us, 'Public Health needs clear sustainable funding, the grant is not yet assured for April and we need to stop rocking back and forth on funding elements.'

In a series of devastating hearings, we heard first hand from those in our BAME community who lost loved ones to COVID-19

We cannot thank our frontline NHS staff enough for how they helped our community. The testimony we have heard has been heart-breaking. We have heard from a wide range of people in our BAME community, including:

- a 35-year-old new mum who died after childbirth, never having the chance to hold her newborn son
- a pastor's wife who lost first her husband and then her best friend while battling the virus herself in hospital. Married since 16, she found out her husband had 24-48 hours to live by text message. She then learned the pastor due to conduct her husband's funeral had also died.
- a son who said goodbye to his dad via WhatsApp while a doctor sat stroking his dad's hand and holding him close "as if he was his own"



Ten key observations from the testimony we heard are striking:

1. Fear of inequitable treatment that might be received in the NHS was a deterrent for many in the BAME asking for help quickly enough. Too many therefore ‘suffered in silence’ for too long before asking for help. The BAME community were not confident that the NHS was a system where their voice would be heard when concerns about treatment were raised. This fear compounded the stigma that began to grow among the BAME community, which contributed to conspiracy theories and the wish of some families to suppress the label of COVID-19 on death certificates.
2. Our BAME community experienced an NHS and care system that was overwhelmed, despite the heroism of our frontline NHS workers, many of whom were themselves from the BAME community. Non COVID-19 patients found themselves on COVID-19 wards without adequate protection. Many experienced long delays getting through on 111 and families found they had little to no proactive information sharing about their loved ones’ condition;
3. Despite the extraordinary efforts of our public health directors, public health messages about symptoms or what to do when in need were poorly communicated by Government to our BAME communities and this created the space for rumour, misinformation and misperception of risk factors to circulate creating significant additional risks.
4. The voice of the BAME community has simply not been heard in the way our health services are designed and delivered. This had a critical bearing on the way families were treated when loved ones were admitted to hospital or lost their lives. Many felt there were failings in the way information was communicated to them, the way visiting rights were organised, the way information about a loved ones’ conditions was shared and the way decisions like ‘Do Not Resuscitate’ plans were formed. Many also reported having to ‘pull strings’ to visit loved ones who were dying.
5. The disruption to the traditions and process for grieving has created significant mental health risks, which cannot be ignored and support urgently needs to be provided.
6. Many of the groups that worked with people with long-term health conditions have been underfunded for years and were simply not used when they could have played a critical role in disseminating public health messages. Given the higher prevalence of long-term health conditions in the BAME community, this is a critical gap
7. Many BAME frontline workers had direct experience of inadequate provision of PPE with some having to make protective equipment themselves. In addition to this they had to deal with inadequate risk assessments that arrived late in the crisis
8. The data we need to track the impact of the pandemic is not available, such as ethnicity recording on death certificates, for example. This will hamper our ability to track patterns and take preventative steps to safeguard our community in the future
9. A clear strategy for understanding the scientific evidence for the disproportionate impact of COVID-19 on the BAME community has not been communicated effectively. This is unacceptable and is hampering effective public health communication
10. Confidence that lessons will be learned and change will come about is low to non-existent. Our BAME community has felt excluded from the governance of the health and social care system for years and they have little confidence change will be delivered. What is sought therefore is not a traditional report, but an action plan.



A Plan for Action

Our 35 recommendations

A Plan for Action

There is a widespread acceptance that systemic discrimination in our health and public systems has costs lives. Dr Jennifer Dixon, of the Health Foundation has said, 'COVID-19 is having a disproportionate and detrimental impact, and discrimination is a key factor. Black and minority ethnic communities have spoken out loudly and articulately in this report and say discrimination is amongst the fundamental causes of ill-health. They should be listened to¹.

The truth is that the Government has commissioned many reviews into race inequalities – but acted on very little. The Windrush Lessons Learned Review (March 2020), the Race Disparity Audit, (October 2017), the Lammy Review, (September 2017), and the McGregor –Smith Review, (February 2017) have all produced.

We therefore recommend:

To Ministers

1. The Government should commence a formal judge-led independent public inquiry into the COVID-19 fatalities in the BAME community and consult with BAME communities on both the Chair and the Terms of Reference.
2. The Government must bring forward methods to ensure death certificates record ethnicity data, as has been the norm in Scotland for ten years.
3. Local Public Health Directors must be given full access to track and trace data down to household level along with ethnicity data to ensure they are able to react instantly to a rise in COVID-19 infections. The Government must ensure ethnicity is a factor in devising testing priority and frequency plans.
4. Government should provide emergency extra resource to reinvest and ensure that cuts to public health budgets, which have disproportionately affected BAME communities, can be reversed to take account of health inequalities and diversity. This budget should be based on a proper assessment of health inequalities and reducing health inequalities should be a statutory obligation, in order to protect funding. This should be confirmed at stable levels for the next three years as a matter of urgency. Programmes to recruit 'health champions', such as the pilot in Newham, need to be put in place to assist public health directors to communicate effectively.
5. Due to the Government's mixed messages, Ministers now need to tackle the trust deficit in many communities, given the neglect and hurt many now feel. Ministers need to bring forward a strategy for co-producing this with communities through local councils and organisations in a more meaningful way. Furthermore, the group most affected (reflected in the PHE Report to Government) are the over 80s, so we must ensure access to information is not only in a digital format.
6. This communications plan should include an explicit set of actions for ways to use community anchor institutions such as schools, churches, temples, mosques, as places and communities where messages can be shared, services delivered and action taken to improve health literacy.

¹ <https://www.health.org.uk/news-and-comment/news/discrimination-is-a-key-factor-behind-the-disproportionate-impact-on-bme-groups>

7. Ministers must now set out a proper strategy for ensuring that frontline workers especially in public services, the NHS, the care sector, care agency staff, the transport sector, including bus and taxi workers and the hospitality industry has support for risk assessment, access to PPE stocks needed to keep them safe. Delivery of this must be monitored to ensure it happens.
8. The Government should be asked to set out its target for investment in research and development into the high incidence of COVID-19 fatalities and the remedies required. To help coordinate this work the Government should establish a research and development unit focused on ethnicity at both regional level with the Mayor and in the Cabinet Office.
9. Members of the House of Commons Health Select Committee, and Science and Technology Select Committees should be asked to scrutinise this research plan over the next six months and thereafter on an annual basis, and set out whether they believe it is adequate.
10. The region's universities should be asked to bring forward research proposals to help lead this work.
11. Public Health England needs to consider the distinct experience of COVID-19 symptoms amongst ethnic minority communities and consider adding 'aching across the body' to be added immediately to the key signs and symptoms which should trigger testing.

To Members of Parliament

12. Our Members of Parliament should be asked to seek debates to present this report to the House of Commons, to seek meetings with ministers to present the conclusions and to table the report with the House of Commons Health and Care Select Committee
13. MP's should commission the Parliamentary Office of Science and Technology to undertake a peer-reviewed assessment summarising what is known about why fatalities in the BAME community is so much higher than national averages.



To the Mayor of the West Midlands

14. The Metro-Mayor should provide vocal, visible leadership, listening to the frontline experience of communities, articulating public health messages and crucially, fighting for the changes required in Government policies as set out in this report.
15. The Metro-Mayor should lead in the task of holding the Government to account for its resourcing of the work tackling health inequalities in the region and should lead on seeking the resources and powers we need to tackle health inequalities.
16. The Metro-Mayor should set out, on the basis of the powers he already has, how he will use those powers to reduce health inequalities

To the NHS and social care system

17. Power and governance structures within the health system have to change. We would like a plan for this from NHS organisations within three months. We believe the right ambition is for us to ensure we have a health and care system leadership that reflects the diversity of the community it serves within the 12–18 months.
18. The Board of every NHS organisation in the region should set out a plan of action for the next 12 months to (a) set targets for ensuring diversity amongst its senior management team and (b) a plan to deliver on these targets.
19. The NHS in the region should create a structured training and development programme for BAME staff seeking to develop their careers at a more senior level.
20. The NHS in our region together with the Clinical Commissioning Groups and public health directors should put the conclusions of this report – in particular action to tackle health inequalities at their core of their next Strategic Transformation Programmes. This should begin at once. In particular, we have to close the gaps in long term condition care and management. This means very strong quality improvement work in clinical commissioning groups and NHSE to close gaps identified in Quality and Outcomes Framework.
21. This work needs to focus in particular on long term health conditions like diabetes and sickle cell disease. Birmingham and the Black Country have the highest rate of diabetes in the country, so ending under-diagnosis and maximising referrals to the NHS Diabetes Prevention Programme is vital. Birmingham has the second highest prevalence of people suffering from Sickle Cell Disease with around 1,500 sufferers and an estimated 20,000 plus who are carriers. NHS England acknowledge that there are “inequities” in access to high quality SCD services, so SCD services should be reviewed against the national clinical quality standard to check any shortfalls in quality and resourcing of services.
22. There should be an emergency plan for mental health support for families, especially children in the BAME community that have suffered loss but who lost the chance to properly grieve. This should be put in place straight away. Clear information needs to be given about how to access bereavement services to offer support in a timely manner. A system must be put in place to follow up with bereaved families by signposting them to appropriate services that are easily accessed, delivered jointly run by NHS and local government. Joined up information from both the NHS and Local authority needs to be provided to families about how to access mental health services quickly. Extra funding should be put in place to reflect the demand we expect in the months ahead.
23. Directors of Public Health should lead a piece of work with funeral directors to develop a charter of safe and common practice to ensure safety and consistency in the way families are allowed to grieve with the loved ones they have lost.

24. Chief Executives of health organisations should immediately review the framework for communicating with patient's families to ensure they are treated with maximum compassion and *proactively* kept up to date with information about their loved ones. BAME communities need to be far more involved in helping define a gold standard of communication in different scenarios. The standards of what people can expect should be designed publicly and communicated publicly into a Charter for Patient's Families and Friends. Health Service leaders should be held to account through Select Committees for this work. The NHS should set out exactly what is needed to fund this adequately, and our MPs, our councillors and our Mayor should fight for this funding in Westminster.
25. Clear information in different languages that explain the testing process and explaining to families why they need to present at an earlier stage which is not confusing.
26. Over the next three months, the region's health system should review the best practice in end of life care which emerged for individuals with BAME communities and their families. Our Members of Parliament should ask the Health and Care Select Committee to specify a gold standard against which local NHS organisation in the region should be judged.
27. Third sector organisations have been vital but they are unable to continue without the proper funding required. We need an emergency plan to transform funding for third sector organisations working with those who (a) are diagnosed with chronic disease (b) advocate for patients for ethnic minority patients. This should come with a plan to hold organisations to account for effective delivery.
28. Local authorities played a vital role to ensure care settings were kept safe during the pandemic but it is important going forward that the funding of social care is addressed by government. Action to ensure effective integration between GPs, hospitals and care homes, to ensure that never again are patients with COVID-19 dispatched into care settings without the exchange of appropriate information and an appropriate plan for on-going care and a specification of safeguards needed to keep other care home residents and staff safe.
29. All NHS and social care institutions must complete risk assessments for their staff. Assessments should be made available for inspection by local scrutiny arrangements. A multi-agency approach should be taken under the auspices of the STPs across the region to ensure effective risk assessments of all BAME staff, and other vulnerable groups, are undertaken across the full range of health and social care settings. The Government must recognise and compensate for the economic impact on individuals where they are assessed as unable to work in particular settings.
30. The NHS and local authorities should should work with the national NHS Workforce Race Equality Standard (WRES) team to improve action to tackle workplace racism across the full range of health and social care settings. This collaborative working to ensure provision of an agreed standard of cross-cultural training for managers and staff, and the sharing and application of evidence based replicable good practices that will make a real difference to the experiences of BAME staff.
31. Where complaints are made against BAME staff, they should be supported by advocates in which staff have confidence to ensure fairness.
32. NHS and social care organisations must ensure they are operating to the highest levels of cultural competence. Cultural competency needs to go deeper than just equality training, and help professionals understand that 'BAME' is not a single homogeneous group. This this needs proper national leadership and consolidation of the evidence, for example through National Institutes of Minority Health, and universities working with the public health community.

To Health and Wellbeing Boards

33. Every Health and Wellbeing Board should ensure that all their members and specifically the NHS Clinical Commissioning Group have in place a stress test and equalities impact assessment to reflect how they can safeguard our BAME communities against a further resurgence of COVID-19.
34. Health and Wellbeing Boards should work with the region's universities to develop a way to improve delivery of preventative measures needed to safeguard our BAME communities from a future rise in COVID-19 infections or other pandemics.
35. The region's local authorities should update planning policy across the region to ensure that a public health strategy designed to address health inequalities is incorporated into the way home-building is permitted.





The Facts

The latest research on COVID-19

The Facts

ONS statistics show that African-Caribbean people are four times more likely to die from COVID-19 than the general population at large. For individuals with South Asia heritage, the rate of death is between twice and three times that of the general population.

As part of our work we commissioned submissions from the NHS system across the West Midlands. A response was provided on behalf of the NHS by Dr. Nigel Sturrock Regional Medical Director Midlands on Wednesday 10th June 2020. Dr Sturrock's evidence was blunt:

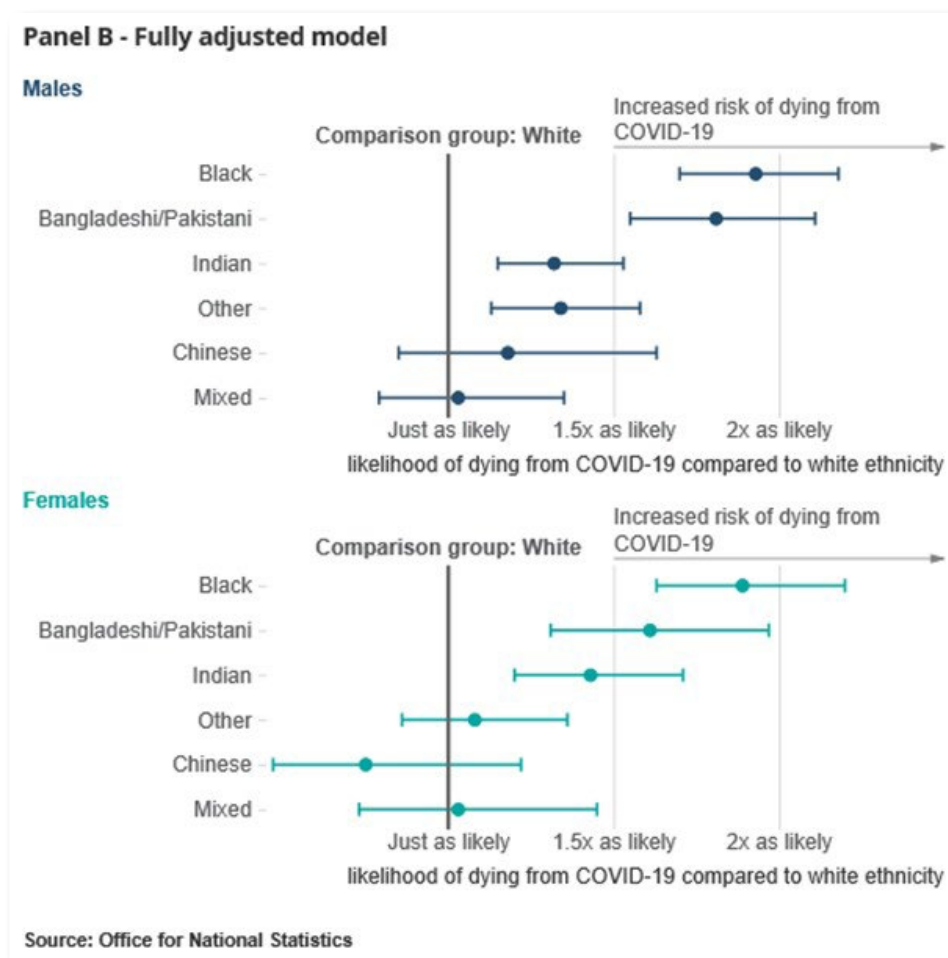
*'We now know there is evidence of disproportionate mortality and morbidity amongst Black, Asian and minority ethnic people, including our NHS staff, who have contracted Covid-19', and underlined that **'this is not just an equality, diversity and inclusion issue – it is an urgent medical emergency'**.*

Furthermore, Dr Sturrock confirmed:

- The Indian and particularly the Pakistani and Bangladeshi populations have an increased mortality risk from COVID-19 compared to the White population. It also confirms the high risk for the Black population
- The higher observed incidence and severity in minority groups may be associated with socioeconomic, cultural, or lifestyle factors, genetic predisposition, or pathophysiological differences in susceptibility or response to infection.
- Possible susceptibilities include an increased risk of admission for acute respiratory tract infections, an increased prevalence of Vitamin D deficiency, vaccination policies in countries of birth and immune effects of those born outside the UK, increased inflammatory burden, and higher prevalence of cardiovascular risk factors such as insulin resistance and obesity. Some of these are also risk factors for increased disease severity in COVID-19.
- In terms of the precautions and protections which are needed urgently, it is of paramount importance that NHS organisations support staff and continue to support those who are vulnerable.
- In particular, people living with diabetes face a significantly higher risk of dying with COVID-19 with a third of deaths in England associated with the condition, according to new NHS research. Professor Jonathan Valabhji, national clinical director for diabetes and obesity and lead author of the study has found the overall death rate for people with diabetes doubled during the early stage of the pandemic and that in both type 1 and type 2 diabetes, men, people of Black or Asian origin, and people living in more deprived communities, were at higher risk.

Furthermore, we solicited advice from Rt Hon Jacqui Smith, Chair of UHB Trust about when hospitals were required to COVID-19 test patients before discharge to care homes. The Rt Hon Jacqui Smith confirmed; 'The COVID-19 adult social care action plan was issued on Thursday 16th April. We received on Friday 17th. This document required us to test all discharges to care homes. We implemented on Monday 20th. An earlier COVID-19 national guidance document relating to care homes (including discharges) was circulated 2 weeks before and did not contain any such requirement.'

Dr Sturrock's evidence underlines the conclusions from a range of reports.



In summary, the findings to date have concluded:

- **Improvements in life expectancy may have halted.** Sir Michael Marmot has reported that growth in life expectancy was reported to have stalled for the first time in 100 years, and even reversed for the most deprived in society².
- **Our BAME community was hit hardest by COVID-19.**
 - Men and women in the black community are over four times (4.2 and 4.3 times respectively) as likely to die from COVID-19 than the white population. Men of Bangladeshi and Pakistani origin were 3.6 times more likely to have a COVID-19 related death, while the figure for women was 3.4 times more likely.
 - Birmingham Health and Wellbeing Board have been given evidence that in March, 64% of COVID-19 deaths in Birmingham City Hospital were from 'the Black African and Asian communities' and in April, the figure was 50%.
 - National Institute for Health Research (NIHR) confirms; 'The risk of death from COVID-19 is generally higher amongst black, asian and ethnic minority (BAME) communities than white British people.'
 - The Institute for Fiscal Studies reported, per-capita COVID-19 hospital deaths are highest among the Black Caribbean population and three times those of the white British majority. Some minority groups including the Pakistani community and Black Africans – have seen similar numbers of hospital deaths per capita to the population average, while

² <https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on>

Bangladeshi fatalities are lower

- After stripping out the role of age and geography,
 - Bangladeshi hospital fatalities are twice those of the white British group
 - Pakistani deaths are 2.9 times as high and black African deaths 3.7 times as high.
 - The Indian, black Caribbean and 'other white' ethnic groups also have excess fatalities
- The white Irish group the only one to have fewer fatalities than white British.
- Pregnant women from black and ethnic minority backgrounds were more likely to be admitted to hospital for COVID-19. This inequality persisted even when women from London, the West Midlands and the North West were excluded from the analysis, meaning the difference cannot be explained by higher rates of COVID-19 infection in those areas³.
- **A perfect storm of factors meant our BAME community was hit hardest.**
 - The NIHR argued the higher fatality rate in the BAME community appears to be due to a complex mixture of factors, and no one factor alone can explain all of the difference. Contributing factors include, in no particular order being poorer; where people live; overcrowded housing; types of job; other illnesses and access to health services'
 - Scientists for Labour underline the broad range of structural causes, concluding: 'It is clear that structural factors, such as discrimination in healthcare and education, play a substantial role, and manifest in a variety of different ways. These range from poorer healthcare literacy, to greater prevalence of underlying respiratory conditions from exposure to air pollution, to reduced access to public services'.
 - The University of Oxford and the London School of Hygiene and Tropical Medicine reported that people from Asian and black groups are at markedly increased risk of in-hospital death from COVID-19, and contrary to some prior speculation this is only partially attributable to pre-existing clinical risk factors or deprivation; further research into the drivers of this association is therefore urgently required.
- **In the West Midlands, the most diverse areas have suffered the biggest cuts in public health funding.** The three most diverse boroughs in the West Midlands are Birmingham, Wolverhampton, and Sandwell which have suffered cuts to public health budgets in the last five years, of 9%, 8% and 15% respectively. The sheer scale of these cuts is well in excess of the English average cuts to public health budgets of 5%. One of our public health directors put to us; 'Public Health needs clear sustainable funding, the grant is not yet assured for April and we need to stop rocking back and forth on funding elements'

³ <https://www.npeu.ox.ac.uk/news/1963-pregnant-women-are-not-at-greater-risk-of-severe-Covid-19-than-other-women-but-most-of-those-who-have-problems-are-in-their-third-trimester>

Local authority	Public health budgets (£ million)			COVID-19 deaths			Ethnicity
	2016/17	2020/21	% change	Number	Crude rate per 100,000 population (to 17 Jul)	Age-standardised rate per 100,000 (to 30 Jun)	
Birmingham	95.6	86.9	-9.1%	1216	106.5	146.9	42%
Wolverhampton	22.0	20.3	-8.0%	316	120.0	129.6	32%
Sandwell	29.8	25.2	-15.3%	369	112.3	140.2	30%
Coventry	23.8	23.8	+0.0%	284	76.4	105.2	26%
Walsall	19.0	18.2	-4.1%	387	135.6	145.3	21%
Solihull	11.8	11.6	-2.4%	277	128.0	108.3	11%
Dudley	23.5	22.3	-5.1%	311	96.7	93.0	10%
West Mids totals	225.6	208.3	7.7%	3160	110.8	124.1	24.6%

Source: House of Commons Library

- Health inequalities are widespread – and stubbornly persistent – in our BAME communities.** Recent studies show that several diseases are more prevalent in these communities (Bradford District Care NHS Foundation Trust, 2016) and that older BAME people suffer from poorer health outcomes as a result of these diseases, even after controlling for social and economic disadvantage (Evandrou et al., 2020). A study on ethnic inequalities in health in later life shows that health inequalities between ethnic groups are greatest in later life (Evandrou et al., 2020), which in turn increases the risk of COVID-19 to elderly BAME people.
- The Government's testing strategy has so far failed to mention the increased risk to BAME individuals.** Without widespread community testing it is hard to get a true picture of the risks and impacts of COVID-19, especially within vulnerable groups. Testing is especially important for BAME people, as they are more likely to work in crucial frontline roles and live in larger, multigenerational households where shielding and isolation are more difficult to maintain.
- BAME individuals are less likely to use GP services and generally more likely to report poor general health than the White British population.** Evandrou et al. noted that “the increasing ethnic inequalities in health with age in the UK could reflect the accumulation of risks over the life course and the long-term consequences of exposure to hazards (such as socio-economic disadvantage, poor healthcare experience and racial discrimination) in early life”; hazards which are exacerbated by structural racism.
- This underlines problems reported over a decade ago, in a report by the Department of Health and Social Care (2009) on the experiences of NHS patients from BAME groups. It reported that in general BAME groups are less likely than their White British counterparts to report a positive experience. Questions relating to ‘access and waiting’ and ‘better information and more choice’ had particularly negative responses from BAME individuals.
- Chronic disease is higher in our BAME community, exacerbating health inequalities.** Diabetes for instance, is a chronic disease in which the pancreas is no longer able to make insulin or use insulin properly to control blood sugar levels (International Diabetes Federation, 2020).
 - The IFS noted that at-risk underlying health conditions are especially prevalent among older Bangladeshis, Pakistanis and Black Caribbean communities. Compared with white

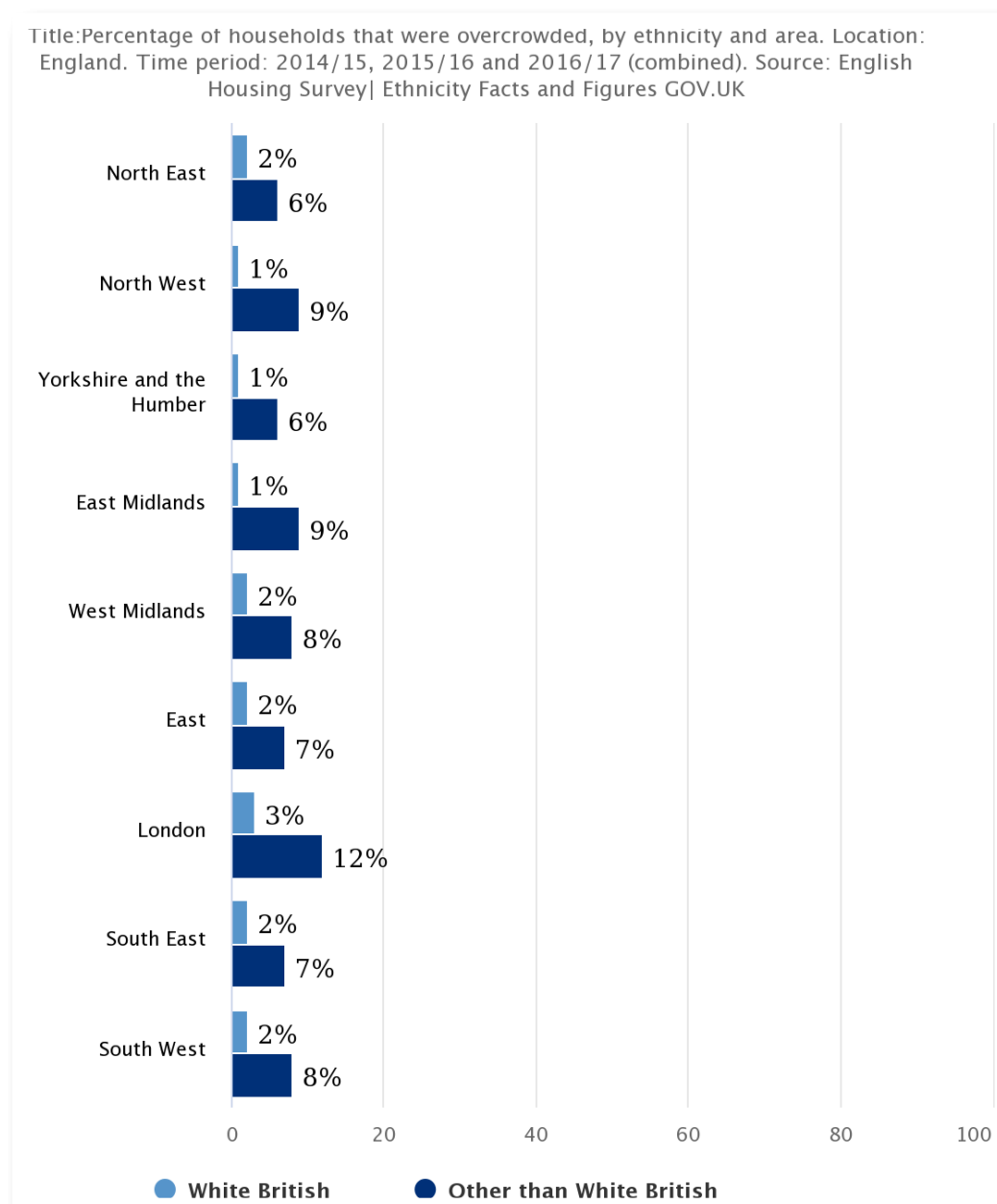
British individuals over 60 years of age, Bangladeshis are more than 60% more likely to have a long-term health condition that makes them particularly vulnerable to infection, which may explain excess fatalities in this group.

- There exists a significant inequality in the prevalence of diabetes on death records from COVID-19 patients. Diabetes was most likely to be mentioned in males aged 60–69 and was more prevalent in all BAME groups than in White patients: 43% for Asian patients in this age range, 45% in the Black patients, and only 18% in White patients.
- Type 2 diabetes is reported to be six times more likely in those of South Asian descent than in White Europeans, and up to five times more likely in people of African and Afro-Caribbean descent (Khunti et al, 2009).
- **The failure to protect key workers exacerbated the risk to the BAME community because the BAME community makes up a disproportionate number of key workers.** The Health Foundation revealed that black and minority ethnic groups make up a disproportionately large share of high risk ‘key workers’, particularly in cities where black and minority ethnic people are more likely to live. This risk was especially notable for those in jobs such as care workers, taxi drives, security guards, transport workers and shop workers. For example, in London, while black and Asian workers make up 34% of the general working population, they represent 54% of food retail workers, 48% of health and social care workers, and 44% of transport workers. The IFS also noted that ‘Occupational exposure may partially explain disproportionate deaths for some groups. Key workers are at higher risk of infection through the jobs they do. More than two in ten black African women of working age are employed in health and social care roles. Indian men are 150% more likely to work in health or social care roles than their white British counterparts. While the Indian ethnic group makes up 3% of the working-age population of England and Wales, they account for 14% of doctors’.
- **This risk was especially high for BAME Health Workers.** Six in 10 UK health workers who died from COVID-19 are BAME. Analysis by the Guardian newspaper shows 61% from ethnic minority background as total reaches 200. One in five NHS staff are BAME, according to the most recent figures.
 - The Health Service Journal noted, among all staff employed by the NHS, BAME account for approximately 21 per cent, including approximately 20 per cent among nursing and support staff and 44 per cent among medical staff. BAME individuals account for 63 per cent, 64 per cent and 95 per cent of deaths in the same staff groups. BAME patients also accounting for 34 per cent of the patients admitted to UK intensive care units with COVID-19 but only 17 per cent of the UK population.
 - With the early evidence of a disproportionate number of BAME staff dying from COVID-19, NHS Employers sent out guidance at the end of April on measures to mitigate the risk of COVID-19. A number of employers were slow in carrying out the necessary risk assessments on BAME staff. An ITN investigation in mid-June found that of the 80 Acute Hospitals Trusts contacted only 14 had completed risk assessments of all BAME staff. Only 15 Trusts could provide precise data for how many staff had been risk assessed, and completion rates ranged between 12% and 85%.
 - In response to the large numbers of BAME staff reporting that they were yet to have their risk assessments completed, on 24 June NHS England instructed all Trusts to ensure risk assessments were completed within 4 weeks, with summaries of reviews to be published.
 - The apparent failure of a large number of NHS Trusts to take swift and effective action to mitigate the risk to BAME staff from COVID-19 is further evidence that many NHS employers are still failing to tackle the systemic racism that exists across the NHS.

- There have however been examples of timely good practice, one being the urgent action taken by the Black Country and West Birmingham STP to risk assess all STP staff. The acute Trust, public health experts and Wolverhampton Council developed risk assessment tools accessible to every organization including those without access to occupational health services.
- This is in the context of evidence of **systemic challenges faced by BAME staff in the NHS**. The report by Public Health England in June *Beyond the data: Understanding the impact of COVID-19 on BAME groups* confirms the findings of other surveys, reviews, and personal accounts, namely that experience of racism, bullying and harassment at work meant that many BAME staff were reluctant to speak up when they had concerns about PPE or risk.
- The report noted that “numerous examples were given of staff not able to access appropriate PPE to protect themselves adequately in line with national guidance and being afraid to speak up about this.” The report quotes one stakeholder as saying “requests for risk assessments or additional PPE by BAME workers are more likely to be refused” adding that in some cases “those requests are less likely to be made because of fear of adverse treatment”.
- Given the numbers of BAME staff employed across Birmingham and the Black Country it is inconceivable that this would not have been an issue for a number of individuals, particularly when the findings of the annual Workforce Race Equality Standard (WRES) for Trusts across Birmingham and the Black Country are taken into account.
- The WRES requires all NHS organisations to demonstrate how they are addressing race equality through the WRES by reporting annually and monitoring the different experiences of BAME and white staff, in order to identify differences and/or gaps.
- The 2019 WRES report showed that nationally BAME staff were 1.22 times more likely to enter the formal disciplinary process compared to white staff. In Birmingham and the Black Country five Trusts scored over 1.75, and in one BAME staff were over twice as likely to enter the formal disciplinary procedure compared to white staff.
- Nationally 29% of BAME staff and 24.2% of white staff reported being harassed, bullied or abused by other staff in the previous 12 months, figures that continue to rise. Three Trusts in Birmingham and the Black Country were identified as being amongst the worst performing nationally.
- Nationally the percentage of BAME staff that experienced discrimination at work from a manager, team leader or colleague in the last 12 months increased from 15.0% to 15.3%. In contrast, the percentage of white staff that experienced this discrimination decreased from 6.6% to 6.4%. In two Trusts in Birmingham and the Black Country over 19% of BAME staff reported being discriminated at work.
- Clearly much needs to be done by NHS Trusts across Birmingham and the Black Country to tackle the deep-rooted cultures of race inequality. Immediate and sustainable improvements in the experiences of BAME staff can be achieved by the wider sharing and application of operational interventions of good practice known to have a positive impact. Examples, of which there are a number, would include involvement of a BAME manager in reviews of disciplinary cases before the formal stage; access to independent BAME whistle blowing guardians and reverse mentoring of white managers by BAME staff.
- **Persistent inequalities in housing provision in our BAME Community exacerbated COVID-19 fatalities.** The House of Commons library noted in each briefing “people from BAME groups are also more likely to live in overcrowded households which could increase the risk of

COVID-19 transmission'. In our region overcrowding is four times higher in the ethnic minority community and in the white British community.

- Furthermore, the IFS noted, 'The connectivity and population density of Britain's major urban centres have made people in these parts of the country particularly vulnerable to the spread of the virus, however in reality, the available information on hospital deaths by ethnic group suggests higher per-capita mortalities for all ethnic minorities in Figure 5 than can be explained by demographics and geography alone'
- Households with low income are more likely to be overcrowded or have damp problems than higher income households, because they cannot afford to move to a larger house or to fix damp problems. Bangladeshi and Black African households, in particular, are more likely to have damp problems than White British households (HM Government, 2020a). This is highly pertinent as COVID-19 attacks the respiratory system, which can be compromised by chronic exposure to damp conditions. White British households are also less likely to be overcrowded than households from all other ethnic groups combined (HM Government, 2020a). This factor is particularly important as the probability of being infected by COVID-19 is likely to be higher in close contact settings; social distancing and self-isolation rules will be much more difficult to uphold in overcrowded households (Holden & Kenway).



- **Inequalities in income in our BAME community, exacerbated the threat from COVID-19.** The University of Oxford and the London School of Hygiene and Tropical Medicine concluded that ‘Deprivation is also a major risk factor with, again, little of the excess risk explained by co-morbidity or other risk factors’. Scientists for Labour noted the burden of COVID-19 has been felt more strongly in regions with greater deprivation. After controlling for age, sex, ethnicity and region, the most deprived regions have 16% greater risk of death when compared with those least deprived. **The income poverty rate varies substantially between ethnic groups in the United Kingdom.** As a percentage of the total UK population of each ethnicity, the percentage of each group that is considered as low-income is: Bangladeshi (65%), Pakistani (55%); Black African (45%); Black Caribbean (30%), Indian (25%), White Other (25%) and White British (20%). For British people who are White, income poverty is similar across areas of the country, whereas for people from minority ethnic groups the rates are much higher in inner London, the North of England, and the Midlands. These regions are also the most deprived in the UK as a whole (ONS, 2020), and people in these areas are dying of COVID-19 at double the rate of more affluent areas.
- **Yet, despite these inequalities, we are working without the data we need to guide us.** The University of Leicester and University hospitals Birmingham NHS foundation trust literature review reported that “Data on ethnicity in patients with COVID-19 in the published medical literature remains limited. However, emerging data from the grey literature and preprint articles suggest BAME individuals are at an increased risk of acquiring SARS-CoV-2 infection compared to White individuals and also worse clinical outcomes from COVID-19. Further work on the role of ethnicity in the current pandemic is of urgent public health importance.’





Testimonies

The evidence of two months of public hearings

Community Taskforce Public Hearings Testimonies

Over the course of two months, we held public hearings to listen to the stories behind the statistics. Here is the precis of some of the testimony we heard.

Joy's testimony

Joy shared with the hearing some of the most harrowing testimony which we heard. Joy's niece was mum, Sarah Scully, who tragically died at the age of 35, from coronavirus shortly after giving birth without ever getting the chance to hold her infant son.

Joy told us that her sister and Sarah's mum, Elizabeth fell ill after working eight days straight, and so did daughter Sarah, who had been using public transport to get around. Sarah complained of fatigue, muscle pains and breathlessness.

But she was reassured by a visit to her midwife, who said her symptoms were all common complaints for mums-to-be close to birth. As a precaution, both mum and daughter took a COVID-19 test and were advised the results would be through within five days. Soon after, as Sarah complained of feeling increasingly unwell, her mum drove her to Birmingham Women's Hospital, where the hospital said that Sarah had to say goodbye at the hospital door.

Soon after, an emergency caesarean was performed and her baby boy was safely delivered on Easter Sunday morning. But quickly thereafter Sarah succumbed to COVID-19 and was placed in an induced coma. The family then confronted a battle to try and see Sarah in the last days and weeks of her life. The hospital would only allow one member of the family to visit and Sarah's twin brother gave up his right to visit to another family member. The family found that it had to negotiate through a friend of a friend of a friend in order to try and secure visiting rights. This together with difficulties in getting information about Sarah's condition exacerbated the family distress. Sarah's six-year-old son made cards for her every day to help keep alive the hope that his mum would come home.

The family say one small act of grace was that they were able to find an undertaker willing to allow for Sarah to be dressed in her favourite outfit and her hair and make up done, ahead of her funeral. It was a final act of love that, it turns out, was denied to many other families at the height of the pandemic because of infection risks.

"The first funeral director we approached said they could only place the body bag used to transport her from hospital into the coffin, which would then be sealed. We could not even view the body,"

Joy told the hearing she was concerned that messages about the virus underplayed the impact on young people. "Sarah was a young healthy woman, it was put out that it was a disease afflicting the elderly. Some of the messages the Government are putting out are wrong."

Paul's testimony

Paul told the hearing about how he supported his father John who sadly passed away with COVID-19. John lived round the corner from Paul and when lockdown started Paul was taking food to his father but leaving it at the front door in order to observe the streets government rules on lockdown. As a result of public policy that encouraged independent living, Paul had for some time helped make sure that his dad was doing well.

But Paul became increasingly concerned that his father was not eating properly and eventually entered the home where he found his father very ill.

Paul called the ambulance and when the ambulance attended Paul asked "is he going into a

COVID-19 ward?’ He was told that John would indeed go on to such a ward. Paul however pointed out that his father only had one symptom and after making some phone calls John was kept out of the COVID-19 ward.

During John’s treatment however the diagnosis of COVID-19 was very unclear, and ultimately the family was not able to join John to console him in the last days of his life.

When John went into the ambulance, it was the last the family saw of their father. Only at the very last moment was the family told by word-of-mouth that COVID-19 had been diagnosed and that COVID-19 was then recorded on the death certificate. This was a terrible shock to the family but apparently a swab test had been undertaken but the results had not been shared beforehand with the family.

As a result all of the arrangements at the funeral had to change and the family which had last seen John when he was admitted to the ambulance was not able to grieve properly around the funeral when John passed away.

Monica’s testimony

Monica told the hearings about the tragic loss of her husband. ‘All of the reports about the numbers’, Monica told us, ‘don’t touch on the horrors that we’ve gone through’.

Monica’s husband began to feel an ache in his joints and over the course of the day said that he felt like he was getting a chill. After a day or two he was bedridden. Monica herself was also suffering. Both had the temperature but neither had the cough. They tried to ring 111, indeed at one stage their daughter spent two hours trying to get through on the 111 number but there was trouble getting through.

Eventually the teams at University Hospital Birmingham rang to say that the pair must come in because of the temperature. Eventually an ambulance was sent and staff descended from the ambulance in full hazmat gear. However, they almost dropped Monica as the staff were finding it difficult to operate in their suits.

The couple were admitted to different hospitals. Monica was taken to Walsall Manor hospital whilst her husband was admitted to University Hospital Birmingham, where he was a dialysis patient.

Monica told the hearings how her husband had been diagnosed and informed that he was in the last hours of his life alone. Monica discovered the news when her husband was able to text with the message “Told 24 to 48 hours to live.” They had been married since the age of 16.

Monica was put on a COVID-19 ward where she saw first hand how staff struggled to cope. She watched how many patients would call for help using the buzzers but they were not staff to attend to them. Some struggled even to get water. There were no visitors and it was sometimes hard to eat the food provided.

Eventually Monica managed to get discharged and was able to see her husband and pray together one last time. In the days that followed a number of her friends also tragically died. Monica told the enquiry “we have a whole community in pain. We are just a microcosm of what communities around the country are going through. In her darkest hours, there was no guidance.’ The emotional and psychological impact of what people have been through has been unattended to ‘I am a strong woman’ Monica told us ‘I’ve had my challenges that I’ve gone through. But this has taken me to the edge. I thought I might as well go myself’.

Noori Awan's testimony

Noori told the hearing how her father fell ill on a Friday, he had the symptoms of a cough and a temperature that night. He didn't get any worse, and it was like that for 6/7 days.

A week later on the Saturday he was breathing heavily so an ambulance came to check his oxygen levels which had dropped from 99 to 94. They said that these were acceptable levels and he could stay at home, however an hour later they had fallen again to 85. He was told he needed to be taken to hospital, but Mr Awan was able to put his coat on and walk downstairs. Noori fondly noted how her father was a very proud man and that he declined getting into a stretcher to help him into the ambulance.

On the Sunday morning Noori rang the hospital and they explained that his oxygen levels were okay and that they were just going to let him rest. At about 3pm they had heard nothing more from the hospital so Noori called them again and they said, "we've got the ICU team here to put him onto a ventilator". The Anwar family had had no information about his condition and when they asked why he was being put onto the ventilator they were told that he had pneumonia in both of his lungs. They were given zero information about what had happened at the hospital.

He was then put onto the ventilators, they were not able to speak to him to ask how he was, not even a phone call. The hospital said that they would let the family know half an hour before he was put onto the ventilator so that they could speak to him, but they were never called. When they rang later on, he had already been put onto the ventilators.

On the Tuesday the hospital told us that one person needed to come in, however they let both Noori and her brother in after resistance. When they arrived, they were told that he only had a few hours left to live. Noori recalls how they were not given any information from the hospitals and then all of a sudden he was dying, despite going into the hospital a healthy man. The following day he sadly passed away.

The family were then given a box with their fathers remains and were told to bury him. They were only given half of his belongings that he went into hospital with and still do not know what happened to the rest of them.

Noori's mum was self-isolating when her dad died and was unwell herself. They believe she too had the virus, but it affected her differently to their dad. She and her brother couldn't go into the house and they had to tell her that their dad had died from the doorstep. She remembers how her mum broke down on her own in the doorway and they couldn't even give her a hug. Noori sat in the garden everyday watching my mother who was so heartbroken that she couldn't even get up to get herself a glass of water.

At one point, an ambulance was called for Noori's mum and Noori told us how she "was just so scared that they would take her to the hospital and that she would be gone as well. I felt that she was safer at home than in the hospital. I was just so scared".

Juleka's testimony

Juleka shared with the hearing that her brother Diloumina went into the hospital on the 30th March and passed away on the 31st March. It was a Sunday evening that he went into the hospital and early Monday morning a little before 6am he sadly passed away.

Her brother was suffering with typical cold symptoms: he had a temperature and he was coughing but as she notes, it was "on and off". He previously went to the doctors and was given some medication to help with his symptoms, but nothing helped.

By Sunday the 31st she recalls that he was struggling a lot more with his breathing and he was taken to hospital in the ambulance. Juleka's sister in law followed behind in her own car but

wasn't allowed to enter the hospital. The family had no contact with the hospital until the next day when they received a call to inform them that they had passed away.

Juleka's brother had just turned 53, he had no underlying illnesses and whilst he used to smoke, he had quit 17 years ago and was very healthy.

Diloumina had been a taxi driver in Birmingham for the last 6 years. Juleka notes that "It all happened all of a sudden and within 24 hours he was gone. It was such a shock to the entire family because it happened so quickly. We had no information from anyone, we did not know what was happening at any point".

Lorna Dell's testimony

Lorna began by explaining to the hearing that on Tuesday 24th March her mum didn't feel too well. She suffered with diabetes and has to keep a close eye on her sugar levels. Which is why when she rang the doctor they asked her come into the surgery. She had made the appointment the previous day and was told to return on the Tuesday so that they could take some blood tests.

Her mother was too weak to attend her appointment. Lorna's niece phoned the doctors to explain and she took a sample of her blood sugars which was 27.3. The doctors said that she was dehydrated, and she needed to go to the hospital.

She arrived at the hospital around 12 o'clock on the Tuesday and had no COVID-19 symptoms. Lorna and her mother were moved to the Medical Assessment Unit by 3 o'clock and a doctor came to start assessing her mum. The doctor said that Lorna should not be in the hospital due to COVID-19 so she left. She asked the hospital to keep her informed of how her mother was. Lorna waited until after 7pm on the Tuesday evening before calling the hospital and they told her that they would get a doctor to call back. When the doctor did call Lorna back they told her that her mum had coronavirus, she wasn't going to make it and they wouldn't resuscitate her.

Thinking this could be her last chance, Lorna went to the hospital to see her mum. They had a quick chat together, Lorna gave her a kiss and left very quickly.

The following day Lorna's sister texted her to say that she had spoken to the hospital and that mum was fine and she'd had breakfast. The hospital also told the family in the afternoon that Lorna's mum was walking in the gardens of the hospital.

On the Thursday morning the family received a call from the hospital to say that the family needed to go to the hospital. Lorna contacted her siblings and they went to the hospital. The doctors told them that her mother had pneumonia. They said that they had tested her for COVID-19 but the results wouldn't come back for another three days.

That afternoon the hospital called to inform the family that their mum was in distress. Lorna and her siblings again returned to the hospital where the doctors let them onto the ward and gave them PPE to wear. The family took it in turns to spend time with her and left just after 5pm to get changed and then returned in the evening. Their mum was in and out of drowsiness, so at 9pm the family decided to go home to rest.

At 12 o'clock Friday morning the hospital called Lorna to say that they had moved her mum to a different ward. Half an hour later, she had another call to say that her mum was showing signs of distress and they should come back to the hospital.

When the family arrived a doctor came out and informed them "this is a COVID-19 positive ward and your mother didn't make it".

The hospital said that the family can go and see her for five minutes but to be careful. The family decided that it was a risk that we were willing to take and were able to hug her for one last time. Their mother was lying there in the corner on a ward with living people.

Lorna asked a woman who was working on the ward “where do we go from here?” the woman handed Lorna a booklet and said “have a read through this”.

Lorna then phoned the hospital on the Friday afternoon and asked the same question. They told her that they would call her on the Monday to discuss it. Lorna got a call on Saturday afternoon from the hospital to tell her that her mother had died of kidney failure, but they were ringing me because the doctor might decide to put COVID-19 on the death certificate. From there it was a waiting game for the family.

Bishop Windsor testimony

Since Bishop Windsor began keeping a record, between the 23rd April and the 5th June, he has officiated over 15 funerals, an average of more than 2 a week. He notes that he expects higher rates over Winter, but he has never experienced anything like the numbers that he has seen during this crisis.

There are times when he has had to officiate four funerals in one week all of which have been subject to restrictions.

The age range of those individuals who have sadly lost their lives has been from 35 to 96 years old. Bishop Windsor cannot specify an exact number of how many those have died of COVID-19 as there has been a reluctance from some individuals to volunteer that information. However, he does indicate that there was a strong proportion who did tell him that their loved ones died directly from COVID-19.

Bishop Windsor is part of a group of local pastors called Churches for Positive Change. Since the beginning of the pandemic, Winston tells us that this group has tried to take a proactive stance on how they could help improve the health of their congregations. He explains that the local pastors felt a responsibility to call their congregations together and have a joint approach to improving health issues such as diabetes and hyper-tension, that might put individuals at a higher risk of COVID-19.

The group also tried to access information from their health authority and they have plans to meet with representatives from the health authority in the future. Bishop Windsor admits that he has found the lack of information has been troubling. He believes that because there has been no clear information on the impact on BAME people it started to lead to speculation in the community.

He candidly told the hearing that “you’ll never get rid of speculation. The world and his brother will always try to come up with a theory about everything. But we could mitigate it if we had documented quality information”.

Bishop Windsor also added that he was afraid that narratives around underlying illnesses such as diabetes were a way of “throwing the blame back onto the communities”.

The final issue that Bishop Windsor raised with the hearing was the issue of Do Not Resuscitate (DNR) being applied equally. He recognised the monumental task that our health service was facing and the fear that they were overwhelmed with patients. However, he recalled that a woman had told him of how a relative of hers was in hospital and she had a doctor come in to speak to her who “started to stack up all her conditions and kind of asked the question: is it worth it to resuscitate?”

Bishop Windsor closed by exclaiming that he was not trying to be political, but notes that we have had the Windrush Scandal, we’ve had injustices with COVID-19 and now we are seeing the black lives matter protests. He asserted that these issues are not going away and stressed the importance of us doing due diligence to deliver justice to the communities affected.

Alicia Spence's testimony

Alicia is the director of service for the African Caribbean community initiative which is a mental health service. She also recently quite unexpectedly lost her colleague and deputy, not due to COVID-19 but other unexpected health issues. She notes that in this climate with all the emotional trauma that there is for the BAME community it had quite a profound impact on her own emotional wellbeing.

In March, Alicia's brother who is 71 was admitted into hospital and they initially told her that he had pneumonia but, in the end, decided it was COVID-19. Fortunately, he survived, but he was in hospital for a total of five weeks, three of which were spent in intensive care. In her own words, she claims for those five weeks "you are living on a knife edge every time the phone rings".

Alicia notes that she had similar issues to the rest of the witnesses, namely of getting information in a timely matter but that she just gives thanks because her brother is alive and on the road to recovery.

For Alicia, she wanted to place emphasis on the emotional trauma and the levels of anxiety that she is seeing as part of the service that her initiative offers. They provide counselling to the community and are seeing referrals from families who are so traumatised that they are too afraid to leave the house in case they contract the virus.

As we are unable to take the usual levels of support from those around us, such as visiting those close to us as we have been abiding by social distancing guidelines, Alicia tells the hearing that this comes with a price. She alludes to the issue around only allowing ten people at a funeral, for example. So many people will have missed out on attending funerals of their friends and families and this will disturb their grieving process and have an effect on their mental health. She also expresses how it is exceptionally difficult to decide on who gets to attend the funeral.

Alicia notes that what concerns her is the 'mental health fall out' post this critical period. She voices her concerns that we will soon be entering a significant period of mental health issues, and asks how her own organisation are going to be equipped to help not only those who have existing mental health problems but also the wider BAME community who are going to need additional help healing as a result of this crisis.

Sam Henry's testimony

The congregation that Sam Henry belongs to has lost at least 5 members from COVID-19. He spoke to not only tell their story but also on behalf of his wife who is a nurse in a care home. He notes how high the proportion of BAME workers we see in our care homes but also other aspects of the front line such as health care assistants and bus drivers.

Sam asks, then, why it was that these individuals were not given adequate PPE in the workplace. He told the hearing that in her role as a care home nurse his wife was not given PPE until very late on in the crisis.

Sam informed us that he himself had some COVID-19 symptoms very early on in the pandemic, such as a cough and his own workplace never offered him PPE.

He accepts that the government have since admitted that there was a lack of PPE but perhaps the key issue for Sam is that we've often found BAME individuals face structural inequalities and they are not always treated with the same dignity as others. He urges the inquiry to delve into why PPE that could have saved so many lives, were denied to the BAME community.

Abbas's testimony

Abbas's journey with his mother started on the 6th April when she first fell poorly at home. Three days after his mum felt poorly the family called for an ambulance as her oxygen levels had dropped really low and she was struggling to breathe.

The ambulance came and they were in the house for no more than ten minutes. They wanted to put Abbas's mum on a stretcher, however, she insisted that she could walk. They took her to the hospital, and she was admitted for ten days. The family had no communication from the hospital. Abbas told the hearing how his family would ring multiple times a day to ask for updates on their mums' condition but would only receive one call back a day, and with very little information.

On the 8th April the hospital told the family that she was doing well. The next morning, they phoned again to tell Abbas and his siblings to come to the hospital as soon as possible because their mum only had a couple of hours to live.

When Abbas arrived at the hospital, the security guard told him and his family that they were not allowed to enter the hospital, despite being told to come. Eventually, they were permitted into the hospital.

They then were taken into a room, where a doctor told them that the hospital had made a crucial mistake. The hospital had left Abbas's mum on her stomach for too long, and water had built up in her lungs. The doctor explained that they wanted to transfer Abbas's mum to a lung specialist hospital in Leicestershire, however the hospital refused to take her.

Abbas expressed to the hearing that he felt he was one of the lucky ones because he was able to sit at his mum's bedside when she passed away. Whilst Abbas was clearly frustrated, he wanted the Taskforce to know that he does not blame the nurses at all for what happened to his mum, as they only follow orders. Whilst he was sat with his mum on the ward, Abbas was able to speak to two nurses who explained to the family that they had only been put on that ward because they had forgotten about Abbas's mum and she had been left for too long.

The Doctor described the mistake as crucial, but Abbas notes that it was life ending.

Pauline Thompson's testimony

Pauline is a member of the Harvest Temple New Testament church in Wolverhampton. She is also active in a lot of community work in Wolverhampton and across the black country and is now working with the wider community in Birmingham as a deputy CEO.

She tells the hearing that what she would like to bring to the inquiry is the impact that COVID-19 has had on her and on her family personally, but she also wants to ask some questions on the BAME report.

Pauline informed us that she felt it had been a challenging time for many, but even more so when you're from a black and minority background. Because as well as having to deal with all of the issues that everyone else has to deal with BAME people are four times more likely to die from COVID-19, if you're a black male and three times more likely if your black woman.

For Pauline, and for what other people have told her, the hardest thing has been not being able to be with their loved ones when they were passing.

Furthermore, she notes that many have struggled with not having the appropriate communication when it was needed with hospitals. She told the members of the taskforce that the depth of hurt in the community was very, very deep.

The support that nurses and care home staff have received, is one of the positives that Pauline wants to outline that have come around as a result of the pandemic. However, she acknowledges

that this itself raises some issues, as many of those carers and nurses are members of the BAME community and are at a higher risk from COVID-19.

The Harvest Temple New Testament church has lost 3 members. One of who was a woman called Joy. Pauline remembers her as “a lovely lovely woman”. This loss has had a tremendous impact on Pauline and the other members of the church, which prompts Pauline to ask the taskforce what are the recommendations for the BAME community and how do we respond to these challenges that we face much faster than what we have seen in the past?

Steve Brathwaite’s testimony

Steve begins by asking the taskforce why the lockdown was so slow to be adopted in the UK. He expresses that he does not understand how some countries who supposedly do not have the ‘technical knowhow’ of our country, and yet they responded quicker and have had better results than the UK.

The virus has devastated the country and, in his own words, completely ruined Steve’s life.

Steve emotionally told the hearing how his wife and he met at 16 years old, they married at 19 and 48 years later his wife was taken from him.

Before Steve’s wife died, both him and his wife had bad colds. Steve remembers one night that his wife left their bed and said, “I can’t sleep with you when you’re coughing and spluttering”, because he too was suffering with COVID-19 symptoms. During this time when they were both presenting symptoms, Steve notes that his wife was still able to run up and down the stairs and go about her day.

He tells the hearing that it took three days from her running up and down the stairs, to her lying in bed struggling to breathe. Once Steve noticed that she was struggling to breathe he immediately called for an ambulance. He fondly remembers how when the ambulance arrived all his wife was concerned with was remembering to take her make-up bag with her to the hospital.

When Steve’s wife was dying, the hospital called him in and allowed him to spend the last two hours of her life with her. He says that he saw “soldiers on the frontline, not nurses, soldiers”. He recalls seeing patients in the Intensive Care Unit trying to pull out oxygen tubes and nurses “quietly, confidently, trying to put them back in”.

Steve explained to the taskforce that he was frustrated with the hospital at first, as he faced many challenges in getting through and getting information about his wife’s condition. However, when he was allowed into the ICU he understood why he could not get through.

It is Steve’s belief that the Government has been negligent throughout this crisis, that they did not lockdown quick enough because they were more concerned with the economy than saving people’s lives. On the Government’s handling of the crisis, he told the hearing that “they had their thumbs where their thumbs shouldn’t be and I lost my wife because of it”.

Robert Palmer’s testimony

Robert lost his sister, Nadiya, to COVID-19 and is also a member of the congregation of the Gloucester Street church, who have lost a total of five members.

Nadiya, was very much loved by all 8 of her siblings. She was taken into hospital on the 21st March and died on the 17th April.

Robert notes how it was a very difficult time for the family as they struggled to get in contact with her whilst she was in the hospital. Her phone was mislaid in the hospital, which meant the family could not directly contact Nadiya, they are still not sure what ever happened to the phone.

When the family confronted the ward they replied that they knew nothing about any phone.

The death of his sister was especially difficult for Robert to process, as he had no contact with her directly once she was admitted to hospital. He told the hearing that it was “very difficult because I don’t know what my sister looked like when she was in the hospital or how she was treated in the ICU”. Robert expressed that it was his belief that sometimes it is the family that really keep those in the hospital going. He goes on to explain that family members are able to give patients a sip of water or something to eat when they require it, this was something that was taken from the families of those who suffered from someone passing away.

The hearing heard how Robert hopes that families will get the opportunity to see their relatives, to see and be there to see what their loved ones are going through.

Because this was not an opportunity that Robert’s family were afforded, it made the experience much harder to accept. As a family they are devastated by what COVID-19 has done to so many families, including their own.

Rachel McFee’s testimony

Rachel is the CEO of Sandwell OSCAR (Organisation for Sickle Cell Anemia Research). The organisation is based in Sandwell, but there is also an OSCAR in Birmingham and there are other organisations operating in the Midlands. She begins her testimony by explaining to the hearing that sickle cell anemia is a blood disorders that predominately effects members of the Black and Asian communities.

Unfortunately, the organisation has lost some members to COVID-19. Those with sickle cell are on the Government high risk list who were contacted to tell them to shield for 12 weeks.

Those with sickle cell are typically admitted to hospital frequently for various reasons. Rachael notes how going to hospital was a frightening experience for many of OSCAR’s clients and many expressed that they didn’t want to go to hospital because they were so afraid that if they went to hospital they would not come back out. Sadly, this was the reality for one of OSCAR’s clients.

Rachel also told the hearing that this particular client’s partner only found out that they had died from COVID-19 when their death certificate arrived. They were never called before the certificate arrived to inform them of the cause of death.

In Sandwell, OSCAR have been trying to support their clients through the grieving process. Rachael explains that Caribbean funerals are usually large- scale celebrations of life. These funerals are characterised by lots of attendees and lots of interactions, but members of the community have not been able to grieve in this way.

Rachel expressed to the hearing her own concerned about the psychological scars that come with this crisis, if people are denied this opportunity to grieve. OSCAR are holding a memorial for all their clients who have passed away to try and help with this grieving process.

Stress can cause a painful sickle cell crisis, which can then lead to that patient having to potentially be admitted to hospital again. Rachael explained this to the hearing and outlined that especially for sickle cell patients, we need to address the mental health issues surrounding the crisis to avoid people being admitted to hospitals which could result in them contracting the virus.

Currently, there is no formal mental health support for OSCAR clients. Rachel notes that funding gets smaller every year but that the clients would absolutely benefit from some kind of mental health support.

Rachel also told the hearing how the food parcels that some of OSCAR’s clients received from various organisations were often not culturally appropriate. She relayed one man’s experience who repeatedly told said organisation that he did not eat meat, yet he received meat in every

food parcel that he received. She expressed that she did not believe there was any cultural input into the food parcels that were being sent to members of the BAME community to ensure they were being sent appropriate foods.

Pauline Brockelsby's testimony

Pauline is a carer to her daughter who is an adult with sickle cell disease. Pauline's daughter was included in those who received a letter explaining that she should be shielding for at least 12 weeks. Their family followed this advice and shielded themselves at home.

The hospital told Pauline's that it was safe to bring loved ones to the hospital if they needed to be admitted, and that they would not be exposed to the virus. The hearing heard that Pauline believed that during the pandemic, sickle cell patients were not kept safe when hospitalised.

Pauline's daughter was admitted to hospital with a chest infection. Re-occurring chest infections are common for those with sickle cell disease. As her daughter had a cough as a result of her chest infection, the hospital tested her for COVID-19. The COVID-19 test result came back negative, despite this Pauline's daughter was placed on a COVID-19 positive ward.

During the ten days that she was admitted, Pauline did not see her daughter. She recalls how her daughter was having panic attacks and rung her to say that she "wished her legs would work, because if they worked, she would walk right out of the hospital". She went on to explain how her daughter believed she had been left there to die.

Pauline's daughter was not given a mask, despite being COVID-19 negative on a COVID-19 positive ward. It was only when Pauline complained to the hospital multiple times did the hospital provide her daughter with a mask to wear.

The family were shielding at home, however, felt that in hospital there was no shielding at all for Pauline's daughter. There were people in the beds next to her who were, in Pauline's words, "coughing for their dear lives".

Pauline's daughter asked the hospital staff if they were able to close the curtains to protect her slightly from other patients coughing, however, the doctors said that they were not able to as they needed to be able to see every patient.

The hearing was told that Pauline intends on making a formal complaint. She admitted that "I do feel as black people that they don't listen to us, when it comes to sickle cell, they do not listen to us. They cover for themselves and do not make any changes for us".

Pauline claimed that the hospital played Russian Roulette with her daughter's life.

Parbinder Kaur's testimony

Two weeks prior to the 3rd of April, Parbinder's brother in law had COVID-19 symptoms as well as both of his parents and her sister. As Parbinder is a nurse herself, her family quickly followed her advice that they should all go into isolation.

Parbinder's brother in law's symptoms presented as diarrhoea, a temperature, muscle aches and he had a persistent cough that stayed with him when he went into hospital.

The family all had SATS machines to checking their oxygen levels because Parbinder was acutely aware that COVID-19 hits your breathing. Parbinder's brother in law's SAT levels were 72% so her sister called for the ambulance. When the ambulance arrived, the ambulance had run out of oxygen.

At no point from the 3rd to the 16th April when Parbinder's brother in law died did the hospital

ring the family. Parbinder notes that it was a constant struggle to get information about his condition.

On Sunday 5th April, Parbinder's sister rung the hospital and was told that her husband was stable in a semi-coma condition, he was on the ventilator, but his lungs were okay and that he was lying on his front.

The hospital informed the family on the 7th April that Parbinder's brother in law was breathing 70% himself and 30% on the ventilator. He remained in this stable condition until the 11th April, when the hospital decided that they would change modes. This resulted in Parbinder's brother in law only being on the ventilator at night to give his lungs a rest, but throughout the day he was breathing himself.

His condition deteriorated, however, on the 13th April and he returned to being 100% on the ventilator, his kidneys had also failed and he was put on dialysis. On the evening of the 14th, his condition had dramatically deteriorated and was in critical condition.

There was a Sikh chaplain at the hospital who was liaising with the family. He informed the hospital not to phone us when he's going to pass away because the family wanted to be there with him so that he was not alone. At 13.14 on the 16th April the family received a phone call and Parbinder's nephew went to the hospital to be with his father. At 17.00 they had another phone call to say that Parbinder's brother in law passed away.

Speaking as a nurse, Parbinder told the hearing that she does not believe there was enough nurses on the front line to cope with this. Her children had to buy her a visor to use at work as she was not provided with one.

On the 6th April, Parbinder had COVID-19 symptoms herself and was sent home from the QE hospital where she works. At this point, she notes, her manager should have then organised for her to have a COVID-19 test but this did not happen. She was persistent but they did not order a test.

Parbinder's children eventually told her that they were going to get her a private test. Once Parbinder had threatened to get a private test, the Trust agreed to test Parbinder. She then did a swab test, and the result came back as negative. Parbinder told the hearing, however, that her manager did a similar swab test that came back negative, but when she did an antibody test it came back as positive. As a result, Parbinder is now pushing for an antibody test, but is still struggling to get her trust to agree to one.

Marty Rose's testimony

Marty knows of 4 people who have all passed away from COVID-19. He expressed to the hearing how difficult it was for him as a vulnerable person himself, as he has both sickle cell anaemia and type two diabetes.

Whilst Marty has been shielding, he has not let anyone enter his property, and he has not left his home. Instead, his family have been doing his shopping for him during lockdown. He notes, however, that people who know that you are a vulnerable person, do not always take the necessary precautions.

"I am fearful. I am fearful of going out and leaving the house because I know that I am more susceptible". This is how Marty described the anxiety he has been feeling as a result of COVID-19.

Marty told the hearing that last year he had to go to hospital with pneumonia- like symptoms. He expressed that he did not feel like his GP took him seriously when he went to them, and he was treated the same when he visited the A&E department. He wonders if he could have had the virus then, as there are many similarities between his symptoms and what he experienced.

He then went on to express his many battles of not being taken seriously by hospitals and medical staff in the past. Marty characterised it as a “constant fight”.

Such a ‘fight’ causes anxiety for many patients and can prevent them from seeking medical help when they need it. Marty also told the hearing that “they say that once in a blue moon you will find someone who actually understands the consequences of having sickle cell and that will take you seriously”.

There are many things that can add to the anxiety being felt by Marty and other members of the BAME community, Marty notes that when you know people who have passed away as he has you are very weary of the disease.

Latoya’s testimony

Latoya has sickle cell trait. As someone with sickle cell trait, rather than sickle cell anaemia, Latoya notes that she typically receives mixed messages in her everyday life about how sickle cell impacts her life. For example, she tells us that she has been told that sickle cell trait does not affect your health as you are simply a carrier of the trait. However, when her daughter (who also carries the trait) was admitted to hospital with asthma, the doctor’s told her it would impact her worse because of her sickle cell.

These mixed messages have been amplified for Latoya during the crisis. Those with sickle cell anaemia, such as Latoya’s cousin, received letters explaining that they were in the Government’s ‘at risk’ group and needed to take extra measures to shield themselves, however, those with the trait did not receive this.

Because Latoya had previously been told by a doctor that the trait can impact your health, and having seen her cousin’s letter, she took extra measures to shield herself and her family.

Latoya told the hearing that she believed that during the pandemic she often did not know what was going on, and what information she should believe.

According to Latoya, this confusion often came from messaging not being consistent across the board, especially for those with sickle cell.

It is Latoya’s belief that the BAME community desperately need clearer guidance as we come out of lockdown so that people like herself are not second-guessing decisions taken by hospitals or local authorities.

She also notes that this confusion and mixed messaging is what has led some people to become reliant on social media outlets for information, resulting in many people choosing to believe in conspiracy theories rather than trusting hospitals and government advice.

Charlie’s testimony

Charlie received a call on the 16th April to inform him that his dad’s condition had deteriorated. His dad was experiencing COVID-19 symptoms that presented as high temperature and a chest infection.

When Charlie’s family asked if they could go and visit their dad, they were told that the care home was on lockdown and that they were receiving patients from the hospital who had recovered from COVID-19 and that they would be isolating at the care home for 14 days.

Charlie told the hearing at this point that the care home was his father’s home, it was the place that he and the entire family knew to be his home, so it was very shocking to hear that they were taking in COVID-19 patients from the hospital without telling the other residents.

On the 17th April, Charlie's family enquired whether or not their father had been tested for COVID-19, but they were told that he hadn't been tested and furthermore they did not have the capacity to test him.

The following day, a Doctor rung Charlie and his family to explain that the family needed to make a decision. This decision was whether the family wanted their dad to stay at the care home or be admitted into hospital. Out of fear of their father being left on a stretcher in a corridor, the family chose for their father to stay in the care home.

When the family had previously asked the manager of the care home, the manager explained that the patients who had been brought back from the hospital had all recovered from COVID-19. However, when we asked the doctor, they told us that there were COVID-19 positive patients in the care home. The family received two different versions of events.

Over the weekend beginning the 18th Charlie made some enquiries of his own. He knew a carer in the home very well, so he phoned her, and she told him that "I'm self-isolating because I'm scared to go into work because we've got no PPE".

On the Monday Charlie phoned the care home and asked that his dad be tested, and they finally agreed but unfortunately his father passed away a few hours after that phone call.

Charlie fought for his father to be tested whilst he was still alive, and he continued to fight after he passed. He contacted the coroner and following an extensive conversation the coroner agreed to test his father. The COVID-19 test came back as positive. The hearing heard how Charlie's father is bed bound and he cannot walk. Charlie notes then that "for my father to have gotten COVID-19 in a care home it had to be served to him on a plate".

They are devastated as a family and are demanding answers of how their father contracted the virus. When they have contacted the care home management their only response is that they followed government guidelines for care homes.

Ameena's testimony

Ameena is a nurse at one of the local hospitals in Birmingham.

She admitted to the hearing that sometimes the hospital is "a bit upside down". Ameena is a nurse who usually works with outpatients but was told that she would be re-deployed, however, was given no information as to when she would be re-deployed. She expressed that they were very much kept in the dark.

Ameena told the taskforce that in her experience, it is that BAME staff who are the ones who are redeployed first.

The hospital that Ameena works at is supposed to carry out risk assessments on all of their staff, however, Ameena notes that risk assessments are often far and few between and that she is yet to be risk assessed.

When Ameena was re-deployed she was not placed on a COVID-19 positive ward, however she was testing patients for Coronavirus. She was not risk assessed before she was redeployed to carry out COVID-19 testing to outline if she had any underlying health issues that put her at a higher risk of Covid-19.

Thankfully, the hospital did have plenty of PPE stocks, even though that in the beginning there was confusion over what the hospital staff should wear, however, Ameena told us that she was "quite insistent" and ensured that she wore what she felt would protect her the most.

Ameena criticised the mixed messaging that many people have received during the crisis. She notes that messages telling people to not go to hospitals or A&E departments really scared

people. As a result of this, she felt that people believed that many in the BAME community felt that they would receive better care if they looked after themselves at home and that there was a worry about the quality of care they would receive if they went to the NHS.

The hospitals trust circulated daily COVID-19 updates and guidelines to their members of staff. In this circulation, Ameena told the hearing that she read a piece of information that said if you are a member of the BAME community and you are 55 years old, it is the equivalent to being 70 years old outside the community.

This detail was not made public to people. It is mixed messaging of this kind that Ameena believes to be a key failure in the handling of this crisis.

Gurbax's testimony

Gurbax has had a long career helping to deliver mental health services to the BAME community in Wolverhampton and campaigning to help ensure BAME people have a voice in the way their care is provided.

Gurbax told us how many of the families that she worked with had family members who had received a negative test only to then discover that COVID-19 had been put on the death certificate – without any apparent consideration for the impact this would have on the families wish to see their loved ones' bodies in order to grieve.

She reported there had been little effective dissemination of information into the BAME community and much of the information that was provided by the government required some kind of access to technology which often was not available. Gurbax underlined the poor diversity of leadership in the governance of our health and social care system across the region. All too often it felt like decisions were being made behind closed doors. Gurbax also wanted to underline how we now confronted an epidemic of poor mental health. "We have to come away from the one shoe fits all approach to mental health" to mental health services, Gurbax told us, and begin driving through new models of delivery which need to be community lead.



Other Key Sources of Evidence

Alexis Paton, et al, Submission of evidence on the disproportionate impact of COVID-19 , and the UK government response, on ethnic minorities and women in the UK: [https://publications.aston.ac.uk/id/eprint/41460/1/ Submission_of_evidence_for_Select_Committee_Aston_University_.pdf](https://publications.aston.ac.uk/id/eprint/41460/1/Submission_of_evidence_for_Select_Committee_Aston_University_.pdf)

Alison M Dunning et al, BAME and COVID-19, Scientists for Labour

COVID-19 and Black, Asian and minority ethnic communities, House of Commons Library, [https://commonslibrary.parliament.uk/research-briefings/ cdp-2020-0074/](https://commonslibrary.parliament.uk/research-briefings/cdp-2020-0074/)

COVID-19: review of disparities in risks and outcomes, Public Health England, [https://www.gov.uk/government/publications/COVID-19 _review-of_ disparities-in-risks-and-outcomes](https://www.gov.uk/government/publications/COVID-19_review-of_disparities-in-risks-and-outcomes)

Health Foundation, Inequalities and discrimination likely to be playing a significant role in higher rate of black and minority ethnic COVID-19 deaths, [https://www.health.org.uk/news-and-comment/news/inequalities-and- discrimination-likely-playing-a-significant](https://www.health.org.uk/news-and-comment/news/inequalities-and-discrimination-likely-playing-a-significant)

Open SAFELY: factors associated with COVID-19 related hospital death in the linked electronic health records of 17 million adult NHS patients. [https:// www.medrxiv.org/content/10.1101/2020.05.06.20092999v1.full.pdf](https://www.medrxiv.org/content/10.1101/2020.05.06.20092999v1.full.pdf)

IFS, Are Some Ethnic Groups More Bondable to COVID-19 Than Others? [https://www.ifs.org.uk/inequality/wp-content/uploads/2020/04/Are-some- ethnic-groups-more-vulnerable-to-Covid-19-than-others-V2-IFS-Briefing- Note.pdf](https://www.ifs.org.uk/inequality/wp-content/uploads/2020/04/Are-some-ethnic-groups-more-vulnerable-to-Covid-19-than-others-V2-IFS-Briefing-Note.pdf)

Exclusive: deaths of NHS staff from COVID-19 analysed, Health Service Journal, [https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-COVID-19 analysed/7027471.article](https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-COVID-19-analysed/7027471.article)

Ziad El-Khatib, Graeme Brendon Jacobs, George Mondinde Ikomey, Ujjwal Neogi, The disproportionate effect of COVID-19 mortality on ethnic minorities: Genetics or health inequalities?, EclinicalMedicine, Volume 23, June 2020, Pages 100430

National Institute for Health Research, The impact of COVID-19 on black, Asian and minority ethnic communities, [https://arc-w.nihr.ac.uk/Wordpress/ wp-content/uploads/2020/05/COVID-19- Partner-report-BAME-communities- BCC001.pdf](https://arc-w.nihr.ac.uk/Wordpress/wp-content/uploads/2020/05/COVID-19-Partner-report-BAME-communities-BCC001.pdf)

Birmingham City Council. Public Health Provision. Coronavirus Special Update. Ethnicity & Coronavirus. 11/05/20

In addition, the work of the Taskforce has been extensively covered in the local media:

[https://www.birminghammail.co.uk/news/midlands-news/taskforce-set-up- find-truth-18270325](https://www.birminghammail.co.uk/news/midlands-news/taskforce-set-up-find-truth-18270325)

[https://www.birminghammail.co.uk/black-country/community-activist- taking-lead-role-18594211](https://www.birminghammail.co.uk/black-country/community-activist-taking-lead-role-18594211) [https://www.birminghammail.co.uk/news/midlands-news/she-didnt-hold- new-baby-18419954](https://www.birminghammail.co.uk/news/midlands-news/she-didnt-hold-new-baby-18419954)

[https://www.birminghammail.co.uk/news/midlands-news/hear-pain- COVID-19-families-share-18399115](https://www.birminghammail.co.uk/news/midlands-news/hear-pain-COVID-19-families-share-18399115) <https://www.birminghammail.co.uk/news/midlands-news/birmingham-will-host-public-inquiry-18246285> [https://www.birminghammail.co.uk/news/midlands-news/families-denied- final-goodbye-COVID-19-18476690](https://www.birminghammail.co.uk/news/midlands-news/families-denied-final-goodbye-COVID-19-18476690) [https://www.birminghammail.co.uk/news/midlands-news/four-specific- actions-maternity-units-18497700](https://www.birminghammail.co.uk/news/midlands-news/four-specific-actions-maternity-units-18497700)

