

WHERE NOW FOR THE PUBLIC HEALTH ENGLAND COVID-19 DISPARITIES REVIEW?

LEGAL AVENUES FOR HOLDING THE GOVERNMENT TO ACCOUNT

22 June 2020

As part of our series considering the human rights and equality implications of COVID-19, [Declan O'Dempsey](#), [Akua Reindorf](#) and [Chris Milsom](#) explore possible avenues for a legal challenge to the government's handling of the Public Health England review and report into [Disparities in the risk and outcomes of COVID-19](#) in relation to racial disparity in prevalence of and vulnerability to the disease.

After a week of confusion, delay, leaks, alleged suppression of evidence and accusations that the issue was being “kicked into the long grass”, the government has now published a second report entitled [Beyond the data: Understanding the impact of COVID-19 on BAME Groups](#). In contrast to the first report, which failed to explore the cause of the racial disparity or to make any recommendations to address it, the second report contains a welcome and wide-ranging plan to address both the immediate and the wider longer-term issues arising from and illustrated by this inequality.

It would be reasonable to conclude that this second report was dragged out of the government. Indeed, it appears from the facts set out in detail below that it was only published because it had already been leaked. Against that background, it seems likely that close political scrutiny will be required to ensure that the government's deeds match its words and it properly actions the recommendations in the second report.

From a legal perspective, we conclude that the most fertile ground on which the government may be held to account in its implementation of the recommendations is the Public Sector Equality Duty (PSED) in the Equality Act 2010. This duty imposes on the government a responsibility to consider how to tackle systemic discrimination and disadvantage affecting particular racial or ethnic groups. The government will have to justify by reference to the PSED any failure to take the positive action measures recommended in the second report. The government must also observe its obligations under the Human Rights Act 1998 to act in a manner consistent with the right to life or the right to respect for private and family life, and/or its duty not to discriminate on grounds of race in relation to those rights. We consider the application of these duties below.

BACKGROUND

On 7 May 2020 the government [announced](#) that an urgent review into *Disparities in the risk and outcomes of COVID-19* would be conducted by Public Health England (PHE), and would report by 31 May. Included in the [terms of reference](#) were that the review would “*consider possible explanations*” for its findings and “*suggest recommendations for further action*”.

The announcement of the review stated that it was intended to take evidence from “*a wide range of external experts and independent advisors, representing diverse constituencies including devolved administrations, faith groups, voluntary and community sector organisations, local government, public health, academic, royal colleges and others*”.

On 1 June it was widely reported in the media that the report was complete, but that the government had withheld publication for fear of inflaming racial tensions and provoking civil unrest in light of the reaction to the killing of George Floyd in the US. After denying that this was the reason for the delay, the government released the [report](#) without fanfare the following day.

At the time of publication it was known that almost three quarters of health and social care staff who had died of COVID-19 in the UK were BAME. All but one of the 12 GPs or GP trainees who had died of the disease were BAME. Those are stark statistics which illustrate what was by that time a clear disparity across the board. Indeed, a [report](#) on the disparity had already been published by the Institute for Fiscal Studies on 1 May and [detailed data](#) had been released by the Office for National Statistics on 7 May. Evidence of a racial disparity continues to emerge: an ONS [report](#) of 19 June suggests that black men in England and Wales are three times more likely to die from COVID-19 than white men.

In that light, the PHE report cannot be said to contain much in the way of surprises. It concludes, amongst other things, that the risk of death from COVID-19 is higher for BAME people than for white people, taking into account age, sex, deprivation, region and ethnicity. It states that BAME people are more than twice as likely to die from COVID-19 than white people, and that BAME health care workers are particularly at risk of infection. It presents statistics broken down into a number of different ethnic groups. It concludes that *“the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them”*.

The report is – and is acknowledged to be – incomplete. For example, in reaching its preliminary conclusions on the disparities between different ethnic groups it does not take into account the prevalence of comorbidities, and nor does it take into account the impact of occupation (eg working in a public-facing role) on vulnerability to the disease.

Moreover the review undertook no analysis of the causes of the disparities it identified. The report does no more than to speculate broadly that the disparities are likely to be the *“the result of a combination of factors”*, including for example a higher likelihood that BAME people will acquire the infection due to living in overcrowded households. Other consequences of social inequality are referred to. The increased prevalence of specific comorbidities in certain ethnic groups is also said to be a likely factor.

The Executive Summary of the report states that the results of the inquiry *“improve our understanding of the pandemic and will help in formulating the future public health response to it”*. However, in addition to containing no serious analysis of the reasons for the ethnic disparity, the report contains no recommendations for a public health response to it, notwithstanding the promise in the terms of reference that it would do so. It contains no action plan to safeguard vulnerable groups, as had been [called for](#) prior to publication by chair of the Doctors Association Dr Rinesh Parmar, amongst others.

Very shortly after publication, allegations emerged [in the Health Service Journal](#) that *“Matt Hancock’s office”* had redacted from the report the evidence given to the review by more than 1000 stakeholders. This evidence had reportedly been contained in an annex to the original version of the report. It is said that these contributions pointed to systemic and institutional racism and social inequality as causes of the disparity.

After considerable outcry over the deficiencies in the report, Kemi Badenoch MP [announced](#) on 4 June that it was *“clear that much more needs to be done to understand the key drivers*

of the disparities identified and the relationships between the different risk factors”. She stated that she will be taking “work” forward on the matter. In response to an [urgent question](#) from Gill Furniss MP (Shadow Minister for Equalities), she described this as the government “reviewing the impact and effectiveness of its actions to lessen disparities and infection and death rates of Covid-19 and to determine what further measures are necessary”. This assertion suggests that some actions were already underway at this time, although it is not clear what those were.

Kemi Badenoch MP also said that the original report did not contain recommendations because the review was “not able” to do so on the basis that “some of the data needed is not routinely collected, but acquiring it would be extremely beneficial ... It is not easy to go directly from analysis to making recommendations, and we must widely disseminate and discuss the report before deciding what needs to be done”.

No date has been given for the completion of this “work”, but the “quarterly updates” mentioned in the terms of reference would imply that it is not intended to be expeditious.

Furthermore the terms of reference do not expressly include the issues of systemic and institutional racism and social inequality which are said to have been raised in the evidence given by stakeholders to the review. However Duncan Selbie, Chief Executive of PHE, has stated in a [blog](#) that the “valuable insights” gained during the original review from “engaging with a wide range of organisations within the BAME community” will inform the work.

On 5 June CORE (the Coalition of Race Equality organisations) [wrote to Matt Hancock MP](#) raising concerns that the further work to be carried out on the review amounted to “kicking the issue into the long grass”. CORE called for a full public enquiry into the matter in the longer term, with a list of urgent actions to be taken immediately¹.

Notwithstanding the government position that insufficient data had been available for any recommendations to be made in the original report, the existence of a previously withheld second PHE report entitled *Beyond the data: Understanding the impact of COVID-19 on BAME Groups* was [revealed](#) on 11 June. This second report was [leaked](#) the following day.

On 15 June, the Prime Minister declared in a [Telegraph article](#) relating primarily to the recent Black Lives Matter demonstrations and retaliatory far-right disorder that “it is time for a cross-governmental commission to look at all aspects of inequality – in employment, in health outcomes, in academic [sic] and all other walks of life”. David Lammy MP [described](#) this proposal as having been “written on the back of a fag packet”. Dr Zubaida Haque, Director of the Runnymede Trust, [tweeted](#): “It’s as though we’re experiencing groundhog day with review after review on racial inequalities – with no implementation of recommendations to address systemic racism and discrimination in policies and structures”.

The second PHE report on the COVID-19 racial disparity was [published](#) on 16 June. It reaches no firm conclusion as to the causation of the disparity, stating that stakeholders had consistently raised issues of racism and structural disadvantage but that “no work was

¹ These are:

Improving the Test and Track initiative, particularly taking into account language barriers.

Ensuring that all key workers have access to PPE, in light of a survey conducted by the RCN which showed that only 43% of BAME nurses had reported that they had received eye and face protection equipment compared to 66% of white British nurses.

Strengthening the social security safety net in recognition of the impact of poverty and disadvantage on access to social and health care.

Increasing statutory sick pay and widening eligibility for it.

Scrapping the No Recourse to Public Funds condition imposed on migrants with limited leave or those without leave to remain.

Scrapping the healthcare charging regulations and data-sharing agreement between the NHS and the Home Office.

done to review the evidence base behind stakeholders comments”. The report makes far-reaching recommendations² arising from the stakeholder contributions, which have been [described](#) by Professor Raj Bhopal of Edinburgh University (who initially leaked the second report) as “*absolutely excellent*”.

It is to be assumed that the recommendations made in the second report will dovetail in some way with the work announced by Kemi Badenoch MP on 4 June (see [above](#)) and/or the cross-governmental review announced by the Prime Minister on 15 June (see [above](#)). The precise relationship between these three projects is as yet unclear.

We consider below what legal recourse may be available in the event that the government fails properly or expeditiously to implement the recommendations in the second report, or in the event that it persists in what appears to be an unfortunate tendency to seek to suppress information that is relevant to this pressing matter.

LEGAL ANALYSIS

The following legal rights are engaged:

- The Public Sector Equality Duty (PSED) in s.149 of the Equality Act 2010 (EqA 2010).
- Section 6 and Articles 2, 8 and 14 of the Human Rights Act 1998 (HRA).

² These are:

1. Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

2. Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.

3. Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

4. Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee’s exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

5. Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

7. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

The Public Sector Equality Duty

Scope of the duty

The legislation imposes a general equality duty on public authorities, including the government. This means that the government must, when it is exercising its functions, have due regard to the following three aims:

- (1) The need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EqA 2010.
- (2) The need to advance equality of opportunity between persons who share a relevant protected characteristic (eg a particular race or ethnicity) and persons who do not share it.
- (3) The need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having “due regard” means consciously considering the three aims. This must be done at the time that the functions are being exercised; it is not enough to say in retrospect that the aims have been met, if they were not demonstrably in the mind of the public authority at the time that the relevant function was being exercised. The consideration of the aims must be meaningful, rigorous and substantial, and not a tick box exercise³. Equality should be at the centre of policy making, side by side with all other pressing circumstances of whatever magnitude⁴.

It is a duty to have due regard, rather than to meet the needs directly. However, and particularly in a political environment, the ability of a public body to show that it has had due regard will be important in maintaining public confidence in it (as well as demonstrating legal compliance). It is an area in which leadership is important. Thus when Eric Pickles told local authorities that they no longer needed to collect diversity data (a policy which itself was not properly assessed under this duty) it ran the risk of reducing the effectiveness of the duty in society generally.

The duty will include a duty to make further inquiries where there is evidence that a disadvantage may be due to a protected characteristic⁵.

Equality of opportunity

The second aim of the PSED, the need to have due regard to the need to advance equality of opportunity, appears to be most relevant.

The EqA 2010⁶ mandates that, in order to comply with this aim, a public body must pay particular attention to the need to:

- *Remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.* ‘Disadvantage’ is not defined in the Act, but the [EHRC Technical Guidance on the PSED](#) explains that it may include exclusion, rejection, lack of opportunity, lack of choice or barriers to accessing services. This

³ R (*Brown*) v. *Secretary of State for Work and Pensions* [2008] EWHC 3158

⁴ *Stuart and others v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, McCombe LJ at para 60

⁵ See the disability case of *Pieretti v Enfield Borough Council* [2010] EWCA 1104

⁶ S.149(3)

would include lack of choice for individuals as to how to take steps to protect themselves based on information as to health risks.

- *Take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it.* This includes ensuring that there is an opportunity for those who share a protected characteristic to receive information of relevance to their situation. Thus, evidence about the reasons why BAME individuals have a greater risk from COVID-19 may affect their life and/or health prospects.

Importantly, the Technical Guidance makes the point that this aim addresses the issue of *historic disadvantage* in a way that the first aim (the need to eliminate discrimination) cannot⁷. In making policy or decisions, the government must take into account the fact that people of a particular race may experience disproportionately poor health (amongst other things) by comparison to people of other races as a result of historic disadvantage, and it must pay due regard to the need to rectify that disadvantage or to meet the particular needs which arise because of it.

A public body may consider the use of proportionate positive action measures to remove or minimise disadvantage or to meet the particular needs of a disadvantaged group. The Technical Guidance spells out that if the public body has identified such positive action measures, but nevertheless decides not to take the action, it should be able to explain how it complied with the general equality duty in reaching that decision⁸.

The second PHE report contains recommendations aimed specifically at removing or minimising racial disadvantage and meeting the health needs of people of particular races. Those recommendations amount to positive actions, which the government initially appears to have deliberately decided not to take forward, but has now announced an intention to implement. If it fails to do so it will have to show how it has complied with the general equality duty in making that decision.

Thus, by releasing the second report, the government has now put itself in a position which requires it to consider taking positive action measures and to justify any decision not to do so.

There is some indication in the report and in the announcement made by government that it might argue that it needs to collect further data before it can proceed to take these positive action measures.

However, the Technical Guidance makes clear that having insufficient data about a relevant issue is not an acceptable reason for non-compliance. If it does not have sufficient data to have due regard, the authority should collect it. It should do this by collecting new data if there is sufficient time and it is proportionate to do so⁹. Where people are dying in a pandemic, there is no time for long-winded, apparently open-ended further evidence gathering. It is also plainly arguable that it is not proportionate to enter into *another* data gathering exercise when the second report as well as various other reviews, reports and recommendations are available.

⁷ Para 3.10

⁸ Para 3.17

⁹ Para 5.20

Enforcement

An individual cannot bring a private law claim against the government for failing to comply with the PSED¹⁰, although a breach may be relevant in evidence in private law claims based on other causes of action (such as a claim for indirect race discrimination).

An individual can make a claim directly against the government in relation to its compliance with the PSED as part of an application for judicial review in the administrative courts. The Equality and Human Rights Commission (EHRC) can also bring a claim as part of its enforcement powers¹¹. The EHRC has specific powers to enforce the PSED: assessment and compliance notices¹². If, following an assessment, it concludes that the authority has not complied with the PSED it can give it a notice requiring compliance and written information about the steps that have been taken or are proposed to be taken. Ultimately the EHRC can seek to enforce the compliance notice by court order¹³. It can also enter into an agreement as an alternative¹⁴.

An individual or BAME organisation might be able to bring a judicial review of an administrative decision which adversely affects them. The administrative court has a discretion to declare a decision unlawful and to render it of no effect (or to require the decision maker to take specific actions).

The Human Rights Act

The government is prohibited by s.6 HRA from acting in a way which is incompatible with rights conferred by the various Articles of the European Convention on Human Rights and Fundamental Freedoms (ECHR). A body such as Public Health England acts as part of the state and therefore also has obligations under s.6 HRA.

Article 8 ECHR

Art. 8 ECHR confers on individuals a right to respect for private life.

Case law of the European Court of Human Rights in Strasbourg has consistently recognised that the right to respect for private life guaranteed by Art. 8 encompasses the right to the protection of one's physical, moral and psychological integrity, as well as the right to choose, or to exercise one's personal autonomy – for example, to refuse medical treatment or to request a particular form of medical treatment¹⁵.

Art. 8 also gives rise to both negative and positive obligations. The Strasbourg Court has found states to be under a positive obligation to secure the right to effective respect for physical and psychological integrity¹⁶.

¹⁰ Section 156 EqA 2010

¹¹ See Chapter 7 Technical Guidance.

¹² Section 31 and s.32 of the Equality Act 2006 (EqA 2006)

¹³ Section 32(8) EqA 2006

¹⁴ Section 23 EqA 2006

¹⁵ *Glass v the United Kingdom* no. 61827/00, 9 March 2004 §§ 74-83; *Tysiarc v Poland* no. 5410/03, 20 March 2007

¹⁶ *Sentges v the Netherlands* no. 27677/02, 8 July 2003; *Pentiacova and Others v Moldova* no. 14462/03, 4 January 2005; *Nitecki v Poland* no. 65653/01, 21 March 2002

In addition, these obligations may require the State to take measures to provide effective and accessible protection of the right to respect for private life through the implementation, where appropriate, of specific measures¹⁷.

It is no great leap from these decisions to suggest that in order for Art. 8 rights to be properly fulfilled, individuals must be equipped with the information they need to make health-based choices. If there remains information which has been suppressed by the government relating to the causes of the health disparity and recommendations, it could be argued that disclosure and proper discussion of that information would enable members of the BAME groups affected to make decisions on matters such as appropriate social distancing and other risk management steps.

The decision of *Vilnes and others v Norway*¹⁸ is illustrative. There, the applicants were former divers who as a consequence of their professional activities suffered damage to their health resulting in disability. The Strasbourg Court accepted that there was a strong likelihood that their health had deteriorated as a result of decompression sickness, due to the use of too-rapid decompression tables. Standardised tables, which could suitably be viewed as an essential source of information for divers enabling them to assess the health risks involved, had not been achieved until 1990. Thus, with hindsight at least, it seemed probable that if the authorities had intervened to forestall the use of rapid decompression tables earlier, the risk could have been averted sooner. Diving companies were not under an obligation to produce decompression tables to obtain authorisation to carry out individual diving operations, but had instead enjoyed wide latitude to opt for tables that offered competitive advantages serving their business interests. There was also no scientific consensus at the time regarding the long-term effects of decompression sickness. In such circumstances, it would have been reasonable for the authorities to take the precaution of ensuring companies observed full transparency and that divers received the information they needed in order to be able to assess the risks and give informed consent. The fact that these steps were not taken and the necessary information provided meant that the respondent state had not fulfilled its obligation to secure the applicants' right to respect for their private life as guaranteed by Art. 8¹⁹.

Similarly, in *Guerra and Others v Italy*²⁰ the applicants waited for a number of years for essential information that would have enabled them to assess the risks they and their families ran by continuing to live in their town, which was particularly exposed in the event of an accident at the factory. The Strasbourg Court found that the state had failed to fulfil its positive obligation to provide the local population with information about the risk factors and how to proceed in the event of an accident. This failed to accord respect for their private and family life and was in breach of Art. 8.

It could be argued that the circumstances of the COVID-19 pandemic are similar to a known environmental risk, and that information concerning the reasons why BAME individuals are more at risk of death would fall under that positive obligation. Thus, the

¹⁷ *Tysiac* at [110]

¹⁸ Nos. 52806/09 and 22703/10, 5 December 2013

¹⁹ See to similar effect in the context of exposure to asbestos *Brincat and Others v Malta* nos. 60908/11, 62110/11, 62129/11, 62312/11 and 62338/11, 24 July 2014

²⁰ [1998] 2 WLUK 442

decision taken by the government and/or PHE to withhold the annex to the original report and/or the second report may amount to a breach of Art. 8 ECHR.

It might be thought that a claim under Art. 10 might be made rather than using Art. 8 arguments. Freedom of expression does not, however, without more, confer on the individual a right of access, nor does it embody an obligation on the government to impart information to the individual: see *Leander v Sweden*²¹.

So whilst Art. 10 rights may not be engaged by the state's actions, there is a stronger argument that there is a known health risk against which BAME communities have been less able to protect themselves as a result of not having full information (thus infringing their Art. 8 rights). The context of this argument leads us to Art. 14 non-discrimination rights.

Article 14 ECHR

Art. 14 ECHR provides that the enjoyment of the rights and freedoms in the ECHR shall be secured without discrimination on any ground such as (amongst others) race.

The flexibility of Art. 14 as recently illustrated in *Gilham v Ministry of Justice*²² is worthy of emphasis. There are four applicable principles for the present context:

- (1) Art. 14 is not a freestanding provision but instead is parasitic upon the substantive Convention rights;
- (2) Art. 14 does not require a breach of the substantive Convention right before there can be a breach of it;
- (3) a case may fall within the ambit of a substantive Convention right even if the state has voluntarily chosen to go beyond its express requirements; and
- (4) the Strasbourg Court's concept of discrimination encompasses not only the need to treat like cases alike but different cases differently²³.

Article 14 ECHR with Article 8 ECHR

Even if there is no substantive breach of Art. 8 here (discussed above) is there an argument that BAME individuals have been the subject of discrimination in relation to their right to respect for their private and family life? If so, there may be an argument that the government has breached Art. 14 taken together with Art. 8.

There may be an arguable case to be made that access to information which would explain mortality rates is available to non-BAME racial groups, but is not provided to BAME groups (as it concerns the reasons for the statistics relative to their group). This could form the basis of an argument that there has been discrimination in the field of respect for private and family life.

The purported justification given by Kemi Badenoch MP for the difference in treatment appears to hinge upon the quality of the data that is available in each case. However the actions of the state must be seen within its framework of laws, and this will include the rights conferred on any citizen to bring a judicial review of state functions because due regard was not had to advancement of equality of opportunity (ie the PSED in s.149 EqA

²¹ 9 EHRR 433

²² [2019] UKSC 44

²³ *Thlimmenos v Greece* (2001) 31 EHRR 15

2010, discussed above). In those circumstances the government would have to justify its failure to supply the information against the background of its own failure to comply with the s.149 duty. If it has failed to comply with that duty, it would seem unlikely that it could justify the difference in treatment for the purposes of Art. 14. Given also that the difference in treatment is based on race, very weighty reasons would be needed before it could be justified.

Article 14 ECHR with Article 2 ECHR

Art. 2 ECHR confers the right to life. It encompasses two positive duties of note:

- (1) The requirement to make regulations compelling hospitals to adopt appropriate measures for the protection of patients' lives²⁴. The court reviewed its position in the *Lopes de Sousa Fernandes* case²⁵ on state negligence in medical cases. A substantive violation of Art. 2 would only be found if the relevant regulatory framework failed to provide proper protection for the individual's life. The second type of exceptional circumstance the Court envisaged was where a structural or systemic dysfunction in hospital services results in a patient being deprived of life saving treatment²⁶. That dysfunction must be objectively identifiable as systemic or structural to be attributable to the state, and not simply individual instances of failure²⁷. Third, the harm must have resulted from the failure of the state to meet its obligation to provide a regulatory framework. Establishing that third stage might prove difficult in the current situation.
- (2) The "procedural obligation" to undertake an adequate, independent and timely investigation into occasions which give rise to a potential infringement of the substantive Art. 2 right²⁸. The essential purpose of an investigation under Art. 2 is to secure the effective implementation of the domestic laws safeguarding the right to life and, in those cases involving state agents or bodies, to ensure their accountability for deaths occurring under their responsibility²⁹. The procedural obligation extends to the investigation of negligent acts endangering or resulting in loss of human life³⁰. The observations of the Court in *Rantsev v Cyprus and Russia*³¹ may be of assistance. The Strasbourg Court determined that the failure of Cyprus to conduct an effective investigation into R's death constituted a procedural violation of Art. 2. As the Court observed: "art. 2 enjoins the state...to take appropriate steps to safeguard the lives of those within its jurisdiction. In the first place, this obligation requires the state to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person backed up by law enforcement machinery for the prevention, suppression and punishment of breaches of such provisions. However, it also implies, in

²⁴ *Calvelli and Cigliò v Italy* [GC] at 49; *Vo v France* at [89]; *Lopes de Sousa Fernandes v Portugal* at [166]; *Trocelier v France* at [4]

²⁵ at [185ff]

²⁶ at [192]

²⁷ at [195]

²⁸ *İlhan v Turkey* at [91]-[92]; *Šilih v Slovenia* at [153]-[154]

²⁹ *Hugh Jordan v the United Kingdom* at [105]; *Nachova and Others v Bulgaria*, at [110]; *Al-Skeini and Others v the United Kingdom* at [163]

³⁰ *Banel v Lithuania* at [70]

³¹ (2010) 51 EHRR 1

appropriate circumstances, a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual”³². That case concerned protection from criminal acts, but it is plain that the same logic applies to other wrongful acts.

Plainly, from consideration of the substantive and the procedural aspects of Art. 2, the right to life is at the least engaged. Whilst a freestanding complaint under Art. 2 is unlikely to succeed, in our view the interplay between Arts 2 and 14 is a more fertile basis of challenge. If the state is aware of a heightened risk to the enjoyment of the Art. 2 rights by those within an Art. 14 category, we are of the view that there is a positive obligation to investigate, at least. This must extend beyond stating the problem; it must instead translate into identifying causes and potential solutions.

Enforcement

An individual wishing to bring a claim that their human rights have been breached can bring a claim under s.6 HRA. Proceedings would be started in the civil courts, either as a claim for breach of the Act or as an application for judicial review.

CONCLUSION

In terms of the applicable law, the Public Sector Equality Duty in s.149 EqA 2010 appears to be the strongest challenge. However it is subject to a very short time limit (without undue delay and in any event within three months). The remedy would also simply be that the government should consider whether to publish the information and justify why it would not be appropriate to do so, if that was the conclusion to which it came.

Underlying all of this is the link between the socio-economic duty under s.1 EqA 2010, never implemented and then repealed, and advancement of equality of opportunity in respect of historical (and current) economic disparity for BAME groups.

There is an opportunity, in the form of the proposed cross-governmental commission, for the government to look again and strengthen the public sector equality duties. The risk otherwise is that should a “second wave” or further pandemic strike, BAME groups may find, again, that the chronic neglect of their specific health concerns will leave them exposed.

³² at [218]