IN THE MATTER OF THE COVID INQUIRY

MODULE 3

WRITTEN SUBMISSIONS ON BEHALF OF THE COVID-19 AIRBORNE TRANSMISSION ALLIANCE (CATA)

SAUNDERS LAW

Preliminary Hearing: 28 February 2023

INTRODUCTION

1. These submissions are made ahead of the first preliminary hearing for Module 3, listed on 28th February 2023, and with sight of the note for the preliminary hearing drafted by Counsel to the Inquiry, dated 8th February 2023.
2. The COVID-19 Airborne Transmission Alliance (CATA) is grateful to the Chair for granting its application for Core Participant ("CP") status in Module 3 and looks forward to assisting this inquiry in pursuing an effective investigation. Our consortium hopes to be able to achieve this by providing our medical and scientific expertise; and informed analysis and insights, especially through our suggested questions and lines of enquiry.
3. By way of introduction, CATA is a voluntary and collaborative forum of professional, scientific and employee organisations and individual representatives, across the UK. It is an umbrella organisation of 12 constituent bodies and 7 individual representatives and over 65,000 members, including professional organisations, trade unions and healthcare charities, which provide a representative voice for a wide range of healthcare workers in both institutional and community settings.
4. CATA is not a legal entity and its membership is taken to comprise those organisations and individuals who were members of the alliance at the time of CATA's application for Core Participant status in the COVID-19 Inquiry. To streamline its engagement with the COVID-19 inquiry, CATA has established an "Executive Team" which can feed instructions to its Recognised Legal Representative (RLR) quickly and effectively. The Executive Team currently

comprises Barry Jones (Chair of CATA and CAPA and Chair of BAPEN faculty), Kamini Gadhok (Vice Chair of CATA and CEO of RCSLT), Kevin Bampton (CEO of BOHS), Nicholas Bull (CEO of QNI), and David Osborn (Co-ordinator of CATA and independent Health and Safety Consultant). In addition, each member organisation of CATA has nominated a "Lead Representative" who will have responsibility for ensuring that its organisation's interests and instructions are fed in to RLR throughout the Inquiry.

5. CATA is formerly known as the Aerosol Generating Procedures Alliance (AGPA), and subsequently the Covid Airborne Protection Alliance (CAPA), which was formed in August 2020, in response to the UK Government's failure to recognise and adequately respond to the airborne route of transmission of the Covid-19 virus. The AGPA's core concern then, was that the UK Government's failure in this regard, was putting health care workers at significant risk of illness and death. In particular, the lack of acceptance of the risk of airborne transmission led to policies, decisions and practices that deprived health workers of the correct Respiratory Protective Equipment (RPE) to protect them from infection, except in the context of "aerosol generating procedures" (AGPs).
6. CATA is a consolidation of the organisations and concerns raised within CAPA and the AGPA. CATA was formed in the wake of the establishment of the Covid-19 Inquiry, to ensure that its knowledge of the existing and developing scientific evidence base for the aerosol transmission of SARS Covid 2, as well as the lived experiences of its members, was made available to the Inquiry. In addition, it sought to also address wider concerns about the effective management and impact of respiratory risks in healthcare and community contexts.

CORE ISSUES

7. CATA has the following core concerns:

i. There was a failure to appreciate contemporaneous science regarding the airborne transmission of Covid-19

8. It is CATA's contention that the UK Government failed to recognise the existing independent scientific evidence base, that was available within the broader scientific and research community and which was communicated to Government directly by CATA, regarding the airborne nature of the Covid-19 virus. The government subsequently failed to promptly and adequately address the emerging evidence base, including from its own commissioned research. This resulted in a prolonged, mistaken focus on a droplet transmission route of Covid-19, and a subsequent misdirection of employers and healthcare workers about how best

to manage the risks associated with the Covid-19 virus. This misinformation on the risk to workers not only undermined worker protection, but also professional decisions about the management of clinical risk and deprived health workers of the ability to make informed decisions about personal clinical risk.

9. The Lancet Commission notes that currently[1]:

> *A paradigm shift in how we view and address the transmission of respiratory infectious diseases is underway. Airborne transmission in both the near-fields and the far-fields is a crucial, if not dominant, exposure pathway for SARS-CoV-2 and other respiratory viruses. Laboratory, field, modelling, and case studies have shown that airborne transmission through the inhalation of a virus-laden aerosol is important, if not dominant, for COVID-19. Although transmission can occur through touch, it is rare for respiratory viruses, and touch and spray transmission are not likely to contribute to widespread transmission or superspreading events.*

10. CATA contends that for a very long time, the management of the pandemic seemed to follow the 2011 UK Influenza Pandemic Preparedness Strategy, and in so doing, wrongly made assumptions that the transmission route of Covid-19 was the same as influenza - despite scientific evidence to the contrary. Crucially, prior to the pandemic, beta coronaviruses including SARS were recognised to be transmitted via the airborne route, but the UK Government's early response was altered to the droplet route without any new evidence to support such a change. Further, the findings of Exercise Cygnus in 2016[2], which had established that the UK's preparedness for response to a large-scale influenza pandemic was inadequate and had made recommendations regarding PPE, were not followed. This was further highlighted by Exercise Iris in Scotland which identified general issues with the capability of the UK and Scottish Authorities to supply, manage and deploy PPE.[3]
11. It is CATA's submission that through the failure to act upon specific advice, scientific evidence and practical learning, about the control of SARS coronavirus, the UK Government and public authorities failed to implement protections of healthcare workers - and the general population - that were scientifically and legally necessary to protect health and life. The precautionary principle was not applied for the protection of health and safety of healthcare workers or in

[1] "*The Lancet Commission on lessons for the future from the COVID-19 pandemic*," September 14, 2022 https://doi.org/10.1016/ S0140-6736(22)01585-9 , at p13

[2] Annex A: about Exercise Cygnus - GOV.UK (www.gov.uk).

[3] See also: Exercise Silver Swan: FOI release - gov.scot (www.gov.scot) and Exercise Iris Report - gov.scot (www.gov.scot)

line with guidance on the management of civil contingencies from the outset in the Government's response to the Covid pandemic.

12. Moreover, even when airborne transmission appears to have become properly recognised, the UK healthcare system failed to reflect this understanding in terms of policy and management practice, and as a consequence, exposed healthcare staff, patients, and the wider community to an unacceptable level of risk resulting in avoidable deaths and illness. CATA therefore believes that this fundamental failure impacted on all aspects of the management of the pandemic and continues to do so.

ii. There was inadequate provision of PPE / RPE

13. As a result of the failure to understand the consequences of the airborne route of transmission of Covid-19, legally required Respiratory Protective Equipment (RPE) was replaced by Fluid Repellent Surgical Masks (FRSM), in healthcare and community healthcare settings, which has never been classified as Personal Protective Equipment (PPE) by the Health and Safety Executive (HSE), the expert regulator in this area.
14. FRSMs are designed to protect others from the wearer expelling droplets during respiration, speaking and coughing. As stated in the Chemical, Biological, Radiological and Nuclear (CBRN) guidance "surgical masks do not protect against the infection following inhalation of small (< 5 micrometres) particles."[4] FRSMs were therefore not classed as effective RPE before 2020 and are regarded as a "source control" in infection control. These are also known as type IIR (European standard) or Level 2 (US standard masks).
15. This followed on from the 2008: Health and Safety Executive (HSE) Laboratories – Research paper RR619 into respiratory protection against bioaerosols. It was commissioned as part of UK pandemic preparations and confirmed that FRSMs were ineffective against bioaerosols, with live viruses being detected behind each type of mask tested. HSE subsequently formally published online guidance (which was later withdrawn) that FFP3 filtering masks should be worn when attending a SARS patient (referring to SARS-1). This guidance and existing knowledge was disregarded in UK policies from the start of the Covid-19 pandemic. A general level of ignorance of RPE persisted amongst policy-makers and consequently there was insufficient infrastructure to support an adequate PPE management programme in healthcare settings.

[4] See Public Health England, CBRN: Clinical Management and Health Protection Guidance (latest version 2018)

iii. There was a lack of transparency in government decision making

16. Since the start of the pandemic, CATA and its members have called for greater transparency and consistency in governmental decision-making bodies. CATA submits that there was inadequate transparency and oversight to prevent the Government from being misdirected on scientific decision-making during the pandemic. For example, there was a lack of transparency on the scientific sources and basis for decisions that were made, such as the focus on droplet as opposed to airborne transmission, the decision to remove the High Consequence Infectious Disease (HCID) status of Covid-19 and the decision to downgrade protective equipment for healthcare workers from effective RPE to FRSMs. Most specifically, the role of the "Infection Prevention and Control Cell" was not previously identified in the governance of pandemic management and its membership and basis for deliberations are unclear. Yet the IPC Cell was deferred to in all matters of health and safety and transmission control in healthcare settings. The result was that the Government, public bodies and employers failed in their legal and public duties to assure public health and safety, particularly in the context of healthcare.

iv. Protection of healthcare workers was not in line with health and safety law

17. There are three strands of law that intersect to define how the UK addresses infectious risk in a serious context such as a pandemic. Firstly, health and safety laws seek to protect workers and individuals. Secondly, civil contingencies legislation and practice guidance are designed to protect the infrastructure and life of the nation. Thirdly, infection prevention and control regimes mitigate the risk of healthcare premises and workers becoming active agents in the spread of infection, and consequently, having a negative effect on patient outcomes. These regimes also support the objectives of health and safety and civil contingency protections.
18. At the outset of the pandemic, the legal and technical requirements for risk mitigation and protection were clear. The proper means for managing respirable biological risk, where there was a potential for transmission via airborne routes in a work setting, are set out under Health and Safety law and applicable HSE rules for implementation. This specifically laid out the appropriate type of equipment, protection factor and management regime required to be compliant with UK law. The application and enforcement of law and standards by HSE, appear to have been changed on or around March 2020. Such a change seemed most apparent in the healthcare contexts, in the downgrading of the classification of PPE (to include type IIR masks which were not classed by HSE as RPE or PPE previously), the requirement assigned for addressing respiratory risk and the market standards for design and fit. This appears to

have reduced the protection below the minimum legal standard of protection. The legally appropriate RPE measures required to deal with SARS coronavirus were unambiguous regardless of what the predominant mode of transmission might be. This legal standard was deviated from.

19. The Civil Contingencies Act 2004 set out requirements for dealing with chemical, biological, radiological and nuclear emergencies. This includes having suitable means for the clinical management of risks, such as explicit measures designed to secure the resilience, sustainability and continuity of healthcare services when faced with SARS coronavirus. The approach required was embodied in Public Health England's "*Chemical, biological, radiological and nuclear incidents: clinical management and health protection*" publication which lays out the RPE measures and approaches that need to be followed to protect the health service and clinical staff. It is fully aligned with the Health and Safety duties. This was deviated from substantially in March 2020.
20. The Health and Social Care Act 2008 and Associated Code of Practice on the Prevention and Control of Infections and Related Guidance set out a duty to protect staff health and wellbeing.[5] This requires effective precautions against the transmission of infections, not only in a way that protects patients, but in a way which protects the mental and physical health of staff. Infection Prevention and Control (IPC) guidance in relation to SARS Coronavirus prior to the pandemic and immediately leading up to it required the use of RPE for contact with patients with diagnosed or suspected infection, mirroring the requirements of Health and Safety and Civil Contingencies law.
21. The lack of recognition for the need to control known and potential airborne transmission in healthcare settings represents breaches of employer's duties under UK Health and Safety law. The IPC guidance was used as the exclusive reference point for the management of hazards, to the exclusion of other legal standards such as the Control of Substances Hazardous to Health Regulations. The protection of staff in healthcare settings and in the community was not maintained in line with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The ultimate result was that the framework of health risk management did not accord with minimum standards of acceptable practice.

v. Policies did not account for the needs of the diverse services making up the health and social care system

[5] See criterion 10 of the Approved Code of Practice (ACOP).

22. The management of risk was not undertaken in a way that demonstrably appreciated diversity in the needs of health workers requiring PPE and increased the risk to women, the disabled and certain ethnic and religious groups. In addition, there was not sufficient consideration of risks in the context of community healthcare as distinct from a hospital setting.
23. There was an inability to see the management of Covid-19 and infection control in a holistic way. Matters were approached in siloes, often from a few narrow perspectives; i.e. from the perspective of a hospital, GP surgery or as a wider public health problem. There was no appreciation of the interplay of the various parts the health and social care ecosystem. This led to poor outcomes for patients and services users and left staff working in critically vulnerable circumstances across a wide range of services and settings, including care homes, ambulances and community health services.

vi. The impact on healthcare workers

24. The consequences of the aforementioned UK Government failures in the response to Covid-19 is an unacceptably high level of avoidable and preventable death, acute and chronic sickness amongst healthcare workers, impacting physical and mental health, as well as an avoidable and at times overwhelming burden on the provision of healthcare to the general population.
25. Further, an important issue regarding the impact that the pandemic has had on health care workers, which CATA seeks to be addressed, is the effect of long Covid. The condition of long Covid itself remains ill-defined and there is much uncertainty about the scale of the impact and implications for individual health and for the wider workforce and service delivery. There has also been limited support made available to the victims of this condition.
26. In addition, there has been inadequate reporting of health care workers Covid-19 infections and deaths under RIDDOR, which requires further investigation.

vii. The wider impact on population in general and patient safety

27. There were significant consequences of the failure to recognise the airborne transmission route of Covid-19 on patients, service-users and staff working in both institutional and community healthcare settings. The exposure of the health care workforce to Covid-19, without effective protection, had a direct impact on patient safety, as it increased the risk of infection in healthcare settings, and reduced access to care as a result of health care workers being unavailable due to illness, both immediately during the pandemic, and since as a result of long Covid.

28. CATA has evidence of the impact of policy decisions which closed or restricted access to healthcare services for the public and patients across all age ranges. Examples include children who are now presenting with more complex communication needs and adults with progressive or acquired conditions e.g. stroke, motor neurone disease, Parkinson's and cancer, presenting with more complex clinical conditions.

IMPORTANT LINES OF ENQUIRY

29. CATA has an interest in the Inquiry conducting a thorough investigation of all the issues within the scope of Module 3, but it holds a particular interest in the following issues outlined in the Inquiry's provisional Module 3 scope:

> *2. Core decision-making and leadership within healthcare systems during the pandemic*
>
> *5. Healthcare provision and treatment for patients with Covid-19, healthcare systems' response to clinical trials and research during the pandemic. The allocation of staff and resources. The impact on those requiring care for reasons other than Covid-19. Quality of treatment for Covid-19 and nonCovid-19 patients, delays in treatment, waiting lists and people not seeking or receiving treatment. Palliative care. The discharge of patients from hospital.*
>
> *7. The impact of the pandemic on doctors, nurses and other healthcare staff, including on those in training and specific groups of healthcare workers (for example by reference to ethnic background). Availability of healthcare staff. The NHS surcharge for non-UK healthcare staff and the decision to remove the surcharge.*
>
> *8. Preventing the spread of Covid-19 within healthcare settings, including infection control, the adequacy of PPE and rules about visiting those in hospital.*
>
> *10. Deaths caused by the Covid-19 pandemic, in terms of the numbers, classification and recording of deaths, including the impact on specific groups of healthcare workers, for example by reference to ethnic background and geographical location.*
>
> *12. Characterisation and identification of Post-Covid Condition (including the condition referred to as long Covid) and its diagnosis and treatment.*

30. CATA contends that the Inquiry needs to explore the following questions when it investigates the above issues in order for the investigation to be adequate:

i. How, by whom and on what evidence were decisions which relate to our core concerns made?
ii. What was the scientific basis and governance process which led to the publicised UK Government conclusion in March 2020 that Covid-19 was not transmitted by aerosol or airborne routes?
iii. Why was there a persistent adherence to the Aerosol generating procedures (AGP) list as a main indication for RPE based on erroneous interpretation of "the science"?
iv. What was the basis in evidence for downgrading from the need for RPE to surgical masks?
v. What has been the impact on healthcare workers in terms of deaths and illness that arose from the downgrading, mismanagement or non-availability of respiratory protection?
vi. How was it possible that IPC guidance and guidance on respiratory protection were inconsistent between home nations and between Cabinet Office guidance and IPC guidance?
vii. Why was there insufficient consideration in planning and execution of pandemic protection on healthcare staff in relation to the known diversity of the workforce?
viii. Why, as the national scale of the crisis emerged, was there no effective national plan for the communication and management of life-saving information in healthcare settings?
ix. What has been the impact on outcomes for patients who could not access services or treatment in a timely way?
x. Why has there been limited reporting under RIDDOR of health care workers infections and deaths with Covid-19?
xi. Why has there not been a long-term illness or disability allocation made available for healthcare workers living with long Covid, similar to the 'death in service' allocation introduced for Covid-19?

RULE 9 REQUESTS / WITNESSES

31. The Inquiry needs to satisfy itself that it can access independent scientific advice and the advice of civil servants who have not been able to publicly speak out about the science and management of the pandemic. For example, it is crucially important for the Inquiry to obtain

witness evidence from the HSE's science division about PPE effectiveness, about the findings of the research of the PROTECT COVID-19 National Core Study on transmission and environment[6] and from current and former members of the HSE's Field Operations Team about the management of the national PPE programme. The Inquiry will need to ensure that whistle-blowers are protected by way of anonymity, where necessary.

32. The Inquiry must explore the issue of how respiratory protection programmes are managed and how there needs to be effective links between the HSE, the British Occupational Hygiene Society and the British Safety Industries Federation, as the three national organisations which lead technical and scientific practice in the area of respiratory protection.
33. CATA has a wealth of evidence that may assist the Inquiry's investigation as part of Module 3, and it would be happy to assist the Inquiry in this regard in due course.

EXPERTS

34. CATA welcomes the Inquiry's commitment in paragraphs 53- 59 of the submissions from CTI in their Note for CPs dated 14th February 2023 to providing CPs with an opportunity to make observations on the identity of the expert witnesses they appoint, and the questions and issues they will be asked to address in their reports, and that it will consider suggestions from CPs as to who should be appointed.
35. CATA will in due course make more detailed submissions on experts that it considers the Inquiry may wish to instruct as the Module progresses. At this stage CATA simply wishes to highlight that, as a representative of a vast range of health care organisations, it hopes that it can be a useful resource for the Inquiry in identifying experts. In addition, CATA wishes to highlight the importance of seeking evidence from experts who were not directly involved in government decision-making during the pandemic to avoid any potential for conflicts of interest.

THE LISTENING EXERCISE

36. CATA welcome's the Inquiry's commitment to the Listening Exercise. CATA's members are anxious to ensure that the wider health care workforce, many of whom are bereaved and all of whom had their lives significantly impacted by the pandemic, have their voices heard in this

[6] See https://sites.manchester.ac.uk/covid19-national-project/.

process. CATA therefore invites the Inquiry to take steps to ensure that the Listening Exercise is brought to the attention of these sectors.

37. In addition, CATA notes that there is a group of workers who have been forced to leave the health care workforce as a result of the impact of the pandemic, and so also invites the Inquiry to seek out the perspective of those individuals.

POSSIBLE INTERIM RECOMMENDATIONS

38. CATA submits that Covid-19 remains a chronic and acute threat to health-workers which requires a better strategy for management now that community precautions have been lifted. The potential for a vaccine-resistant or more harmful variant cannot be overlooked or ignored. CATA submits that this Inquiry should commit to being open to making such interim recommendations as are appropriate, with a view to saving lives in the future. The Inquiry must not wait many months until the conclusion of the Module 3 hearings before making such recommendations. Urgent interim findings may be needed to manage the safety of healthcare workers who continue to operate within the context of an ongoing pandemic.

Mr. Stephen Simblet KC – Garden Court Chambers

Mr. Philip Dayle – No5 Chambers

Saunders Law

February 21, 2023