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: 27 September 2023

Introduction

1. As the Inquiry knows, CATA is a voluntary and collaborative forum or consortium, made up of professional, scientific and employee organisations and individual representatives, from all across the UK. It was formed in response to the UK government's failure to recognise and adequately respond to the airborne route of transmission of the Covid-19 virus.

2. CATA's central contention is that the UK Government's failure to recognise airborne transmission of COVID-19 in a timely manner put health care workers at significant risk of illness and death and caused other serious problems. In particular, the concern is that the failure to respond to the nature of airborne transmission resulted in policies, decisions and practices that deprived health care workers of the correct Respiratory Protective Equipment (RPE).

3. CATA hopes that its current and previous submissions will help the Inquiry to adopt the correct starting point. Simply, it had been known for many years prior to the pandemic that beta coronaviruses, including SARS are transmitted via the airborne route. Rather than being a "*little-known virus*," there was already a lot known about these types of viruses and importantly, there was an appropriate regulatory framework already in existence for responding to such viruses. CATA anticipates that one important issue

that will be canvassed by the Inquiry in its upcoming Module 2 hearings, is why there was deviation from these existing policies and procedures – and instead, why there wasn't effective implementation of the appropriate framework for response. For the first preliminary hearing for Module 3, we said at paragraph 9 of our written submissions: "*the prolonged, mistaken focus on a droplet transmission route of Covid-19 misdirected all from proper and effective risk management, undermining both worker protection and measures to manage clinical risk."* This essentially, encapsulates the nub of our concerns for the Inquiry's investigation of the healthcare system in Module 3.

Scope of Inquiry

4. CATA welcomes the broad scope of enquiry for Module 3 that has been indicated by the Inquiry team, and is pleased that some of the stated areas appear to have taken onboard CATA's previous submissions, including:

    i) The implication(s) of the decisions to classify and then declassify Covid-19 as a High Consequence Infectious Disease ("HCID");
    ii) How scientific understanding of the route of transmission evolved during the pandemic, and what implications this had for IPC in healthcare settings;
    iii) How IPC guidelines were created and updated during the pandemic;
    iv) The IPC measures adopted to prevent the spread of Covid-19 in healthcare settings, including the designation of certain procedures as aerosol generating and any changes to this guidance;
    v) How RPE and PPE guidelines were created, updated and communicated during the pandemic;
    vi) Adequacy of RPE and PPE provided to healthcare workers during the pandemic including;
    vii) Whether the standard of RPE and PPE provided to healthcare workers followed the scientific understanding of the virus as the pandemic progressed;
    viii) The ability of healthcare workers to access PPE and RPE at work including requesting further supplies of PPE and RPE, and whether the risk of shortages had any effect on guidelines; and
    ix) RIDDOR reporting requirements for health care workers who were infected and/or died from workplace contracted Covid-19.

5. In these brief submissions, we will seek to contextualise and reinforce key lines of enquiry that we have advocated for in Module 3. At this point, our primary emphasis in Module 3 may be described in three thematic parts: i) knowledge of the scientific evidence of COVID-19 transmission and how it evolved; ii) transparency and governance in the development of Infection, Prevention and Control ("IPC") and other guidance regarding infection control; and iii) significant issues concerning the healthcare workspace, including RIDDOR, diversity and non-institutional settings.

6. CATA will also make some submissions on matters of procedure and evidence.

I. Knowledge of the scientific evidence of COVID-19 transmission and how it evolved.

7. Until March 2020, SARS was classified as an Airborne HCID, by the UK Health Security Agency, the management of which in clinical settings required the use of FFP3 masks. In January 2020, COVID-19 was specifically added to the list.

8. An HCID is defined as having the following features:

    - It is an acute infectious disease;
    - It typically has a high case-fatality rate;
    - It may not have effective prophylaxis or treatment;
    - It is often difficult to recognise and detect rapidly;
    - It has ability to spread in the community and within healthcare settings; and
    - It requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely.[1]

9. In March 2020, around the time the UK decided to implement its first national lockdown and COVID-19 deaths peaked at almost 1,000 in one day, the following statement was made:

> *"Now that more is known about COVID-19, the public health bodies in the UK have reviewed the most up to date information about COVID-19 against the UK HCID criteria. They have determined that several*

[1] 'High consequence infectious diseases (HCID)' Guidance, UK Health Security Agency, published 22 October 2018 (gov.uk).

features have now changed; in particular, more information is available about mortality rates (low overall), and there is now greater clinical awareness and a specific and sensitive laboratory test, the availability of which continues to increase.

The ACDP is also of the opinion that COVID-19 should no longer be classified as an HCID.

The World Health Organization (WHO) continues to consider COVID-19 as a Public Health Emergency of International Concern (PHEIC), therefore the need to have a national, coordinated response remains and this is being met by the government's COVID-19 response.

Cases of COVID-19 are no longer managed by HCID treatment centres only. Healthcare workers managing possible and confirmed cases should follow the National infection prevention and control manual for England (or the equivalent devolved administration infection prevention and control manuals), which includes instructions about different personal protective equipment (PPE) ensembles that are appropriate for different clinical scenarios."[2]

10. It is to be noted that SARS-CoV-2 had previously been defined as an airborne HCID along with its close relative SARS-CoV-1 (which remains classified as an HCID). The reason for this change in classification was not based on changes in the evidence base around its route of transmission; rather, the mortality rate and testing capability. To many scientists and healthcare workers, it seemed incongruous to no longer consider this a disease with high consequence and slavishly apply the pre-defined criteria without any degree of flexibility, given that:

    - The disease had significant transmissibility;
    - Symptomless transmission had been confirmed, making it a more dangerous disease;
    - A significant number of deaths (4,613) had already occurred around the world;
    - A significant number of deaths had occurred to healthcare workers, as evidenced in Italy, for example; and

[2] 'Status of COVID-19', 'High consequence infectious diseases (HCID)' Guidance, UK Health Security Agency, published 22 October 2018 (gov.uk).

- Just days earlier, the WHO had declared a global pandemic.

11. The revised IPC guidance published March 2020 removed the requirement for aerosol precautions, including RPE, from most treatment contexts. The availability of FFP3 protection was restricted to those undertaking so-called Aerosol Generating Procedures ("AGP").

12. In early 2020, there was no definitive review or evidence to prove that SARS coronavirus was transmitted by means other than aerosol transmission. Nor was there evidence that this was not the main route of transmission at the time. However, in March 2020, the WHO, despite the protestations of many of the world's experts, declared it to be a fact that COVID-19 was not transmitted via aerosols and categorised any claims that the disease was airborne as "*misinformation*".[3] It is hallowed principle that when considering matters of medical risk, in the absence of scientific certainty, the precautionary principle is to be applied. In other words, the default position should be to err on the side of caution. Healthcare workers should therefore have been afforded the far higher level of respiratory protection provided by FFP3 and similar respirators. By December 2021, the WHO had reverted to the common understanding that SARS coronavirus could be transmitted by airborne routes. It then became apparent that the "*misinformation*", such as it was, had actually begun in March 2020, with the WHO declaration. This "misinformation" contributed to inappropriate and ineffective risk control measures being implemented, presenting great risk to UK healthcare workers.

13. CATA submits that the Government was misdirected on scientific decision-making during the pandemic, in the focus on droplet as opposed to airborne transmission. The consequent decision to remove the HCID status of Covid-19 and to downgrade protective equipment for healthcare workers from effective RPE to Fluid Repellent Surgical Masks (FRSMs), which are not classed as RPE, was nothing short of catastrophic for healthcare workers and their patients.

14. Management of the UK healthcare RPE stockpile and the capability to fit that equipment effectively and safely was determined by NERVTAG (New and Emerging Respiratory Virus Threats Advisory Group), who made these decisions based on the assumed requirements needed to manage an influenza pandemic. Surgical masks, or FRSMs are designed to protect others from the wearer expelling droplets during respiration, speaking, coughing etc. As stated in the CBRN guidance (Chemical, Biological,

[3] See World Health Organisation (WHO) Twitter post, 28 March 2020.

Radiological and Nuclear guidance), "*surgical masks do not protect against the infection following inhalation of small (< 5 micrometres) particles*" because they only reduce the risk of the wearer infecting another. Because they do not provide material protection to the wearer from respirable risks, FRSMs are not, and never have been, classed as RPE. FRSMs have never even been formally classed by the regulator, HSE (Health and Safety Executive) as PPE. Nonetheless, government departments, politicians and the media regularly and erroneously referred to them as such. Respiratory protection that is 99% efficient in filtering small particles, was the required protection for health workers for protection against SARS infection by patients in the CBRN guide. Disposable filtering face pieces with this protection level are known as FFP3 (UK and Europe) or N99 in the United States.

II. Transparency and governance in the development of Infection, Prevention and Control ("IPC") and other guidance regarding infection control

15. From the outset of the pandemic, the management of health risk in the healthcare sector was entrusted to the UK's healthcare IPC infrastructure for management and technical leadership. The UK's IPC focus was on major risks of patient infection, which were not perceived as including diseases transmitted via aerosol or aerosol/droplet routes, except where AGPs were performed. Neither IPC nor pandemic strategy considered in detail, the implications of the management of health and safety duties towards frontline healthcare staff. The assumption was that if patients were protected against infection, then staff would be protected by the same systems and to the level of protection required by health and safety law. It is CATA's contention that IPC guidance failed to protect both HCWs and their patients.

16. Throughout the first and second waves of the pandemic, IPC guidance was prescriptive in that it specified that FRSM must be worn when providing direct care within two metres of a suspected or confirmed COVID-19 case. Later in 2021, IPC guidance was amended such that if an "*unacceptable risk of transmission remains following a 'hierarchy of controls' risk assessment*" then RPE, such as FFP3 respirators, may be used for non-AGP activities. However, the IPC guidance authors introduced the concept of *'risk assessment'* without any appreciation that, in virtually all scenarios of patient care (other than in purpose-built HCID rooms), it is impossible to undertake a '*suitable and sufficient'* risk assessment in the context of close-quarter care of infectious patients without a clear understanding of the routes of transmission, including the airborne route. One of CATA's major concerns is the lack of stakeholder engagement in how IPC guidance was developed. CATA members appreciated the need for appropriate

guidance and not only launched their activism to address this issue, but in their professional circumstances, sought to engender the use of appropriate standards. It is hoped that these matters will be examined by the Inquiry as a matter of critical importance.

17. A notable risk in the pandemic context, is that staff can infect other staff, whether frontline or not, irrespective of infections acquired from patients. However, because of their specific public-facing nature, the risk of acquiring infection from patients in the healthcare context is higher and predictable. Therefore, it is necessary for high-risk settings to have measures in place to control the risk of infection between frontline staff and other frontline staff, or between frontline staff and support staff. Those measures themselves should be planned according to the Hierarchy of Controls, in standard infection control intervention. The barrier between staff and infection by patients in standard infection controls is solely through the use of RPE. There is no provision in the IPC guidance beyond PPE, other than handwashing (and specific provision around staff with diarrhoea in relation to intestinal viruses remaining off shift), to restrict the potential that infection may be spread from staff to staff. The sort of measures used for the management of inter-staff infective risk in other occupational contexts were not articulated or planned for in the healthcare setting. PPE is at the bottom of the Hierarchy of Controls because it fails to danger. In the context of infectious diseases, this means that when PPE fails, its result is predicted to be infection of a member of staff. In the absence of other control measures, then a transmissible disease such as COVID-19, has no further barriers against the infection of other workers.

18. CATA is keen for the Inquiry to focus on the consequences of the decision to restrict respiratory protection against SARS-CoV-2 transmission for healthcare workers to a few categories of medical procedures (AGPs). CATA holds the view that the official list of designated AGPs fell far short of the mark in that it did not include all the medical procedures which generate aerosols. Neither did it address the fact that natural activities such as tidal breathing, talking, singing, coughing and sneezing generate large amounts of aerosol which present a significant hazard to healthcare workers if they are not provided with adequate respiratory protection. This is particularly pertinent to asymptomatic patients and to close quarter care.

III. Significant issues concerning the healthcare workspace, including RIDDOR, diversity and non-institutional settings.

19. In paragraph 26 of CATA's written submissions for the first Module 3 preliminary hearing, we raised the issue of inadequate reporting of COVID-19 infections and deaths

among healthcare workers. Such reports are required by the Reporting of Injuries Diseases and Dangerous Occurrence Regulations 2013 ("RIDDOR"). We made the observation that it appears to have been almost a policy decision not to investigate COVID-19 deaths in inquests. As an example, recently produced statistics by the Scottish Health Boards appear to suggest that not one single health care worker of working age died of COVID-19 between 2020-2022.

20. CATA has paid keen attention to the issue of under-reporting of healthcare workers' infections under the RIDDOR regulations and some of its members were involved with a BBC Panorama investigation on this subject. There appears to have been a lack of consistency in the standard that was applied in determining whether health care workers who contracted COVID-19 or succumbed to it, did so through work. Such determination would have resulted in disentitling claimants of compensation. CATA invites the Inquiry to pursue a robust investigation into this issue and further states that we are ready to assist in providing more information by way of Rule 9 statements, on the Inquiry's request. On a more general point, we maintain that under-reporting under RIDDOR was a huge problem because: a) it severely undermined the base of data for infectivity in the pandemic; and b) created a gap in accurate public health modelling, for case studies and general tracking of the disease.
21. CATA seeks to reinforce the point that RPE is available to meet the varied morphology of human faces. There is a global market for RPE meeting industrial use of it for the filtration or aerosols and dusts. Manufacturers provide for the full variety of different ethnic groups and gender differences. In purchasing RPE for a large workforce such as the NHS, consideration of the diversity of that workforce and a model of the proportionate selection of size and type would be expected. This was required, not only to be pragmatic, but also to discharge any duty under the Equality Act 2010. Prior to the COVID-19 pandemic, available PPE in the UK was modelled on Caucasian males, so that women, smaller individuals and people of non-Caucasian ethnic backgrounds, or those with certain disabilities and illnesses, were not likely to gain a good fit from standard RPE. At the commencement of the pandemic, the experience of member organisations of CATA was that RPE was not readily fitting groups other than Caucasian males. This tends to indicate that the stockpile had not been managed through the proper selection of RPE, with any regard to the known diversity of the workforce. The provision of RPE suited to those for whom close fitting respirators would not be suitable, for medical and ethnic reasons, did not appear to have been a factor considered in stocking or preparing for RPE availability. Neither were other factors considered such as the importance, in some circumstances, of voice

communication between healthcare worker and their patient or service-user. This is particularly relevant for persons with certain disabilities, including those with communication difficulties, for example due to strokes or hearing impairments, where lip-reading assists communication.

22. CATA encourages the Inquiry to take an expansive approach to investigating "*healthcare*". This requires considering not just what went on in institutional settings, but also in community settings. There was a direct personal impact of COVID-19 on CATA members and their families, but this also affected patients and their families. There are significant continuing issues for patient care and provision, with ongoing effects. For example, children presenting with more complex communication needs, as they did not have speech and language therapy and access to services at the height of the pandemic [See para 28 of CATA's written submissions for the first Module 3 preliminary hearing]. CATA invites the Inquiry to explore: i) 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? and ii) What has been the impact on outcomes for patients who could not access services or treatment in a timely way?

Procedure, evidence and witnesses

23. There has so far been no disclosure of documents for Module 3. CATA hopes that the Inquiry will have in mind the need to organise disclosure in a timely manner, and in a way that enables all Core Participants to give as much assistance as possible to the Inquiry in the formulation of submissions, suggestions as to approach, identification of witnesses and suggested questions for witnesses. It is expected that there will need to be further preliminary hearings between now and the time that the Inquiry begins its hearings in the autumn of 2024.

24. While disclosure and a timetable for further progress is awaited, CATA has been able to help in other ways. Ahead of these written submissions, CATA has submitted a detailed witness statement, signed by Barry Jones, which it hopes will be a useful and informative narrative. CATA has also corresponded with the Inquiry by sending a table of suggested expert witnesses, both local and international. CATA hopes that such dialogue can be maintained. CATA hopes that the Inquiry will be receptive to the input from it and other Core Participants on the composition of its panel of experts.

25. It has been mooted that the Inquiry might pay focused attention on an individual trust in order to illustrate particular issues during Module 3. CATA recommends Southampton University NHS Trust as one such potential candidate due to the forward-thinking way in which they engaged with the issues that are core concern for us – and the opportunities that it may provide for learning. This Trust introduced and deployed powered respirator hoods to all healthcare workers and support staff with good effect and workforce uptake.

Conclusion

26. CATA invites the Inquiry to carefully consider its submissions herein and looks forward to the amplification of these points in oral submissions.

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September 11, 2023