Other data sources which might have provided greater insight into the level of occupationally-acquired disease amongst healthcare workers (namely the 'RIDDOR' Regulations, with which the Inquiry will be familiar) have been denied to us.

RIDDOR reporting of healthcare worker infections was systematically suppressed following a meeting held 'behind closed doors' between officials of the Health and Safety Executive and the Department of Health and Social Care during the first wave of the pandemic at a time when it was becoming clear that they were falling ill and dying of the disease.

HSE have acknowledged that such a meeting took place in the context or RIDDOR-reporting, but have so far refused to divulge details of that meeting (even to MPs in the Work and Pensions Select Committee). The HSE's Chief Executive has claimed protection under "legal privilege" for refusing to release details of that meeting.

As the Inquiry lawyers will of course be aware, the most likely reason for hiding behind legal privilege is where an organisation anticipates having to defend lawsuits such as personal injury claims.

So, whilst the four nations' brave healthcare workers were 'stepping up to the plate', knowingly putting themselves in harm's way for the public good and, whilst the public were enthusiastically "clapping for healthcare heroes" at their doorsteps on Thursday nights, covert talks seem to have been underway as to how best to protect the NHS from personal injury claims from these 'healthcare heroes' when they were laid low by the virus.

Reports under RIDDOR are made when cases of "occupational exposure" occur. It was no doubt perceived that a host of such claims would likely ensue once the fallacy was recognised of assertions by Professor Doyle and other senior healthcare figures that surgical masks were "Personal Protective Equipment" (which they are not) and that these would keep them safe whilst dealing with infectious patients (INQ000130506).

It is to be hoped that the Inquiry will wish to further investigate these areas of concern during module 3. They will no doubt be able to rely upon the assistance of core participants such as the Covid-19 Airborne Transmission Alliance (CATA), BMA and RCN

2) Misleading evidence concerning High Consequence Infectious Diseases

I refer to the evidence given by Prof Doyle beginning at p183/L21. It would appear that the professor does not properly understand the basic principles of an HCID and has misled the Inquiry in this respect.

She purported that the declassification of COVID-19 as an HCID was in some way linked with laboratory safety. This is absolutely not the case and is quite untrue. She gave the clear impression that the declassification of COVID-19 from HCID was necessary in order to de-escalate from "category 3" to "category 2" precautions in the laboratory environment.

This was not a one-off "slip of the tongue" as she twice reaffirmed this point in response to Counsel who sought confirmation on this point (183/19 and 184/2).

For the avoidance of doubt the "categories" referred to here are, in fact, the "containment measures" imposed by the COSHH Regulations {Control of Substances Hazardous to Health 2002, as amended}, Regulation 7(6)(h), as set out in Schedule 3, Part II to the Regulations and clarified by paragraphs 130-132 of the Approved Code of Practice (L5).

These "containment measures" represent an important safeguard, not only for the health and safety of laboratory workers whilst culturing and handling highly dangerous bacteria, viruses etc, but also for the wider safety of the general public in preventing escapes of these dangerous organisms from the laboratory facilities out into the community where they may trigger an epidemic or pandemic.

The "Hazard Groups" referred to are explained in Schedule 3, Part 1(2) of the regulations and listed in the document "The Approved List of Biological Agents" produced by the Advisory Committee on Dangerous Pathogens (ACDP). This list classifies pathogenic microorganisms (into 4 'hazard groups') HG1 to HG4 with HG4 being the most dangerous, such as Ebola.

Schedule 3, Part 1(3) then sets out that, in a laboratory, a minimum of containment level 4 (CL4) safety precautions must be applied when working with HG4 pathogens, CL3 precautions when working with HG3 pathogens and CL2 precautions when working with HG2 pathogens.

A further explanation of HCIDs and Hazard Groups may be found expressed in more "layman's terms" at section 4 of this report prepared at the invitation of the Chair of the Commons Health and Social Care Select Committee (Rt Hon Jeremy Hunt MP) to inform its "Lessons Learned" Inquiry in 2021 (INQ000130585).

The virus SARS-CoV-2 which causes the disease COVID-19 was, at quite an early stage in the pandemic, provisionally classified as HG3, the same as the original virus which caused the SARS outbreak in 2002/3 (SARS-CoV, or SARS-CoV-1 as it is now known). However, since this would, as Professor Doyle correctly asserted, have resulted in a lack of laboratory capacity to cope with the COVID-19 emergency something needed to be done.

The Health and Safety Executive therefore allowed a "waiver" in the sense that laboratories equipped only with CL2 facilities would now be permitted to undertake a limited number of specified laboratory procedures involving COVID-19, despite it being a HG3 organism. This was a very sensible and pragmatic step for HSE to take. They published their revised instructions to laboratories in the document "COVID-19: Safe Handling and Processing for samples in Laboratories". It should be noted that this was published on 2 March, long before the declassification of COVID-19 as an HCID. In other words the declassification could not have possibly have happened in order to facilitate the change in laboratory procedures as indicated by Prof Doyle.

For the record, two further points of Prof Doyle's evidence need correction:

- p183/24: that HCIDs require analysis to be undertaken in a category 3 laboratory. She is incorrect on this point in that several HCIDs require laboratories with category 4 facilities (e.g. Ebola, Lassa Fever, Nipah virus etc).

- At p184/19: she confirmed that Covid was declassified as an HCID on 16 March. It was actually declassified on 13 March. Although seemingly a minor point, the actual context of the declassification should be of importance to the Inquiry. The requirement to declassify COVID-19 from HCID status is clearly explained, without any doubt or ambiguity, by reference to the minutes of the NERVTAG meeting on that day (INQ000130525).

  It can be seen at paragraph 2.3 that the Deputy Chief Medical Officer had, the day before, already instructed the NHS to downgrade from FFP3 to FRSM. It can be seen at paragraph 2.9 that members of the NERVTAG committee were cognisant of the fact that the use of FRSMs was not permitted under the health and safety rules for HCIDs. It can then be seen at paragraph 2.10 that the decision to ask ACDP to declassify COVID-19 as an HCID was prompted solely by considerations about respirators and masks. There was no discussion about laboratory safety and the need to de-escalate to containment level 2 as suggested by Professor Doyle.

It is not for me to speculate whether Professor Doyle deliberately set out to mislead the Inquiry as opposed to her genuinely failing to understand the basics of pandemic management as regards HCIDs. It should, however, be noted that she had already misled the Health and Social Care Select Committee on 26 March 2020 by denying that the downgrade in respiratory protection from FFP3 to FRSM was due to a shortage of FFP3 when that quite clearly was a major factor (INQ000300292).

As an 'aside', the Inquiry may find it informative to review the above facts (where the DCMO was clearly very instrumental in the process of downgrading HCW protection from FFP3 to FRSM) against his evidence on 22 November (at p216/7) where Counsel for Covid Bereaved Families for Justice UK sought to understand why, 'at the eye of the storm' with cases going up exponentially and at a time when HCWs were at their greatest risk since the start of the pandemic was the protection afforded to them by respirators suddenly withdrawn?

In his answer, the former DCMO sought to assign responsibility for this decision to Public Health England, with the associated suggestion that they felt that the predominant route of infections was droplet and therefore a surgical face-mask was adequate. I do not believe that any evidence exists to support this. On the contrary, evidence certainly does exist which demonstrates that the IPC guidance was not written by Public Health England but originated in Scotland and was personally sent to PHE by the former DCMO. It was mischievous of him to suggest it was the other way around.

It may assist the Inquiry if I set out the actual sequence of events during those fateful days in March 2020:

10 March - Health Protection Scotland has already taken the decision to downgrade worker protection from FFP3 respirators to FRSM masks and they publish version 9.0 of their National IPC guidance. At the same time they remove reference to the "precautionary principle" which had previously been a feature of their policy towards respiratory protection of healthcare workers.

11 March - The first draft of the IPC guidance (soon to become version 1.0 of the new "4-nations IPC guidance") is sent to the DCMO by a professional colleague of his in Health Protection Scotland. This contains the downgrade from FFP3 to FRSM for most routine care of infectious patients by the majority of healthcare workers ranging from doctors and nurses to paramedics in the ambulance service.

12 March 16:46 - The DCMO personally emails this revised guidance to Susan Hopkins (Deputy Director at Public Health England), Peter Horby (Chair, NERVTAG) and Keith Willett (NHS Strategic Incident Director).

13 March 10:00 - The NERVTAG and ACDP meetings both take place, COVID-19 is declassified as a HCID and, overnight, the new "4-nations IPC guidance" is issued to the NHS, the length and breadth of the UK.

14 March - Healthcare workers arrive at work found that they are no longer to be issued with respirators but are made to wear surgical masks instead except in certain locations and whilst conducting certain procedures. Many of those who try to continue wearing FFP3s are ordered to remove them and don FRSMs.

17 March - Keith Willett attends a meeting of the Health and Social Care Select Committee and the Chair (the Rt Hon Jeremy Hunt MP) reads him a letter he has received from a frontline A&E doctor in a London hospital "*It's absolute carnage in A&E, utter chaos. We don't have any proper PPE. We are being given paper masks, not the gowns, not the FFP3 masks we need and not everyone even gets those. I am in shock. I feel like we are being thrown to the wolves here.*"

Finally the doctor prophetically concludes "*Some of us are going to die*".

Should you require any further information please don't hesitate to contact me.

Yours Sincerely

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David Osborn BSc CMIOSH SpDipEM

iosh Chartered Safety and Health Practitioner

QSHCR Registered Consultant