IN THE MATTER OF
THE UK COVID-19 INQUIRY

MODULE 3
Impact of Covid-19 pandemic on healthcare systems in the 4 nations of the UK

OPENING STATEMENT on behalf of
COVID-19 AIRBORNE
TRANSMISSION ALLIANCE ("CATA")

"*I understand that people are worried. I know that people are paying more attention to the news than usual.*

But I know this too: if we work through our plan and we follow the science, if we act decisively with level heads, if we all play our part and we all look out for each other, then with clean hands and calm heads, we will get through this."

– Matt Hancock, Secretary of State for Health and Social Care, Address to the NHS Chief Nursing Officer's Summit, 12 March 2020

1. INTRODUCTION

1.1 The Inquiry will recall that the Covid Airborne Transmission Alliance ("CATA") is the successor organisation to the Aerosol Generating Procedures Alliance ("AGPA") and latterly the Covid Airborne Protection Alliance ("CAPA"). Although the name has changed, CATA's focus has not. It is to ensure that policy makers, employers and professionals make decisions and form policy and guidance based on the well-established science regarding airborne transmission of SARS-CoV-2. This is deliberately presented in the present tense: there are still many ongoing issues around how to deal with SARS- CoV 2, and many of the mistakes which can be seen to have been made in the response to this pandemic will likely recur unless significant action is taken.

1.2 CATA's membership brings together a wide range of different bodies covering individuals and organisations working in hospitals and the community, professional representative bodies, trades unions and charitable bodies working across the four nations' healthcare systems. Between its constituent organisations, CATA represents over 65,000 healthcare professionals across doctors, nurses, paramedics and therapists.

1.3 In addition to those organisations, CATA is supported by a number of individual multidisciplinary experts in the fields of health and safety, epidemiology, microbiology and the management of pandemic emergencies.

1.4 The depth and breadth of CATA's membership reflects the common interests which brought them together. CATA's membership are professionals who, throughout their professional lives have endeavoured to deliver healthcare in and out of hospital in a safe manner. This involves protecting themselves, their colleagues and – above all – their patients from infection. CATA came together during the early months of the pandemic to address concerns that the Aerosol Generating Procedures ("AGPs") List, which in March 2020 had become the gateway for workers to access respiratory protective equipment, was inadequate. Its membership and focus broadened as it became apparent that the AGP List was one manifestation of a wider failure to "follow the science" on the routes of transmission for SARS-CoV-2 and follow safe infection prevention and control ("IPC") practice.

1.5 In this Inquiry, CATA has not and will not seek merely to ascribe blame to any individual or organisation. It has and will engage with the COVID-19 Inquiry in the same spirit as its members engage in their work:

a. to investigate thoroughly what happened;
b. to reflect on that practice to identify why something went wrong; and
c. to develop new practices, policies and procedures to avoid the repetition of those mistakes in the future.

1.6 This Opening Statement aims to assist the Chair and Inquiry team by summarising some of the key concerns of CATA and the themes which it hopes that the public hearings and the Inquiry's reports will address. Although CATA is a Core Participant in Module 3 alone, it has been reassured by the Chair's words that the evidence and learning from this Module will support and influence the work of the Inquiry on other modules where airborne transmission is no less relevant.

1.7 CATA will also invite the Inquiry to build on the work that it has already brought to this Inquiry, and the approach that the Inquiry following its Module 1 report has already taken, and what can be seen in the evidence called in other modules, and in the expert reports provided to Module 3. In particular:

a. the fact, for that is what CATA submits that it is, that SARS- Cov 2 is primarily transmitted via the airborne route.
b. the existence of pre- existing arrangements for dealing with infectious diseases, including new unknown infectious diseases, which mandate particular precautionary measures.

1.8 This Opening Statement is divided into the following sections:

a. Section 1: Introduction
b. Section 2: The risks from saying that policymakers are following the science
c. Section 3: Defence and Denial
d. Section 4: Shifting Accountability
e. Section 5: An urgent interim recommendation
f. Section 6: Conclusion

2. THE RISKS FROM SAYING THAT POLICYMAKERS ARE FOLLOWING THE SCIENCE

2.1 The use of the phrase "follow the science" is a powerfully seductive one for decision makers. While on the face of it, it sounds to be an informed and rational approach, it is replete with danger.

2.2 For politicians, such a phrase enables them to deny their own agency and delegate all responsibility (and therefore accountability if a decision is wrongly made) to their advisors – they are merely following the "science" as relayed to them by others. In addition, the process of operationalising scientific advice will involve considerations that are not exclusively scientific. Where these considerations are economic or perhaps just pragmatic, invoking the slogan "follow the science" can have the consequence of attributing a scientific justification for matters that are economic, pragmatic or even political.

2.3 For the scientific advisory groups, it can:

a. Create an insufficiently planned scientific bureaucracy which will coalesce around a position taken, and which makes it resistant to new, conflicting emergent information or challenge from external bodies, because they have an interest in defending critical decisions which have, in effect, been delegated to them; or

b. incentivise them to further shift blame to a particular constituent member of the group (it is always someone else who "held the pen" on guidance or a decision) rather than accept collective responsibility.

2.4 There is a very real risk that responsibility ends up being diffused to such an extent that no policymaker is responsible for any given decision, because everyone was responsible.

2.5 For fields such as pandemic response which involves shifting, evolving evidence amongst multidisciplinary experts such as responding to a pandemic, this dynamic can, and CATA submits did, become downright dangerous. It is the antithesis of good science and good healthcare that an initial hypothesis ossifies into an inflexible dogma, the defence of which becomes the primary aim rather than the provision of accurate scientific advice and protecting the public.

2.6 CATA submits that the Inquiry must establish and make findings about the science of SARS-CoV-2 routes of transmission. Such findings are an important end in and of itself, because it is central to establishing the correct strategy for protecting healthcare workers and those they treat.

2.7 CATA welcomes the important recognition in the report of Professor Clive Beggs [INQ000474276] that the UK IPC and HTM guidelines require urgent revision to reflect the physical science of COVID-19 and the continuing use of the "droplet route" of transmission, which continues to underpin UK guidance, "is ambiguous and has no basis in physical science." This has been CATA's consistent position since it was formed. The reason for the continuing failure to update the guidance is, currently, inexplicable – though CATA hopes the Inquiry will be able to uncover the explanation. Indeed, this is a matter of such urgency and importance that it may be appropriate for the Inquiry to be making an interim recommendation, and soon.

2.8 Establishing the science is also critical for understanding how, when and why matters went wrong.

2.9 When the pandemic began, the United Kingdom adopted a position on the then-called Wuhan Novel Coronavirus was likely to follow the pattern of previous Coronavirus pandemics: the extra-ordinary meeting of the 4 Nations HCID group on 10 January

2020, where it was decided to treat COVID-19 as an airborne HCID, noted that although the transmission routes were unknown at that stage it was "*reasonable to assume airborne transmission (droplets and aerosols) is possible, consistent with what we know about transmission routes for other coronaviruses*." [INQ000223380]

2.10 As a result, PHE adapted the MERS infection prevention and control guidance and, as a result, placed significant emphasis on precautions against airborne transmission and using respiratory protective equipment [INQ000101202].

2.11 That initial position was the right one to take – it extrapolated from the existing evidence base, making reasonable assumptions about the nature of the virus and which could be maintained until evidence was secured demonstrating that they were incorrect. It is also entirely consistent with basic scientific and healthcare practice, namely to apply the precautionary principle and to implement existing procedures for managing diseases of this type.

2.12 That position was, however, not maintained. On 13 March 2020, COVID-19 was declassified as a HCID, although this declassification did not, in itself, alter the 'airborne' status. It is also the date on which the IPC Guidance switched from being based on MERS IPC guidance to being based on the Influenza IPC guidance. It brought with it not only a change in the level of PPE to be used by frontline workers, but changed the entire understanding of the route of transmission – SARS-CoV-2 was now said to be spread by the droplet and fomite route alone, with aerosol risk limited to a short list of so-called aerosol generating procedures (AGPs). All without any new scientific evidence in favour of droplet/fomite transmission and in the face of growing data regarding the importance of airborne transmission.

2.13 From all that has been said, including what has been provided as the disclosure so far in Module 3, it appears to CATA that:

a. Nothing had changed on "the science".
b. No new evidence suggesting that COVID-19 was <u>not</u> transmitted via the airborne route had emerged. In fact, the opposite was true. The airborne route was known to leading scientists determining health response policy both nationally and internationally, as set out in the report of Professor Beggs. Scientists in the "Environmental Modelling Group" (a subsidiary of SAGE)

started raising concerns about aerosol/airborne transmission shortly after the downgrade in HCW protection (see also [INQ000203933]).

c. The evidence provided by ARHAI and the IPC Cell in an attempt to justify the stepdown in protection to surgical masks was seriously flawed.

2.14 CATA welcomes the recognition by Shin, Gould and Warne [INQ000474282, 6.9], that the decisions to declassify COVID-19 as a HCID and the guidance prescribing the use of surgical masks instead of respirators for routine patient care, should have been entirely separate. CATA agrees the conclusion of Shin et al that *"it was entirely possible to declassify Covid-19 as a HCID and retain the need for enhanced PPE measures if considered appropriate"*.

2.15 If the Inquiry accepts that view as correct, then it raises an important question: why were those two decisions taken at the same time in the precipitate manner they were on 13 March 2020? What science was being followed? If not following the science, what motive or instincts were driving this radical change of position?

2.16 One of the Inquiry's important functions will be to allay suspicion, but this radical, poorly documented and – as yet – inadequately explained decision creates the distinct impression of one explanation for this change in position. That those involved appreciated that the United Kingdom was inadequately prepared for a respiratory disease pandemic and, fearing a lack of proper Respiratory Protective Equipment (RPE), downgraded SARS-CoV-2 to fit our pre-existing plans.

2.17 The cascading consequences of that decision were profound and reverberate to this day:

a. It created an institutional orthodoxy around which the responsible organisations, particularly the 4 Nations IPC Cell members, have refused to move on from;

b. Decisions around the acquisition, supply and distribution of appropriate PPE were taken on an entirely incorrect and misleading basis;

c. The confidence of healthcare workers on the frontline, crucial to ensuring effective compliance with IPC measures, was and continues to be adversely affected (this was raised in early feedback on the IPC guidance, see *inter alia* the Royal College of Nursing's comments on 30 March 2020 [INQ000348321]);

d. Irrespective of the degree of confidence in the new guidance, healthcare workers across all sectors – not just in hospital, but in community and care settings – were sent out with PPE which was fundamentally unfit to protect them from acquiring COVID-19; and
e. Patients, families and healthcare workers alike bear the heavy cost – not only in mortality, but with Long COVID – of unnecessary, preventable infections.

2.18 The Inquiry has received powerful impact evidence from a wide-ranging number of sources. From CATA's membership alone, the Inquiry has before it accounts from the following:

a. Gillian Higgins, a Registrar in Plastic and Burns Surgery in Glasgow during the pandemic, whose experiences of RPE shortages led her to found the charity Med-Supply-Drive-UK [INQ000421873]. Ms Higgins describes working on COVID-19 wards where colleagues were treating their own teammates, some of whom sadly lost their lives. Teammates who had been denied adequate RPE, despite working in confined, poorly ventilated spaces.
b. Nathalie MacDermott, a leading expert in epidemiology working as a Paediatric Registrar in March 2020, who describes the frustration and confusion caused by the downgrading of PPE requirements on 13 March 2020 [INQ000492279]. Despite her own expertise, she found valuable RPE being held back by her employer NHS Trust because it felt it necessary to follow the IPC Guidelines. Dr MacDermott sourced her own supply of FFP3, but by the time it arrived she had acquired a second infection of COVID-19 and developed Long COVID sufficiently severe that she is left exhausted mentally and physically.
c. Tracy Nicholls, the Chief Executive of the College of Paramedics, who will give oral evidence to the Inquiry. In her statement, Ms Nicholls describes the profound conflict and sense of guilt which paramedics felt when donning and doffing RPE (for those fortunate enough to have access to it) in life threatening emergencies – stuck between the need to protect themselves and the need to administer life-saving treatment to their patients.

3. DEFENCE AND DENIAL

3.1 In both December 2020 and December 2021, there were serious disagreements within the 4 Nations IPC Cell. On both occasions, Public Health England ("PHE") and the United Kingdom Health Security Agency ("UKHSA") took the position that the

precautionary principle and their "understanding of aerosol transmission [had] changed" meaning that there should be a switch to Respiratory Protective Equipment and FFP3 masks.

3.2 How did their colleagues react according to the contemporaneous documentation ([INQ000398244], [INQ000398184], [INQ000130587])? By:

a. Insisting on evidence that existing IPC recommendations were being fully implemented, when many of those recommendations would have done little to ameliorate airborne transmission;
b. Citing a lack of evidence, when such a lack of evidence (not to be confused with evidence of absence) in the midst of a pandemic is the foundation of the precautionary principle;
c. Raising concerns as to whether, if they changed course now and switched to FFP3 masks, NHS staff would feel they had been under-protected previously;
d. Raising process questions about the 4 Nations IPC Cell being "overruled" by PHE, which arose in response to representations made by Dr Colin Brown of PHE who repeatedly sought to have FFP3s recommended more widely beyond AGPs in light of increased evidence of airborne transmission;
e. Raising concerns about the availability of FFP3 masks, the capacity to "fit test" them and the willingness of healthcare workers to accept reductions to PPE requirements subsequently; and
f. Dismissing the evidence of increased transmission following singing, shouting and enclosed spaces as "separate" from the new variants.
g. Ignoring emerging evidence that the old definition of an aerosol was seriously flawed so that, in fact, so-called droplets were actually aerosols. CATA considers this to be "the elephant in the room". Every decision made underpinning protective measures in IPC guidance for HCWs was predicated on the wrong science relating to aerosols.

3.3 In CATA's analysis so far of these materials, it is difficult to detect within these minutes a respectful exchange of views on the merits of the science on the modes of transmission of SARS-CoV-2 as a first order question. Instead, second order questions of process and operational questions are proffered in order to shut down discussion of the scientific evidence.

3.4 It is notable that Lisa Ritchie and Laura Imrie, two prominent voices in those 4 Nations IPC Cell discussions speaking out against airborne transmission, make no concessions and offer no reflection on the issue of airborne transmission in their rule 9 witness statements ([INQ000421939], [INQ000485024]). This is a topic about which they will need to be questioned during the Inquiry.

3.5 In the COVID-19 Inquiry's Module 1 report, the Inquiry considered the dynamics of expert advice to the Government in Chapter 6 and the risk of "groupthink". The Inquiry was right to observe in that Report that "groupthink" is a conclusion, not an explanation.

3.6 The Inquiry may wish to pay close attention to this particular incident in the pandemic, where CATA and other specialist institutions expressed a dissenting, but ultimately correct view and was shut down. Why was that? PHE and latterly the UKHSA were offering a reasonable interpretation of the scientific evidence base which can and should have been taken seriously. If not following the science, what instincts or motive had the other members of the 4 Nations IPC Cell decided to follow?

3.7 Likewise, the same can be asked of incidents of *external* dissent to the prevailing view in the 4 Nations IPC Cell. As reflected in the disclosure and as a matter of public record, the RCN raised concerns of their own in January 2021. Professor Dinah Gould, an experienced IPC nurse, provided a report to the RCN which was critical of the extant COVID-19 Protocols for having failed to follow the evidence on the role of airborne transmission and needed to be urgently replaced [INQ000114357]. That report was made publicly available and provided to the relevant decision-making bodies.

3.8 In these circumstances, what one would expect to happen would be an objective review of Professor Gould's report, consultation with colleagues outside of the 4 Nations IPC Cell who could offer independent analysis and a careful review of the evidence base on airborne transmission.

3.9 Instead of that happening, what in fact took place (as per the 4 Nations IPC Cell Minutes [INQ000398178]) was that it was decided that ARHAI Scotland, whose rapid reviews had been criticised by Professor Gould, would respond, defending their own work. Other IPC Cell Members expressed concern that trades unions were

approaching MPs to express their concerns about adequate RPE and letters such as that put out by the RCN "create anxiety amongst staff." The decision was taken for the 4 Nations IPC Cell to input into ARHAI Scotland's response and effectively "fall-in" behind them. ARHAI Scotland's own published response [INQ000348388] then robustly dismissed the review as "seriously flawed" in its premise and asserted a series of other factual errors in the Gould review. Those criticisms can clearly be seen to be invalid and not in hindsight, but in a way which would have been clear at the time.

3.10 This is a stark, but not isolated episode. The 4 Nations IPC Cell Minutes later record requesting PHE to take out specific examples from one of their papers "in order to avoid challenges and concerns being raised by staff/unions as proposed by [Laura Imrie]" [INQ000398233].

3.11 Another long-repeating action point on the 4 Nations IPC Cell Minutes for 2022 (see, *inter alia*, [INQ000398196]) was the institutional reaction to a paper by Professor Greenhalgh of the University of Oxford concerning airborne transmission. The action point was "A strong response to be developed as this review is continually cited in relation to Fluid Resistant Surgical Masks (FRSM) and 'FFP3' respirators". What is meant by that was not a careful peer review, but a strong rebuttal dismissing it. This must be because it had become a source of challenge to the prevailing wisdom within the Cell.

3.12 The early indications from this disclosure confirm CATA's own experience during this period. Rather than the trades unions, the Royal Colleges and other professional bodies being treated as equal partners in pandemic response with a valuable role to play, they were treated as a problem to be managed. Concerns, criticism and challenge were to be prevented, minimised or strongly refuted.

3.13 This attitude is particularly concerning. The issues being raised were not tittle tattle on social media or the opinions of uninformed bystanders. Nor was this from agitators or troublemakers.

3.14 In fact, these were the legitimate concerns of the people who had significant academic and practical expertise, a leadership role in supporting implementation of the guidance and ultimately would be the ones who would deal with the consequences of the decisions.

3.15 They had every right to be treated with respect. They were not.

3.16 The same concerning pattern can be found in the development of the AGP list which originally drew CATA's membership together as AGPA. As Shin, Gould and Warne detail at [6.38-6.50] of their report, the evidence base for a "list" of defined AGP procedures was never there. The studies on which it was based were weak and of a very low quality.

3.17 The AGP List itself started off as an indicative list. The Guidance on 19 February 2020 [INQ000348304] gave examples of AGPs without suggesting it was limited to them. By 6 March 2020 edition [INQ000348309], however, it had transformed into an exclusive list of AGPs which would then, as of the 13 March 2020 guidance, be the definitive list of procedures which would define access to RPE.

3.18 Again, the same process of an initial decision which is taken and becomes an article of institutional faith played out.

3.19 As CATA said at the time, and subsequently, the healthcare focus shouldn't have been on trying to control each and every clinical procedure for aerosol generating potential, but instead to look at the main routes of generating aerosols – including coughing, talking or simply breathing – and ensure that proper RPE was available to all healthcare workers providing close-quarter care rather than only to those carrying out procedures on a flawed list.

3.20 The flaw of the prevailing AGP List led to absurd consequences. Sputum induction, where the patient is assisted through the use of saline to cough up lung secretions for analysis, was included in the AGP List. Insertion of a nasogastric tube and dysphagia assessment, which both reliably induce a cough, were not. Cardiopulmonary resuscitation was not, despite the fundamentally respiratory nature of the procedure and the close proximity of those conducting the resuscitation. There are a whole host of equivalent procedures which were excluded which affected doctors, paramedics, nurses and speech and language therapists alike.

4. SHIFTING ACCOUNTABILITY

4.1 No one, including CATA, underestimates the significant pressures which decision makers operate under, because as healthcare workers they are used to making those high consequence decisions as part of their own clinical work.

4.2 It is, however, important that there are clear lines of authority, responsibility and the accountability that goes with them. The absence of those clear lines at the time can make decision making particularly difficult.

4.3 In this context, on what has featured in the witness evidence so far provided, there were no clear lines of authority. This is telling.

4.4 In the evidence so far provided to the Inquiry, nobody has taken clear responsibility for drafting the IPC Guidance. How it came about is obscure. So far, the Inquiry has heard from:

- **a.** The DCMO, Jonathan Van Tam, who said that "the people who wrote the guidance, Public Health England" were the ones who felt that droplet transmission was the predominant route and FRSM would be adequate.
- **b.** Sir Stephen Powis, on behalf of NHS England, says that PHE drafted and changed the IPC guidance in a way which was approved by NERVTAG. The role of the 4 Nations IPC Cell, who NHS England had several members on, merely advised PHE on the operational implications of their guidance [INQ000412890].
- **c.** Lisa Ritchie, who played a pivotal role in drafting the 13 March 2020 guidance, characterises the IPC Cell as "not a decision-making body" which instead combined expertise to provide advice and consensus statements. Dr Ritchie says this while being unable to recall an occasion on which any constituent member made any changes to the IPC guidance [INQ000421939]. She was well aware of the reaction of the IPC Cell to PHE/UKHSA's dissent over the adequacy of the RPE guidance.
- **d.** Susan Hopkins, on behalf of PHE/UKHSA, characterises their role as merely publishing the IPC guidance on behalf of the 4 Nations IPC Cell after the Cell had reached a consensus position [INQ000410867].

4.5 Why do each of these witnesses' accounts conflict on the responsibility for the IPC Guidance? It isn't a lack of clarity on terms of reference, reporting responsibilities and

lines of accountability. It is shifting attribution of a key decision which has gone wrong.

4.6 To date, not one organisation has provided evidence to the Inquiry acknowledging their role in the decision-making process, reflecting on how the decision was taken and accepting responsibility for their part in it. Instead, there is either an absence of explanation or it is apparently the responsibility of somebody else – exactly the dynamic this statement set out at the beginning of Section 2 above. Had the IPC guidance been a resounding success they would all seek to claim credit. The fact that they are not, and are continually seeking to shift responsibility onto others, is an indication that they appreciate the issues with the science behind it, how unfit for purpose it was and failed to meet its objectives.

4.7 A related theme of shifting responsibility in the evidence on the IPC Guidance appears to be to suggest that any shortfall or oversight in the national Guidance could be remedied by a local risk assessment. This features as a repeat statement in the contemporary evidence, as well as in witness statement evidence: ultimately, it was down to a matter of individual risk assessment as to whether Respiratory Protective Equipment was needed.

4.8 It is difficult to overstate the seriousness of the flaws in that approach. An ostensibly authoritative position on the necessary IPC is given at a national level which gives clinicians and their managers reason to believe that its correct and definitive. It tells clinicians that the primary route of infection is droplet or fomite transmission and to adapt their IPC measures accordingly. Clinicians will, like all others, be keen to ensure that supplies of appropriate PPE are maintained – not least because they will have all had recent experience of appropriate PPE running out.

4.9 It also understates the other risks of claiming that everything was, ultimately, a matter of local decision making – it is impossible to plan national supplies of appropriate RPE if each Trust, each hospital or even each ward or clinician is ultimately responsible for making a decision about whether RPE was required. It is a recipe for confusion, disorganisation and shortage of the necessary protective equipment.

4.10 In any event, it is unclear how any frontline healthcare worker was supposed to carry out a suitable and sufficient individualised risk assessment if they were not equipped

to understand the airborne route of transmission, appropriate RPE and issues around ventilation.

4.11 From June 2021 the IPC guidance advised that decisions about wearing RPE vs FRSMs could be decided locally by risk assessment. When considering the activity of a HCW providing close-quarter care to an infectious patient, CATA contends that such a risk assessment is impossible given that:

a. The infectious aerosols in the air around the patient cannot be detected by any human sense (sight, smell etc);
b. The concentration of the infectious agent (i.e. SARS-CoV-2 virus) suspended in the air around the patient cannot be directly measured by any meter or monitor;
c. The effect of infection cannot be reliably predicted. Even young and otherwise healthy HCWs can (and have) become seriously ill, with many going on to die or develop Long Covid.

4.12 The UK's experts in risk assessment, the Health and Safety Executive (HSE) have been asked how they would undertake such a risk assessment but they have remained silent on the subject. In the absence of any credible risk assessment methodology, the precautionary principle must prevail and RPE worn to protect against infection. This should be the default policy for close-contact care of infectious patients.

5. AN URGENT INTERIM RECOMMENDATION

5.1 Finally, CATA is concerned to assist with meaningful changes arising out of these issues to help the United Kingdom manage a future pandemic. This is a topic which is now particularly pertinent given the recent declaration of mpox as a global health emergency, but with the threat of future respiratory viruses ever present.

5.2 There needs to be an immediate effort to rectify the existing UK IPC manuals and to recognise the airborne route of transmission. CATA agrees with Professor Beggs that the implications of recognising airborne transmission are far-reaching for IPC guidance and procedures. There are, however, steps that can be taken urgently to ensure that workers on the frontline have the risk of airborne virus transmission mitigated as much as possible – not only with the benefit of saving lives, but avoiding the long term health complications of COVID-19 and reducing days lost to avoidable illness.

5.3 While COVID-19 remains a year-round issue, the winter influenza season will start to take effect during these hearings. Proper RPE and an IPC manual which is based on the up to date science of transmission routes will help protect healthcare workers and patients at a time when services are under the greatest stress and pressure.

6. CONCLUSION

6.1 This opening statement has primarily focused on a preliminary analysis of the evidence that the Inquiry has received to illustrate the gravity of CATA's concerns. Sitting behind those concerns is a fundamental point: this is not an issue of practice, procedure or finessing a policy position, but the way in which the United Kingdom discharges its duties under Article 2 to protect the life of its healthcare workers and citizens. The Article 2 systems duty is not confined to having in place a framework of Health and Safety legislation but involves ensuring that framework is realised in a way which gives practical and effective protection on the ground.

6.2 The COSHH and RIDDOR regulations are critical component parts in retaining state responsibility for health and safety of healthcare workers. These are especially important in the context of a pandemic, where the requirements of public health and fundamental human rights are in sharp focus. An important part of the Inquiry's Module 3 investigation is the way in which there was a *de facto* suspension of State duties and obligations under these regulations – and the consequent, fundamental impact on health and safety protections of healthcare workers. The Inquiry will need to conclude whether there has been a dereliction by the UK government, in respect of its Article 2 ECHR duties.

6.3 One of CATA's main concerns for the future is that many HCWs have lost trust and faith in the healthcare organisations that are supposed to protect them. They have seen colleagues die and suffer Long-Covid with devastating effects on their lives, with a complete denial that this could have been anything to do with their work and the adequacy of PPE they were provided with. They are therefore without work and no support from the State.

6.4 CATA hopes that this opening statement assists the Chair and the Counsel to the Inquiry team at the outset of the Module 3 hearings. The opening of these hearings represents a small, but important part of the process. CATA and their representatives

remain available to assist the Inquiry over the coming months and in ensuring that the Inquiry is able to provide a full and thorough examination of the issues.

STEPHEN SIMBLET KC
STEPHEN CLARK
FALLON ALEXIS
PHILIP DAYLE
<u>Counsel</u>

CYRILIA KNIGHT
BEN CURTIS
CHRISTINA ASHIBOGU
<u>Solicitors</u>

23 AUGUST 2024