Monday, 16 September 2024

(10.30 am)

LADY HALLETT: Mr Scott.

MR SCOTT: Good morning, my Lady. May we call Kevin Rowan, who can be sworn.

MR KEVIN ROWAN (affirmed)

Questions from COUNSEL TO THE INQUIRY

MR SCOTT: Good morning, Mr Rowan.

A. Good morning.

Q. Would you please give your full name.

A. My full name is Kevin Rowan.

Q. And you are the head of organisation and services department of the Trades Union Congress; is that correct?

A. More or less, I was until about a month ago, I now I have a new role. But thank you, yeah.

Q. In terms of that role, which I think was the role that you gave when you provided the statement to the Inquiry, could you provide a very brief summary of what that role entails, please.

A. That role heads a large department in the TUC which covers a range of policy and campaign areas including across all public services, health and safety, trade union renewal, and -- a few other things, but they're the main kind of core elements.

Q. Was it as part of that role that you were a non-executive director of the HSE from 1 June 2016 until 31 July 2021?

A. Well, there's a relation between the engagement with the Health and Safety Executive, but non-executive board members are appointed in an individual capacity rather than on behalf of an organisation, but there's direct relationship.

Q. But it wasn't a **de facto** role?

A. No.

Q. Mr Rowan, just to contextualise questions I'm going to be asking you today, so I hope you forgive me if I don't ask you any questions about the structure of the TUC, you've set that out in detail in your statement and also her Ladyship has heard that evidence I think in the previous four modules. We have also had Ms Gorton's evidence last week about engagement forums and partnership arrangements. So I want to focus with you on health and safety protection.

You heard Mr Brunt's evidence from last Thursday. Is there any comment that you wish to make in relation to that evidence?

A. I think the one particular issue that struck me with listening to Mr Brunt's evidence was around his response to the purpose of RIDDOR reporting. He seemed to imply,

and it's my impression of his evidence, that RIDDOR was principally a benefit for employers in their efforts to manage health and safety in the workplace. While I think clearly there's -- you know, all employers who end up in a situation where they have to exercise a RIDDOR report, there needs to be a learning from that, a review of their health and safety management practices, but there's a step before that that employers, all employers, need to undertake, and that's a risk assessment. The risk assessment should inform the health and safety management regime of employers.

RIDDOR is effectively a scenario where that health and safety management system has failed, where someone's been injured, made ill or where there's a dangerous occurrence in the workplace that could have led to a serious injury. So I think the bit that I thought was -- I'd have liked to have heard from the Health and Safety Executive was that RIDDOR reporting should trigger evidence to the Health and Safety Executive for them to act in an enforcement and regulatory action, because it's evidence of an employer failing to manage health and safety in the workplace.

So RIDDOR is absolutely useful in terms of it's a test, if you like, of the employer's health and safety -- the duty, all this health and safety

management, but it should also be an alert for the regulator -- regulatory authority.

Q. So it's more --

LADY HALLETT: Sorry to interrupt. Can I just challenge one of your statements, if I may, as a non-expert in this field, Mr Rowan. You said that if someone becomes ill, that indicates that there has been a management system failure. That's not necessarily so, is it? Someone might become ill and it may not be the employer's fault at all.

A. No, absolutely, my Lady, that's right. But it's an indication that there could be something wrong with the management of the health and safety system.

LADY HALLETT: So they need to investigate.

A. Exactly so.

MR SCOTT: So effectively it's a two-stage process, isn't it, RIDDOR making the report identifies to the employer that something's gone wrong because the employer feels that a report has to be made, and then there's a second stage which alerts the regulator and then it's up to the regulator to have a much broader systemic view; is that an encapsulation of it?

A. That's how it should happen, yes.

Q. Before we deal with the RIDDOR system and going into any great detail on that, you said that you were

a non-executive director. What is the benefit of having independent directors, non-executive directors within a regulator such as the HSE?

A. Well, I was an employee representative on the board of the Health and Safety Executive, and, you know, the value I think that I brought in that role was I -- a direct connection with, in my case, the kind of trade union movement and, if you like, therefore, a direct connection with trade unions and a direct connection with workplaces and working people, and I could bring to the board, if you like, the insight of that -- that network of health and safety representatives who voiced concerns around health and safety issues at a workplace level, and bring that kind of, if you like, perspective to the strategic and operational decisions that the Health and Safety Executive takes. Similarly, there would be employer representatives on the HSE board and independent members, sometimes from academia, sometimes from other sectors.

Q. Because we've seen from the statement from the Health and Safety Executive in Northern Ireland -- sorry, the statement about the Health and Safety Executive in Northern Ireland that for a number of years there hadn't been any non-executive directors in place. Would you wish to make a comment on whether that reflects

a failing that needs to be remedied?

A. My view, and TUC's view, is that there's real value in that tripartite conversation happening at a strategic level in organisations like the Health and Safety Executive. I think the absence of those representative voices to inform, to challenge, to check the strategic operations of bodies like that, I think -- the absence of that I think is problematic. I think it weakens the organisation. And I think you see this in Acas, you see this in the Health and Safety Executive, the Low Pay Commission, and I think the kind of feedback from all of those organisations is that they're more effective when they have the opportunity to hear those voices.

Q. Just dealing with the devolved nations as a whole, so Wales comes within the auspices of the TUC as a whole, Scotland and Northern Ireland don't, they have their own separate structures. Again, I'm not going to go over the detail of that.

Were you having discussions with your opposite numbers across Scotland and Northern Ireland in particular about the type of issues that they were facing in relation to healthcare systems in Scotland and Wales?

A. I mean, I don't think that I could say in all honesty that there was a systemic, consistent engagement with

colleagues in the Scottish TUC or the Irish Congress of Trade Unions, but we would certainly speak informally on a fairly regular basis, particularly I think in scenarios like this where we're all, if you like, struggling to kind of respond to, you know, a hugely serious issue such as this.

Q. From your perspective, arising out of those discussions, as far as they related to healthcare settings, were there major differences across England, Wales, Scotland and Northern Ireland, or were, effectively, the basic concerns the same, even if there may have been nuances arising in each individual country?

A. I think the basic concerns were principally the same, slightly different approaches in that in Northern Ireland in particular I think relationships are much closer, so there's, in my view -- and it's not my area of expertise, but in my view there's a higher degree of collaboration simply because of the nature of that part of the world, everybody knows each other really well, it's quite a small -- it's quite a small community in relative terms.

In our experience, in our kind of reflections, if you like, looking back, we weren't in a position where we had the same level of relationship or engagement with government, certainly in the UK, so that was different.

And I think similarly in Scotland, relations between the Scottish Parliament and the Scottish TUC were much closer, if you like, than I think we had with our Westminster government.

Q. Was that, just to make sure I'm focusing on the right issue, just in the healthcare setting or was that across all sectors?

A. For us I think it was across all sectors.

Q. Okay.

I'm going to steal a line from Mr Jacobs last week when he said to Mr Brunt that, rather than the niceties of RIDDOR, let's focus on what needs to happen in the next pandemic. I would like to explore with you in healthcare settings in the event of a future pandemic, what should happen, what your view is in relation to reporting and regulators and the actions of the regulators.

So do you agree with Mr Brunt that RIDDOR was not intended to be used in a pandemic involving thousands of instances of infection, it was really designed to capture single one-off unexpected events, accidents and incidents?

A. No, I don't agree. I mean, I think -- and if I could be allowed a little bit of leeway to respond to this -- I think there are three stages that I think have been

exposed as flaws in our health and safety system. I think certainly the first point is identification of data which would alert both employers and regulators to the existence of significant risk.

The way that report -- RIDDOR was actioned and the way that employers were advised around RIDDOR, so the argument that they needed medical certificates around Covid-19, meant that there wasn't the gathering of intelligent data about the presence of risk of Covid-19 exposure in workplaces. In my view, that is what RIDDOR should do, because what RIDDOR does is it gathers data about risk beyond the workplace level, because it's a report to the Health and Safety Executive. So that's the first thing.

I think that would have informed or should have informed that healthcare settings, with the emergence of the pandemic, then became a high-risk sector. So the intelligence would provide evidence of risk, gathering that intelligence in a systemic way would identify sectoral risks. That would then inform the Health and Safety Executive's enforcement strategy. And HSE's enforcement strategy is very effective: where it identifies a high-risk sector there's an enforcement and inspection regime which results in a significant impact in those workplaces. A 40% material breach rate is

about standard. That's where an inspector will identify a material breach of health and safety law in 40% of cases --

LADY HALLETT: Sorry to interrupt, Mr Rowan. I appreciate you're in full flow, it's just that you're going very quickly. I've got a feeling I might get some complaints from the stenographer.

A. Well, my apologies to the stenographers, my Lady.

LADY HALLETT: Sorry, I interrupted you.

A. No, that's all right.

LADY HALLETT: An inspector will identify a material breach of health and safety law in 40% of cases.

A. Yeah. So if you have -- the data point starts in workplaces where employers identify where health and safety regulation in their own management systems has broken down. That leads to a RIDDOR report. The RIDDOR report is then collected by the Health and Safety Executive. That would have identified the health and care sector as being a high-risk sector. That should have then informed a Health and Safety Executive operational and strategic approach, which would have resulted in other high-risk sectors' inspectors identifying material breaches and issuing enforcement actions to correct those breaches.

MR SCOTT: Can I just ask, Mr Rowan -- a very helpful

explanation -- in your view, did RIDDOR work, in terms of reporting incidents within the healthcare setting during the pandemic?

A. I don't think RIDDOR worked anywhere near as well as we would like it to. As I say --

Q. Is that a structural issue?

A. I think there are a number of factors. One is I don't think most employers generally understand the duty that they have under RIDDOR. That's one factor. The second factor is I think they were given advice that, unless there was a medical certificate proving that Covid was contracted, they didn't need to produce a RIDDOR report. And thirdly, there was the issue of cause and effect.

We know that there was a lot of contraction of Covid in non-workplace settings, and it's not, you know, it's not always going to be absolutely clear that Covid was contracted in the workplace, but I -- I don't think that employers were encouraged or particularly enabled to provide evidence of Covid exposure in the workplace.

So I think there were three failings in the RIDDOR system which, you know, if the first thing that you need to act is data of risk, there are three different factors that prevent that data being produced. So straight answer is that, no, RIDDOR didn't work in the way that we would want it to.

LADY HALLETT: Are you saying that -- what's the timing for that comment, Mr Rowan? In the early days, obviously there was a great deal of uncertainty, whether or not people would get tests. Are you saying it didn't work throughout the pandemic or are you saying that it was when the uncertainty had gone and people could say whether or not they actually had Covid?

A. I don't think it worked during the pandemic, my Lady. I think -- and my understanding is that the guidance around RIDDOR changed a number of times during the pandemic, which wouldn't have helped clarity for employers in what they report. But we've seen very little evidence of RIDDOR being the mechanism that then informed regulatory or enforcement action. So I find it hard to identify a scenario where RIDDOR has worked in this Inquiry question.

MR SCOTT: Well, then, let me ask you three different options, and you may tell me it's none of the three: could RIDDOR work in its current format, is option 1; option 2 is could RIDDOR work but actually does need effectively to be rewritten to deal with the pandemic; or, number 3, do you need, in a pandemic time, something separate to RIDDOR which does a different job but has the same aims?

A. I mean, they're three different questions. I think for

RIDDOR to work well, it needs to be clear, understood and employers need to respond to the -- their duty under RIDDOR. For a long time, we have been reporting that RIDDOR produced significant under-reporting of health and safety risks generally. So it doesn't work in its current format.

To answer the last question first, if I may, and I think, to be fair, we were all learning about the Covid pandemic and how risks were -- how infections were, you know, being spread. A sensible approach would be to say: where we're unsure about, you know, kind of those airborne viruses or how viruses are transmitted, the most safe approach would be to gather as much data as possible and to share that data as early as possible.

I don't think that was the case with RIDDOR. In fact, you know, some of the guidelines, particularly around things like medical proof of Covid, actually dissuaded employers from gathering and reporting that evidence. So I think there's certainly -- the indications would be you need a specific approach to managing those risks in a pandemic. I think there's a specific set of circumstances that would apply in that. So I guess yes is the answer to your third question: I think it needs specific circumstances for specific hazards.

Q. Because this comes back to your point, doesn't it, in terms of the breadth of the view of the regulator that it would have much wider knowledge if it's receiving RIDDOR reports from across the entire country, or England and Wales, rather than individual employers who are making individual reports, who may have an understanding within their own employment area but a regulator should be able to identify more than that?

A. That's absolutely right. If you don't have intelligence from -- if you don't have data then you can't have intelligence, and if you don't have intelligence you can't act, and the systemic process by which you identify and gather that data and intelligence to then inform your actions was absent.

Q. Because I think, again, Mr Jacobs was saying on Thursday that healthcare settings in a non-pandemic time tend to be considered low risk because they're well aware of infection risks and control. Don't they then switch to high risk when you're in a setting, such as a pandemic, where you have a novel infection that is spreading in a way that people aren't entirely certain about?

A. It seems to me that -- I mean, certainly, it is the case that, because, of the regulatory nature of the healthcare sector, there are procedures, there are processes, people kind of tend to work within a very

regulated system and they are low risk. I mean, to my understanding, there are huge numbers of incidents of injury or ill health spread amongst the healthcare workforce generally.

In a pandemic, and I think this was especially evident when we were hearing about failings around protective equipment, any logical assessment would identify that relatively early as a potentially high-risk environment, and that should have, in my view, led to a review of the Health and Safety Executive's regulatory priorities. It's a very effective organisation in high-risk sectors. What my concern is that it didn't pivot to treat the healthcare sector as a high-risk sector.

Q. Do you think that every infection of a healthcare worker should have been reported to the HSE?

A. I think, given what we know about the exposure to risk, that it was a high-risk setting, that there were huge problems with personal protective equipment and the potential risk to individuals, I don't think it's unreasonable that an employer in that setting should be required to record and report incidents of Covid -- all incidents of Covid.

Q. Is it fair that, simply because there has been a report, that there doesn't necessarily have to be

an investigation. It can simply be that you're recording information about the circumstances of that individual, in this case, infection?

A. Yeah, I think that's fair. There'll be scenarios where people work in the healthcare environment, that don't have direct engagement with patients who have Covid, will contract the virus. People working, you know, in kind of ancillary roles often will not come into direct contact with a patient but it's important that they're recorded because we also know that people working in those, if you like, less direct roles were less likely to be in the front of the queue for personal protective equipment. So their risk of exposure would have been different to healthcare workers in the frontline.

So it is -- but their lives are equally valuable, their health and wellbeing is equally valuable, so it is important that when they do contract, if they do contract Covid-19, that that is recorded, and it may be that that would then inform the health and safety management practice of those employers.

Q. Because without those reportings, based on your experience in the role at TUC and as the non-executive director of HSE, are you actually able to track all the various different groups, and I mean that, whether it's protected characteristics, or the equivalent in Northern

Ireland, or otherwise, in terms of their job role, unless you know who's been infected in a healthcare setting, how do you actually know, effectively, what the impact is and where people are getting infections from?

A. That's exactly right. I mean, the first step any employer should do, and all employers have a duty to do this, is to assess risk. They should, in situations where those risks change, so when we have a pandemic coming into our society and our economy, they should be reviewing those risk assessments. If they're monitoring then the health of their workforce, as they should, and you may have, you know, a group of, you know, cleaning staff who, again, may not have been able to access personal protective equipment in the way that frontline healthcare workers, if that group of workers, a high percentage of them contract Covid, then you would need to look at your health and safety management system to make sure that those workers are protected.

So, unless you have that data, you're not going to know that you need to change your health and safety management practice, and the same is true when you take that above the workplace on to a sectoral or wider level. If the Health and Safety Executive don't have the intelligence that sectors or groups of particular workers have a higher prevalence of exposure to the

virus among certain groups of our community and certain groups of workers. And again, that would inform an intelligent approach to how you regulate and enforce amongst those group of workers.

We know that ethnicity was a particular concern in the experience of Covid-19 -- exposure to Covid-19. We also know occupational groups were more or less prevalent to contracting the virus depending on their roles.

Q. When you say occupational groups, would you also then be looking to record where they were actually working at the time, in case somebody's been redeployed, for example?

A. So the -- we know from our experience that, you know, workers who were in more populated occupations or populated areas would certainly be more likely to contract the virus, so that was a factor, and there are -- so there's an occupational, if you like, characteristic that would inform any kind of regulatory or enforcement regime, and as we've just been discussing, we know that the healthcare sector as a whole moved from low risk to high risk. So there are sectoral factors to consider as well as occupational factors as well as personal characteristics.

LADY HALLETT: Can I interrupt, can I just go back to the

virus than others, then the Health and Safety Executive has no evidence or intelligence to change its regulatory regime.

Q. Could I take the next part in three different sections: first it's going to be reporting; then there is going to be recording by the regulator; and then investigation by the regulator.

So dealing first with the reporting point: in healthcare settings, should there be any limit on what is being reported, do you think, in terms of whether someone suffered an infection?

A. I don't see a case for not providing as much evidence and information as you've got when you're dealing with a Covid pandemic that's killed tens of thousands of people. I just don't see how that's a reasonable approach.

Q. Would that then extend to what should be recorded by the regulator about the information that's provided to them?

A. I think the kind of information that should go to a regulator -- you know, again, the more you limit it, the less intelligent decision-making the regulator is able to make. So the more information you have, the better decisions you can make.

Q. So factors such as ethnic group should be included?

A. We know that there were a particular prevalence of the

basics, if I'm an employer and I make a RIDDOR report, is there a form I fill in or -- and if so, what information does that form require of me? Very roughly.

A. Yeah. So there's both a hard copy and an online form that employers are required to complete, my Lady, and that will detail the nature of the incident, the nature of the injury or illness, that's provided, and a description of the factors that the employer might believe have contributed to it.

LADY HALLETT: So will it depend on whether the employer thought that ethnicity was a relevant factor?

A. I'm not sure I can answer that, my Lady, to be honest. I'm not an expert in the report --

LADY HALLETT: But ethnicity isn't necessarily a factor that has to be reported, so, for example, with the pandemic --

A. Correct -- sorry, yeah.

LADY HALLETT: So that wouldn't have been -- even if the employers had all been fulfilling the RIDDOR regulations, as you say they weren't, that ethnicity would not necessarily have come through, it depends on the employer?

A. I think that's right, my Lady. I couldn't say with certainty, but I think that's right.

MR SCOTT: Do you need to record the same information from

the healthcare system as you would from other sectors, for example, in the middle of a pandemic or, as you say, that the risk in the healthcare sector is maybe higher than it is in other sectors?

A. I think the reporting is standard across sectors as it currently -- currently operates. I think the point that we were discussing earlier is relevant in that we know that there was a significant increase in risk in the healthcare sector, so the kind of things that would have been normally recorded in any kind of RIDDOR investigation would apply to the healthcare sector. So things like provision of PPE, things like work systems, things like social distancing, and the existence of risk assessments and good management would be the kind of the normal things that are recorded and reported.

Q. But reporting may be standard but does it need to be standard, when you're talking about in the context of a pandemic, to make sure that you're getting the best information?

A. I mean, I think because I think we were in a particular scenario where there was a new set of risks because of the existence of the virus, there was a need to record more data than RIDDOR would require. So what RIDDOR would normally demand is that incidents were -- occurred as a direct relation to something that happened in

an occupational setting.

I think for a lot of cases and a lot of circumstance it wouldn't necessarily have been obvious that the -- if someone got -- you know, contracted Covid that that had occurred in the workplace. But it may have done. So I think in these particular circumstances, it would be more important that employers were reporting incidents of Covid across the board rather than where they could directly associate the risk of exposure with something that had happened in the workplace.

Q. Would you also be looking to record, although this might not be something that was reported at the time when, in this case, an infection has been caused, would you be looking to record any long-term effects such as Long Covid?

A. I think that's important, as, you know, we were -- and to some degree still are -- learning about the longer-term impact of Covid, and there's ongoing conversations around industrial injuries benefit and whether this is a prescribed illness in the workplace. So I think gathering the evidence to support that debate and that discussion is going to be really important, yeah.

Q. Do you think in the way that RIDDOR was applied to Long Covid do you think that there was sufficient

reporting of instances of Long Covid or do you think it was underreported?

A. I think there's significant under-reporting in all aspects, including the impacts of -- long-term impacts of Covid.

Q. Moving then to the regulator has received this information, at what point should it look to start to investigate or take steps in relation to what information it has received?

A. So I think if the reporting system was working well, it would identify occupations or sectors that are more at risk of contracting the virus than other sectors. That should trigger a systemic response from the regulatory authority to pay -- you know, to investigate more, to inspect more, in those sectors. So that would be one instance.

I think where there's clear evidence of occupational activity, and that could be inadequate supply of personal protective equipment, it could be evidence of employers not following the guidelines that were issued to try to protect workers, any of those incidents should lead to some kind of regulatory activity, some kind of enforcement activity.

Q. Because what's the benefit in the context of a pandemic of having enforcement?

A. Well, the benefit of enforcement is fundamentally to correct poor behaviour or poor management systems that are there to protect employees. As I've said, the HSE is extremely effective, in my view, in informing employers about the right way to manage health and safety and to act as a check against employers who aren't effective at managing health and safety, and removing those hazards and making sure that employers do manage health and safety well. That's what saves lives.

Q. How effective, in your view, was the Health and Safety Executive at actually carrying out that inspection and enforcement process during the pandemic?

A. Well, what the -- in my view, the Health and Safety Executive should have done was understand that the health and care sector became a high-risk sector during the pandemic and applied its very effective regulatory regime in high-risk sectors to the healthcare setting. It would have then led to more inspections, more engagement with employers and would, undoubtedly, in my view, have improved health and safety management in those sectors.

I think -- and I think you have the numbers, but I don't think we saw any increase in engagement between the Health and Safety Executive and the healthcare sector during the period of the pandemic.

Q. Again, from your perspective, was that a capacity issue or not?
A. I think certainly there are huge capacity challenges in the Health and Safety Executive, the number of warranted inspectors has gone down dramatically in the last 10, 15 years or so, so the ability of the Health and Safety Executive to be agile and to respond to, if you like, sudden changes in the health and safety risks across the economy is limited. But we also know that the Health and Safety Executive stood down from proactive workplace inspections in that period. So I think there's certainly capacity issues across the HSE but I'm not sure that's the only factor that informed, in my view, a lack of engagement in the healthcare sector.
Q. Is one of those factors funding?
A. I think funding is absolutely a factor, I think the budget of the Health and Safety Executive's been halved in the last 15, 20 years, so it's huge impact.
Q. You are aware in terms of what was said to Ms Gorton yesterday about the Chair's understanding of funding positions; are there any other factors that arise in relation to the Health and Safety Executive in the way that it was carrying out enforcement?
A. I'm not sure that I'm really able to answer that, I mean, I think the Health and Safety Executive knows

where it's very effective and how it's very effective, but I think as -- and I would agree with Rick Brunt's comments last week, that inspections and enforcements through enforcement action is one, if you like, arrow in their quiver. They work with employers to provide good quality guidance and to develop good practice and lots of kind of education of duty holders in that regard.

But for me the most effective way to correct employers who are not managing health and safety well is warranted inspectors. I have been on workplace visits with warranted inspectors: they walk through the door, employers stand to attention, they listen and they act immediately when the warranted inspectors give them an instruction to do so. It's a hugely effective tool and it wasn't deployed, in my view, as well as it could have been during the pandemic.

Q. In terms of any future pandemic, does it follow that you believe that the HSE does have the tools and it's simply a matter of deployment, rather than there are additional tools required?
A. I think certainly the Health and Safety Executive manages really well with the resources that it's got but, if it was to be required to respond in an agile way to a new and significant health risk, it would struggle to do that with the resources that it's got, in my view.

Q. Does it have sufficient technical skills, or is there a bit of a grey area between it and, in this example, the CQC about the areas that it has oversight of?
A. No, I think it's probably the other way round, I think the Health and Safety Executive certainly has the technical skills and expertise to understand risks in the workplace, to understand what management controls are needed in the workplace and to provide the advice and guidance to those employers to manage those risks.
Q. So, in terms of any lessons learned from your perspective about the way that the Health and Safety Executive was able to approach its enforcement functions, are there any recommendations of lessons that you think should be learned that haven't yet been learned?
A. Across the whole, because I think you have to look at this at all three stages, I think certainly the ability to gather sufficient valuable data about how Covid was impacting on workplaces and causing infection and ill health was systemic, a huge systemic flaw, in my view, we didn't find the right way to gather data about where people were being made ill in the workplace.

Secondly, that didn't then lead to an intelligent gathering of that data to inform decision-making that then, thirdly, would have encouraged and enabled the

regulatory and enforcement regime to pivot and operate differently to try and make sure that as few people were injured as possible.

MR SCOTT: My Lady, given the breadth of the answers and the look forward in terms of the health and safety perspective, I have no further questions.
LADY HALLETT: Thank you very much, Mr Scott.

I think there's one question, is it, Mr Puar?

Questions from MR PUAR

MR PUAR: I ask questions on behalf of a group of bereaved families in Wales, and I just have a few questions for you.

In your written evidence, and your evidence today, you contrast the relationship that the TUC had with the UK Government and that of the relationship that they had with devolved nations, and you make reference to the term "machinery" being in place to allow regular dialogue between the TUC and the Welsh Government. Can you perhaps expand upon that and explain what was that machinery in place?
A. I can try but, perhaps, my Lady, if we could kind of follow that up with (inaudible), it's not my area of expertise but, certainly, my understanding is that we have a social partnership and social dialogue forum and arrangement in Wales, where the Welsh TUC has pretty

close and pretty regular dialogue with the Welsh Government across the board.
Q. Can you provide any practical examples on the ground where this dialogue with the Welsh Government led to a better health and safety outcome for healthcare workers in Wales than it did in England?
A. Apologies, I'm not able to provide that level of detail, but I'll happily kind of provide some evidence later if that's helpful.
MR PUAR: Thank you.
My Lady, those are the questions.
LADY HALLETT: Thank you very much.
Thank you very much, Mr Rowan, that completes all the questions we have for you. Thank you very much for your help.
THE WITNESS: Thank you, my Lady. Cheers.
(The witness withdrew)
LADY HALLETT: Mr Fireman.
MR FIREMAN: Thank you, my Lady, may I please call Ms Rozanne Foyer.
MS ROZANNE FOYER (affirmed)
Questions from COUNSEL TO THE INQUIRY
MR FIREMAN: Ms Foyer, could you please give your full name?
A. Yes, my name is Rozanne Foyer.
Q. Thank you. You have given evidence before to this

Inquiry, but you have given a witness statement to Module 3. That's INQ000411604. Can I just check you've got that accessible to you?
A. Yes, I do.
Q. Thank you.
You are the general secretary of the Scottish Trades Union Congress; correct?
A. That's correct.
Q. We just heard from Mr Rowan of the Trades Union Congress, and I think it's clear, isn't it, that the Scottish Trades Union Congress operates in a very similar way to the Trades Union Congress --
A. Yes, we do.
Q. -- albeit, of course, its remit is in Scotland?
A. Yes, we cover over 500,000 members based in Scotland and have a similar range of affiliates who separately affiliate to the Scottish TUC.
Q. Thank you. With respect to the work that the STUC does, you've explained in your witness statement that it co-ordinates, of course, work that's done with health and social care unions among other unions, in terms of their engagement with the Scottish Government and ministers and Cabinet Secretaries.
Would you consider that, generally speaking, you have a good level of access to and liaison with the

Scottish Government?
A. Yes, we have had a long-standing close engagement with the Scottish Government, I would say that we have a high level of engagement, it's constructive and it's robust.
Q. Did that remain the case during the pandemic?
A. I would say it became even more -- the engagement was more intense during the pandemic and more regular because of the nature of what we were dealing with.
Q. You've set out in your witness statement that you agreed something called the Coronavirus Fair Work Statement with the Scottish Government.
If we could just get that on screen, it's INQ000107242, and if we could go to page 2, please.
What we're looking at there are some principles that you have agreed with the Scottish Government in terms of how to approach the workplace and protecting workers during the pandemic; is that right?
A. That's correct, yes.
Q. We can see obviously some of those, particularly those towards the bottom of the page, are particularly pertinent to healthcare workers, protecting the health and safety of all workers, particularly those on the frontline and, of course, ensuring that workers are provided with clear and comprehensive information on work related risks on an ongoing basis.

How effective do you consider agreeing this sort of statement was in terms of establishing, I suppose, a sort of contract between the Scottish Government and workers?
A. The feedback we received from our member trade unions, including those in health and social care, was that this was a very effective document, it was used widely by reps on the ground to remind employers of the obligations that Scottish Government expected of them, and a particular clause in it that was actually very widely used by reps was the area around making sure that workers didn't suffer any detriment for following medical advice during their own sickness or absence. So that was something that was used widely.
Q. So is it something that you would consider would be an appropriate thing to agree, were there to be any other pandemic in the future, having this sort of framework in place between the government and --
A. Yes.
Q. -- trade unions?
A. Yes, I would. I mean, it was agreed very early doors, I believe it was agreed March or April 2020 and, as I say, it was something that could be referred to by reps across a range of settings, and empowered them to demand, you know, certain obligations from their

employer, if they felt they weren't getting anywhere.
Q. Thank you, that document can come down.
If I can ask you about some of your specific concerns that you had during the pandemic, of course staffing is obviously something that is particularly in your mind at all times, but you had, of course, just -- I think like the TUC -- raised concerns prior to the pandemic, hadn't you, about the level of healthcare workers within the workforce and vacancy levels; is that right?
A. That's right. I believe we produced in our evidence examples of motions that had come to our congress in 2017, 2018 and 2019, all of which came from healthcare affiliates who were raising concerns around staffing vacancies, lack of adequate workforce planning and issues around the resourcing of the sector.
Q. There were, of course, some steps taken to bolster the workforce during the pandemic, weren't there, in terms of bringing back workers who were retired or unregistered? Do you think those steps adequately filled the gaps?
A. No, I don't. There was much evidence provided by our affiliates that what was already a bad situation at the outset of the pandemic caused by, you know, the austerity measures that had been taking place for up to

a decade before were really compounded and it became a really, really vicious cycle for our members because we had people who were having to shield and take time off sick through the virus itself, but we increasingly had workers who were succumbing to burn-out, mental health issues, and the more people who were taking time off, the harder it became for our workers who were on the frontline to keep their services going.
So we had a really acute set of circumstances for a prolonged period that the workers were having to deal with, and that really made the situation extremely difficult, and we just didn't have the resilience and the capacity from the beginning to really allow us to deal with that. So even though extra resources were put in, the experience of our members on the ground was that the situation was extremely difficult.
Q. That's specific to healthcare?
A. That's specific -- you know, we saw that coming through very highly in healthcare, yes.
Q. You touched on some of the other factors that you mention, including, I think, what you phrased as burn-out.
A. Yes.
Q. So would it be the case that you consider there's an inextricable link between levels of staffing and

burn-out, or the impact on the mental health and wellbeing of those workers?
A. Yes. There's a number of our healthcare affiliates that carried out surveys over that period that we've touched on in our evidence, and you can see that coming through, that staff having to work excessive hours, that levels of understaffing are, you know, consistently quoted and that word burn-out, you know, 80, 90% levels of burn-out being quoted in various different staff surveys.
Q. I think within your witness statement one of the areas you touch on is pharmacists.
A. Yes.
Q. But was it the case that this assessment in terms of burn-out and the impact on all healthcare workers was the case across the board, both primary and secondary care, or were there particular areas where it was more acute?
A. We had evidence came in from Unite, from the Pharmacists' Defence Association, from UNISON, from the royal college of midwifery, a whole range of different areas. So my observation would be that we were really talking that this was quite a general picture, rather than it being one particular area.
Q. Are you aware of whether there was any national programme in Scotland designed to tackle supporting

healthcare workers in terms of maintaining their mental health and wellbeing during the pandemic, or indeed generally?
A. I'm not aware of specific programmes within NHS Scotland, however I have seen evidence that -- well, health and social care was merged by the Scottish Government and integrated in 2016, so some of our surveys cover health workers and social care workers. But my understanding is that, certainly in social care, there was evidence that there wasn't support, there was a survey carried out by GMB which is in our evidence bundle that referenced a real lack of support for workers' mental health. My understanding is that there were some provisions with NHS Scotland but I'm not familiar with them, you'd have to ask them about the specifics of that.
Q. Thank you very much, that's fine.
In terms of the wider picture, it's not just, is it, about the staff who were suffering? Of course that's very important, but it's also about the impact that the staff suffering with their own mental health issues may have on patients. Do you -- and I appreciate it's quite a difficult question to assess -- but certainly from a concern perspective, did you have any concerns that, in fact, mental burn-out was having an impact directly

on the quality of care that was being provided to patients?
A. Yes, I think that that's something that came through in the reports back that we were receiving. That was part of the level of stress and concern that our members expressed. They felt that, due to the staffing levels, the lack of resources, that they weren't -- you know, that added to their burn-out, the feeling that they weren't able to give the sort of public service that they would want to, to care for people. I think that the very nature of the role of care giving and healthcare workers, there's a lot of emotional investment involved, in fact it's very important, that human element is a very important aspect of care, and there was real frustrations coming through from staff that they weren't giving what -- you know, their feeling of a high standard of care because of the sheer lack of resources available and the burn-out that they were themselves experiencing.
Q. So what's coming through from what you're saying is that this is all linked, really. Staffing levels are linked to mental health issues; mental health issues are linked to the way in which you provide care; and not being able to provide good quality care can impact on, again, mental health of healthcare workers.

A. Yeah. One of our affiliates, Unite, described their members who worked in healthcare as being at breaking point, and that was in, I believe, around August 2020, and I think that that just illustrates the level of anxiety that staff had about the provision.
Q. Just moving to a linked topic but from a slightly different perspective, one of the things that you mention in your witness statement is the particular impact on workers from ethnic minority backgrounds, and you cite a report that was done by UNISON Scotland in June 2020, looking at underlying inequalities and infection risks, specifically looking at black workers.
I don't think this was specific to healthcare, but it was looking at specifically the impact on ethnic minority workers, particularly black workers, in this report; is that right?
A. Yes, and I think it needs to be seen through the lens that there are high levels of BME workers in health and social care in Scotland, it's, you know, a higher level, so it would have been very -- that report would have been reflective of workers in that sector --
Q. In fact, if we have a look at that, or a section of it, in fact, that's INQ000215615.
If we just go to page 3, just can see some of the summarised points that arise from that report, and we

can see there, under the heading "Black workers and fear", we can see first of all that black workers are more fearful of infection. This was a report, it should be said, done in June 2020?
A. Yes.
Q. So of course then there may be multiple factors contributing to this but it would probably be sensible to infer that one of the reasons for that fear may have been the higher proportion of deaths among black healthcare workers; is that right, at this time?
A. Yes, it became clear very early on in the pandemic that there was a disproportionate, a really stark disproportionate effect on BME workers that was emerging, and this report was really trying to get at the underlying inequalities that might be contributing to that, and it was felt -- I think the report quite clearly articulates that that lack of empowerment in worker voice, and that if you're fearful in work in general or you feel less empowered to raise issues, then that could be directly linked to the higher infection rates there were. There was more fear about raising issues, there was more fear about asking for appropriate PPE or refusing to carry out duties or citing health and safety protections.
Q. So do you think that there is potentially a link between

fear of some of these other aspects, fear of losing your job, more worried about reduced income, a link between that and perhaps the areas in which healthcare workers were required to work, which may in fact have been riskier than other areas, because those workers didn't necessarily have the confidence to challenge the fact that they may have been placed in particular riskier places?
A. Yes, I think that this is an area we really need to look at, because it's not only black and ethnic minority workers, but I think that there are definitely socioeconomic factors at play when we look at -- and this is something that I covered actually in my evidence to the Scottish Inquiry on health and social care, so it will be available to yourselves. But, you know, that dynamic of workers who are in lower grades on poorer pay and conditions, workers who are perhaps in more precarious work in areas of the care sector who didn't feel empowered to demand the appropriate PPE, who might not have had as much sight of the appropriate guidance or had it explained to them or had training to carry out appropriate risk assessments if they were, you know, visiting people in home settings, et cetera, we think there's definitely a link there that warrants further investigation because people feeling empowered to be

able to raise issues is a massive factor. So if you're, you know, affected by inequality, you're less likely to feel that empowerment to be able to protect yourself in such a grave situation.

Q. That can come down.

I suppose, following on from what you're saying, do you think that there was a link between the quality and level of risk assessments that were being done and the fear that workers were experiencing and then, again, another link to the types of workers who were experiencing that fear?

A. Yes, definitely. We found that many workers who were being expected to self-risk assess hadn't been given adequate training to do so when visiting people in home care settings, and that would have affected a range of health and social care workers. We also had a range of agency workers, et cetera, who were not able to adequately access sick leave, and there were real concerns, certainly on the social care side of things, that these workers were, you know, choosing to report for work, you know, rather than have -- be unable to feed their families, effectively. And that's a really unfair decision to ask someone to make. So there were some serious issues that we had that we raised at the time with government around these areas.

Q. I suppose just tying that again back to what we were looking at before, do you think there is a higher proportion of -- in fact I think you may have just touched on it -- a higher proportion of ethnic minority workers in more precarious roles --

A. Yes.

Q. -- therefore that's perhaps an explanation for why they were more fearful?

A. Yes, I think if you look at across healthcare and social care settings, we have high numbers of workers from BME communities working in these areas and working in the lower paid jobs in these areas.

Q. Did the STUC take any action to raise these concerns during the pandemic about the lack of risk assessments or appropriate risk assessments for ethnic minority workers?

A. Yes, we did. We had a number of meetings with the Scottish Government through our Covid group, where the issue of the lack of statistics in relation to BME workers was raised with government and the need to do more work on this area, and we had general concerns as well around the under-reporting and lack of adequate health and safety reporting in healthcare settings and other areas.

Q. This is something you also touch on in your witness

statement, and of course we've just heard from Mr Rowan and he touched on the role of the Health and Safety Executive in some detail. One of the points you make in your statement is you say that you weren't informed of the fact that the HSE was pausing inspections of healthcare settings during the initial period of the pandemic. Why would you have expected to have been informed of that?

A. Well, I think if we had been informed of it, we would have been extremely concerned, because we would have, in -- you know, for us, the healthcare setting at that point was an extremely high-risk area for our members to be working in, and we would have expected enhanced reporting and resources going into looking at some of the issues happening in those areas, not a withdrawal of resource, which was the reality.

Q. I can understand what you're saying about reporting, but can you clarify what you mean by inspections, because presumably because of the infection prevention and control measures, it was not surprising that there may have been steps taken to reduce more people going into a healthcare setting at the time, so do you think that, notwithstanding the infection prevention and control measures that needed to be complied with, inspections were so important that in fact it was necessary to

continue those even during peaks of the pandemic?

A. Yes, that's exactly what I'm getting at there. We -- I think we would have had the view at the time that the opposite needed to be happening, we needed to understand as we were moving forward and learn lessons as we were moving forward in what was a very difficult situation, but nonetheless that lesson learning was a very important aspect of work that was missed.

Q. Without repeating evidence, you've also spoken about RIDDOR and the requirements under those regulations. I suppose if I could just give you the opportunity to comment on anything further that was said by Mr Rowan in relation to that, whether you have anything that you'd like to add or anything you'd like to endorse or anything from a different perspective?

A. Yeah, I mean, I would very much endorse Mr Rowan's comments from the earlier evidence. It's our view that there was an under-reporting that was problematic. We actually had a situation where, in 2021, we had a dispute with the Scottish Government at a later stage sort of re-lockdown where they did not put manufacturing, non-essential manufacturing, and non-essential construction back into lockdown even though we had a real prevalent strain of the virus re-emerging, and we took issue with Scottish

Government's policy on this, and they used Health and Safety Executive statistics to push back on us and say to us: well, you know, we don't think there is an issue with work-based infection in these areas, because the statistics are not showing it. And we believe that had there been less under-reporting that, you know, that wouldn't have been the picture that emerged.

So they were pointing to figures that -- you know, to back up their arguments that perhaps were skewed because of the under-reporting, and we actually took the TUC report to Scottish Government on under-reporting of RIDDOR when we continued the discussion about these particular sectors, because we felt that there was not enough resources going in across a range of sectors.

So I know that's not directly linked to health and social care, but I think it's a good example of, you know, our concerns more generally around the lack of proper reporting.

Q. I'm just conscious that you mentioned the discussions you had with the Scottish Government. Is the issue of RIDDOR reporting a devolved matter or a reserved matter, do you know?

A. It's a reserved matter, but the Scottish Government were using that UK information to inform their decision-making, so it's -- it's very much a reserved

matter. And, you know, it is something that we raised, we did have discussions with the Health and Safety Executive around a range of -- sometimes problem areas with the devolved parts were around public health, you know, public safety in Scotland and public health, and so we did have devolved workplace guidance that we felt sometimes the Health and Safety Executive at UK level weren't really paying much attention to.

Q. Following on from your earlier comments about having a good level of access and liaison to the Scottish Government, of course it's a counterfactual scenario but if this was in fact a devolved issue, is it something that you think you would have had a better opportunity to have challenged the Scottish Government on?

A. I think that we feel that there was certainly issues with the fact that health and safety wasn't devolved. We had a situation where there was public safety guidance getting issued and perhaps not getting adequately enforced or taken account of by the Health and Safety Executive, and that was something we felt was problematic.

Q. Could I turn now to a separate topic to ask you about, that's the provision of PPE for healthcare workers.

You say in your witness statement at paragraph 53, if you want it for reference, that you were aware of

reports from trade unions at an early stage of the pandemic that there were issues with staff in healthcare settings getting access to PPE.

A. Yep.

Q. Do you recall or are you able to summarise what you think the main issues were in terms of access, was it one of supply or was it simply a case of there just not being access within hospitals to the PPE or, in fact, just inadequate PPE in terms of the way in which it fit --

A. I mean, there was a whole -- there was a whole range of issues. At the very beginning, there were some really acute supply issues at the beginning. It became then a more complex range of issues, so we definitely had issues with Scottish Ambulance Service at the very beginning, where there was a really acute lack of appropriate PPE; we had people across healthcare settings being asked to reuse, wash and wipe down PPE, buy their own PPE; there was inconsistent supplies; there was sometimes PPE in the building but it was locked away; there were a range of debates about the type of PPE being fit for purpose, so there was a huge debate around the FFP3 masks being rationed to only certainly job roles and procedures, when it was actually felt that aerosol-generating procedures were happening

much more widely than the provision of the PPE was being given out for; and there were also issues with ill-fitting PPE and symptoms that healthcare workers were suffering from as a result of that ill-fitting PPE.

Q. Thank you, that's a very comprehensive summary. But if I focus on the first point that you made, that was supply.

A. Yep.

Q. If we could please look at Jeane Freeman's statement, of course she was the Cabinet Secretary for Health and Sport for a considerable period of this period's of this module's relevant period.

A. Yep.

Q. Her statement and the paragraph I want to take you to is 24, it's INQ000493484. If we start with paragraph 24, I just read the beginning of it to you, it says:

"A unique feature of the distinctive health infrastructure in Scotland, and one which made a significant contribution to the pandemic response, is the existence of National Services Scotland ('NHS NSS'). Amongst other functions, NHS NSS acts as a procurement arm for the whole of the NHS in Scotland."

If we leave that there and then go on to paragraph 191 of her witness statement, which is at page, I think, 44, she expands on the benefits of NHS

NSS and she says at 191:

"As noted, in terms of PPE, we had the advantage of a single procurement arm for the whole of NHS Scotland, namely NHS NSS which has a long-standing relationship with the providers and manufacturers of PPE. That being the case, at the very outset of the pandemic and despite very high global demand and associated pricing, we were able to increase the volume of PPE on order."

Pausing there and having taken that in, I suppose my question to you is: did you consider or did you feel that the supposed benefits of NHS NSS as they are explained within Jeane Freeman's statement, were translated into a good level of access of PPE for healthcare workers on the ground?

A. So I guess at the outset what I would say is that we didn't have any anything to compare what we were getting to -- you know, perhaps what was happening across the rest of the UK, so it's hard to know whether it made a positive difference or not, from our perspective. But what I can say to you is we consistently had a range of issues raised with us which we raised with government, and I know that these issues were also being raised directly with NHS Scotland and with, you know, across the social care sector as well where there were definite failures to provide appropriate fit for purpose PPE to

the right people on the ground.

And I think that's the real value that we brought to the table because you can have all these procedures in place and all the procurement and all the systems, and, from Jeane Freeman's point of view, it might have all looked tickety-boo but what we were able to inform the minister of and government of was that that was not the reality for workers on the ground, in far too many cases, and, particularly, at the start things did get better but there were still ongoing and consistent issues that took place throughout the pandemic for our workers on the ground.

LADY HALLETT: You say you informed the minister, so you informed Ms Freeman at the time of these issues?

A. Yes, there were early meetings that took place with the minister, particularly around -- now, it was either with Ms Freeman or it was with Fiona Hyslop, the Economy Minister, but they're both cabinet secretaries, but at very senior level of government, we were raising issues. There was actually a point at which the Scottish Ambulance Service was about to walk out, very early on, on health and safety grounds and we had very high level emergency meetings to get issues dealt with, because they just didn't have the access to the PPE they required.

MR FIREMAN: My Lady, I'm conscious of the time.

LADY HALLETT: Yes, certainly.

I hope you were warned that we take regular breaks for the benefit of those trying to transcribe the proceedings. So I shall return at midday.

(11.47 am)

(A short break)

(12.00 pm)

LADY HALLETT: Mr Fireman.

MR FIREMAN: Thank you.

Ms Foyer, before we broke, we were just discussing Jeane Freeman's evidence, and you were explaining how the levels of supply of PPE may not always have translated into access to PPE for healthcare workers on the ground, so to speak.

If we could go back to something that Ms Freeman says in her evidence, and this is at INQ000493484, paragraph 200. She describes at paragraph 200 something called the "PPE helpline", and she says that:

"... the Scottish Government set up and managed a dedicated PPE helpline mailbox for HSC staff to contact if they did not have access to the PPE that they needed, or if they had other concerns regarding PPE ..."

And that was set up in April 2020.

Was this helpline something that you were

particularly aware of and, equally, something that you felt that healthcare workers were properly aware of in case they needed to contact the helpline?

A. So I do -- I am aware that there was such a helpline, but I think you probably have to ask the health unions in Scotland for more specific examples of how widely used or helpful they felt the helpline was. It was certainly something that was publicised and that we were aware of and promoted, but it was really more done at the level -- there were direct discussions between healthcare unions in Scotland and NHS Scotland, through STAC and industry leadership groups, that took place that the STUC wasn't party to, and I think there's probably better people than myself to comment more deeply on that.

Q. Okay, thank you very much. That can come down in that case.

Turning then to a topic which I think you touched on briefly before in relation to aerosol-generating procedures, and you said that there were concerns about that and the distinction drawn between aerosol-generating procedures and other procedures, particularly, I think, you're drawing the distinction between areas in which respirators were recommended and areas in which they weren't.

You mention a particular concern about a specific procedure, chest compressions, not being designated as an aerosol-generating procedures. Just to clarify, is your concern that it should have been, in terms of what you were hearing from healthcare workers, they wanted it to be deemed an aerosol-generating procedures and it wasn't, or were there concerns that it was in fact something that shouldn't have been and there was time being taken up putting on unnecessary PPE?

A. No, the concern was very much that they wanted it to be classified as an AGC -- sorry --

Q. An aerosol-generating procedure?

A. Yeah, and it wasn't, and that was something that, according to the feedback we received, caused a lot of resentment and a feeling of, you know, unfair practice among the workforce. So it was -- it had a bad effect on morale. There were also other areas that the chartered society for physiotherapists raised, that they felt key practices they carried out were also aerosol-generating procedures but weren't recognised within the guidance as such.

Q. You mentioned you felt this caused resentment. Are you able to explain a bit more about what you felt the effect of not designating these procedures as aerosol-generating procedures had on healthcare workers

and, indeed, their trust in national guidance?

A. Yeah. Well, it was very detrimental, because we're talking about workers who were already scared, stressed, felt they were putting themselves and their families at risk in going to work every day, and if they felt that they were being denied access to appropriate PPE, that would only intensify that stress.

Q. Okay. You also describe in your statement the -- I think it's from the RCM, the Royal College of Midwives, saying that they reported that FFP3 masks had been or they felt were being rationed.

Do you see any link between the designation of aerosol-generating procedures and that concern that FFP3 masks were being rationed?

A. Yes. I do, and ultimately I think our preference would have been for access to PPE to be worker-led. We're talking about well trained, experienced clinicians who should have been allowed to determine in what circumstances they would require the PPE, and, you know, there's a difficulty there when -- you know, if a midwife or a physiotherapist or, you know, a nurse identifies that they need that when it's been denied to them through guidance, that we felt shouldn't have been happening, the workers should have had more agency in those situations.

Q. Just to pick up on that, is it your view that there should have been more discretion for healthcare workers to make decisions about what the appropriate PPE was for them to wear rather than --

A. Yes.

Q. -- it being mandated by national guidance?

A. Yes, I mean, there's a place for national guidance and we probably would have wanted to see an improvement to it, but ultimately I think we would have wanted to see workers' voices being given a primary consideration in that, and if it was felt to be required then it should have been provided.

Q. You also mentioned concerns about ill-fitting masks, and is that also with respect to respirator masks, FFP3 masks in particular?

A. Yes, there were issues raised with our affiliates about resultant skin conditions and issues for workers wearing ill-fitting FFP3 masks, but also there was a gender issue in relation to the default seemed to be that it was fitted for a male face and that for many women working in healthcare settings this was a problem that was identified. So it is something that I'm aware that healthcare unions were raising consistently.

Q. This issue about the potentially gendered aspect to it, and indeed I think you even describe in your witness

statement that there was also an issue in terms of ethnic minority --

A. Yes, that's right.

Q. -- healthcare workers as well --

LADY HALLETT: It was -- the white male face was the default setting, I think, wasn't it?

A. Yes, indeed, indeed.

MR FIREMAN: Is this something which you were aware of or indeed the STUC were aware of prior to the pandemic or is this something which in fact came to light as the need to use these respirators was increased?

A. So, again, I think that's probably a question for our healthcare unions. It certainly wasn't something that I was aware of the STUC being aware of prior to the pandemic, but I think it's something that during the meetings it became clear to me that this had been a long-term issue that healthcare unions had been raising. I certainly remember a meeting where we had officials from healthcare unions and that that was a topic of the meeting, and that was the inference I took from the discussion at the meeting that this was not the first time it had been raised and that it was a long-standing issue that had been raised in the past.

Q. Something that had been raised by healthcare workers in the past?

A. Yes.
Q. But not something which the STUC had actually taken an initiative and --
A. No, I'm not aware of the STUC itself, as the umbrella body, having raised it with government in the past, but most of the detailed discussion around issues like that would not have been a topic for the STUC to raise, because of the very well established partnership structures that existed between NHS Scotland and healthcare unions, so that's an issue that I would have expected to be raised in those structures in the past.
Q. Just finally on PPE, now, you also mentioned, I think, particular concerns about the ambulance service, and you talk about, in your witness statement, the concerns you had about out-of-date PPE being used. Could you just elaborate a little bit on that.
A. Yes. There was a case raised by the GMB Union, I believe, where there was a whistleblowing case, and they raised the issue that out-of-date PPE had been in use and the dates had been covered up, so they made a formal whistleblowing complaint in that regard. So I'm aware that that did take place.
Q. Just to summarise, you obviously have given a lot of evidence about a variety of different concerns that the STUC had, is there anything that we haven't touched on

but you think, in terms of looking forward and with a particular focus on healthcare workers, you think there are particular lessons in that regard that we need to learn were there to be a future pandemic?
A. Yes. I mean, I think that overall, when we're looking at this, there was definitely serious failures by government and healthcare employers to be properly prepared and give the adequate resources and support to workers on the frontline during the pandemic. That ranged from, you know, the inadequate staffing levels that we talked about and the effects that were compounded on staff as the pandemic progressed; the lack of PPE, which we've covered quite comprehensively; the lack of mental health support for workers, as the effects deepened, and the real trauma and burn-out that was being experienced; the lack of appropriate resources for proper safety inspections and learning to take place as the pandemic progressed.

And I think that we need to remember that government and employers have a duty of care to protect the workers that work in our healthcare settings in a pandemic or a serious high-risk situation like that, and we know that the workers who worked in health and social care were disproportionately affected and, indeed, infected during the pandemic, and people paid the ultimate price

with catastrophic effects on themselves and their families.

I referred to a report in the Scottish Inquiry from Professor Phil Taylor, which stated that workers in health and social care were four times more likely to be exposed than workers in other industries and our own affiliate, the HSCA's report Never Again, in 2022, stated that severe disease, ie --
Q. Sorry, can you just slow down slightly --
A. Yeah, no problem.
Q. -- for the stenographer.
A. Yeah, no problem. So the HCSA's report stated that severe diseases -- and what we're talking about here is hospitalisation or death from Covid -- was seven times more prevalent in healthcare workers. So I think that, given all of that, we really need to ensure, going forward, that these failings are addressed, we need to make sure that there's proper PPE guidance and support put in place for the future, we need to make sure that there is more effective reporting and enforcement of health and safety in high-risk areas, and we need to recognise Covid and Long Covid as occupational diseases and ensure that those who suffered detriment through the act of undertaking their work are properly -- you know, were properly compensated, are properly compensated

going forward and that these protections are in place so that this can never happen again.
MR FIREMAN: Thank you very much, and thank you very much for that comprehensive summary.

Those are my questions, I think there are some others.
LADY HALLETT: Thank you, Mr Fireman.

I think it's Ms Mitchell KC. I think you may remember Ms Mitchell.

Questions from MS MITCHELL KC

MS MITCHELL: Yes, indeed, I'm obliged, my Lady. We have asked Ms Foyer a few questions before.

Ms Foyer, I act on behalf of Aamer Anwar & Company for the Scottish Covid Bereaved.

You spoke in your evidence about well-trained staff who were able to complain in relation to PPE and suchlike. I'd like to ask you about the staff who weren't so well trained and, indeed, weren't trained for the purposes or the jobs that they were being asked to do.

I don't need to have it up on screen but, at paragraph 29 of your statement, you raised this issue and you explained that there were nurses who were asked to work in intensive care units to deal with critically ill and dying patients when they'd not been trained or

properly trained to do so.

My question is: did your body complain about this direct to NHS management or the Scottish Government and, if so, what response did you receive?

A. Thank you. I believe that was our affiliate, the GMB, that submitted that report back to us, and my understanding is that this is something that they had been actively raising during the pandemic. I think if you want, you know, more detail on exactly how that was done, you would need to question them. But my understanding is that that was an issue that was raised and, you know, it had really deep effects on those workers. They have members who suffered PTSD, you know, as a result of some of the experiences. But it was common practice during the pandemic that wards -- you know, certain wards were closed, people were redeployed because of the acute difficulties with staff going off sick and staffing shortages. There were lots of areas where staff were redeployed to areas that they weren't well trained on and, you know, it's certainly not an isolated occurrence.

MS MITCHELL: Thank you.

My Lady, I've no more questions.

LADY HALLETT: Thank you very much, Ms Mitchell.

Thank you very much for your help again, Ms Foyer,

I'm very grateful to you.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: Right, Mr Fireman.

MR FIREMAN: Thank you. My Lady, may I please call Dr Lisa Ritchie, who will be sworn.

DR LISA RITCHIE (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: I hope we haven't kept you waiting too long, Dr Ritchie.

MR FIREMAN: Dr Ritchie, can you please give your full name?

A. Lisa Ritchie.

Q. Thank you. Dr Ritchie, you have given a witness statement to Module 3 dated 23 July 2024. That's INQ000421939. Can I just check you have that accessible should you need it?

A. I do.

Q. Dr Ritchie, you are the National Deputy Director of Infection Prevention and Control at NHS England; is that correct?

A. That's correct.

Q. Is that a role that was formerly referred to as Head of Infection Prevention and Control at NHS England?

A. That's correct.

Q. You have responsibility for leading the national IPC

team at NHS England as a result of that role?

A. I do.

Q. Is it right that by background you are a general registered nurse?

A. I am.

Q. You have a postgraduate diploma in infection control nursing and also a PhD in a specific infection prevention and control matter?

A. I do.

Q. From 2009, you were a nurse consultant in IPC, infection prevention and control, in the Antimicrobial and Healthcare Association Infection group, ARHAI, which was then part of Health Protection Scotland, HPS; is that right?

A. That's correct.

Q. That Health Protection Scotland, HPS, latterly became part of Public Health Scotland but not when you were there?

A. Not when I was there, no.

Q. Then you began your new role as Head of IPC at NHS England in April 2020; is that right?

A. That's correct.

Q. During this module's relevant period, that is March 2020 to June 2022, you were a member of various scientific subgroups including NERVTAG, the UK IPC cell, which

we'll come to in a moment, and the Hospital Onset Covid-19 Infection Working Group; is that correct?

A. That's correct.

Q. As I said, the majority of your evidence is focused around your role in the UK IPC cell, which you chaired for a period, I believe, between June 2020 and the end of March 2021; is that right?

A. To June 2021.

Q. To June 2021?

A. A year.

Q. Okay, for a year.

I'm going to ask you some questions about the IPC cell but, before I do, my Lady, it's been said before but it does bear repeating, that this witness was not the only individual who was on the IPC cell. She acted as the chair of the cell for a substantial period, which the Inquiry is examining, and she's, as a result, one of the most appropriate individuals for the Inquiry's question but, of course, some of the time she may be referring to decisions which were made collectively.

In fact, Dr Ritchie, if I could ask you to make clear, where relevant, if you are speaking from a personal opinion, a personal professional opinion, or indeed the opinion which was reached from the UK IPC cell as a whole.

A. Okay.
Q. In terms of that cell, it formally started meeting, I think, in early February 2020; is that right?
A. That's correct.
Q. Did it evolve from NHS England's own IPC cell, which was part of its emergency preparedness, resilience and response unit?
A. That's correct.
Q. It may have varied but how regularly did the UK IPC cell meet?
A. So when the NHS England IPC cell was stood up, which was part of a number of cells under the emergency preparedness and resilience for NHS England, I was not working in NHS England at that time. So my predecessor, who was the head of IPC, invited the other UK IPC leads from Scotland, Northern Ireland and Wales to join the IPC cell meeting of NHS England, and that evolved into what became known as the UK IPC cell.
Q. Thank you, that's very helpful.
You summarised the purpose of the UK IPC cell as being to provide a UK-wide consensus on issues relating it infection prevention and control and, of course, that includes, perhaps most pertinently, the use of PPE?
A. So the cell did not advise specifically on PPE, so the role and purpose of the UK IPC cell and for NHS England

was to come together to agree consistency on infection prevention and control guidance, so that we had standardisation across the four nations. So that was our purpose, to make sure that, when we were drafting guidance, that that was aligned with WHO and the scientific evidence that was emerging.
Q. You acknowledge, of course, though that PPE falls within infection prevention and control as a relevant issue?
A. It does indeed but it is one part of a very complex number of IPC measures.
Q. Just focusing, if we can, on the actual onset of having an IPC cell in the first place, are you aware of whether or not this featured in any specific pandemic planning documents or, in fact, whether it was something that was thought up as the emergency was convening? I appreciate you've spoken about the way in which it developed, but the actual necessity to convene a cell, was that something that was always within pandemic planning or was that just something that was put together as the emergency was developing?
A. I believe it evolved. It did evolve as the emergency developed. I mean, I think what would have made a real difference to me, as a new start in NHS England on 1 April, would have been having a clear structure, outlining the functions, the roles and responsibilities

of key national organisations and understanding what the governance, the decision-making processes and the primary knowledge resources, evidence bodies and guidance leads would have been invaluable. So, in hindsight, it would have been very useful to have understood or known what that structure was, and maybe something for the future.
Q. We'll come to the structure of the cell in due course but, before we do so, can I just ask you about the members of the cell and who was represented on it. You've listed them out in your witness statement at paragraph 134, and they are NHS England, Public Health England -- which then became the UKHSA -- Public Health Wales, ARHAI Scotland, the Scottish HAI unit, the Association of Ambulance Chief Executives and the Department of Health and Social Care.
Can I clarify, was membership of the cell then specific to those organisations, rather than to any specific individuals?
A. Yes.
Q. The Inquiry heard from Richard Brunt of the Health and Safety Executive last week and he talked about having a direct input to the cell. You didn't mention in your witness statement them being a member of the cell. Is it right they weren't actually attending cell meetings

but they did have direct lines of correspondence to those who were on the UK IPC cell?
A. That's correct. So HSE was not a member of the UK IPC cell but we did engage with HSE on many issues.
Q. You were a member of the cell, both at Health Protection Scotland, as a representative of Health Protection Scotland, and then subsequently as a representative of NHS England; is that right?
A. That's correct.
Q. One of the things that was mentioned by Dr Barry Jones of the Covid Airborne Transmission Alliance on Thursday, when he gave evidence, was he said there were more members on several occasions attending the cells from NHS England than any other organisation. Sometimes, I think he said, there was up to 20. I don't know whether or not that's accurate but, dealing with the issue of why there may have been more members from NHS England attending these cell, is it right that NHS England bore the secretariat function for the cell and would, therefore, have sometimes have had more members attending to take notes, et cetera, or were there other reasons why they may have had more members attending?
A. So because the UK IPC cell had evolved from what was the NHS England IPC cell, we did continue -- we had the infrastructure and we had that cell in place, so we

continued to manage the cell in terms of doing -- organising meetings and doing the minutes and action notes from those meetings.

In terms of membership, from the representative organisations, it was down to those other national organisations to bring to the meeting who they wished to represent their country, public health body, ARHAI Scotland, from Public Health Wales, so there was no bar from those organisations by the chair or anyone else about who from those organisations could attend those meetings.

Q. So it goes back to the point that we were speaking about earlier that it was the organisations which were represented on the cell, rather than specific individuals?

A. Correct.

Q. You could have sent many more individuals if you wanted or much fewer?

A. Indeed.

Q. Are you able to recall, and I appreciate that to some extent you may not know in detail the qualifications of absolutely everyone who attending every single cell meeting, but are you able to recall whether or not there were individuals from non-medical backgrounds or non-clinical backgrounds, for example engineers or

physicists or physical science experts who attended the cell?

A. So, predominantly, the membership was clinical and probably nursing, I would say, more than medical, and I think that was appropriate for the function of the cell and the role and purpose of why we had been established, given the expertise that we had in infection prevention and control. We did not want to duplicate the efforts of other meetings, and we were aware that there were many meetings happening at the same time. For example, there was an engineering management group that was a subgroup of SAGE, and we would obviously look to the outputs of such groups and review what we could translate from the outputs of those meetings into the IPC guidance, if it was relevant.

Q. I appreciate that you have said that it was appropriate, but the Inquiry heard last week from Professor Beggs who comes at things, I think, from a physical science perspective and it was his view that, in terms of the science associated with transmission of infectious diseases, there has been a bias towards epidemiological evidence over physical science. I don't know whether or not you agree with that at all or if you disagree. Perhaps I'll give you an opportunity to comment on that.

A. Can you repeat the question again, sorry?

Q. Professor Beggs told us that he considers that, in professional infection prevention and control spheres, there has been a bias towards focusing on epidemiological evidence over considering what the physical science may say and, as a result, a more narrow picture has been obtained. So my first question is: do you accept that criticism?

A. No. I do think there has been a lot of studies now being undertaken by physical scientists and others but I think, from an IPC perspective, we would follow the epidemiology and the scientific literature in terms of the infection prevention and control guidance that we would put together. So we would be taking the views of our scientific experts, be that from SAGE, UKHSA, Public Health England.

Q. So you don't think then, on reflection, that perhaps the cell would have benefited from having the expertise of a physicist or an engineer or someone from that background?

A. There's always room for improvement and, in terms of the different backgrounds, maybe that is something for future, a lesson learned, that some of these organisations, it's how they're plugged in, I suppose, it goes back to the structure, doesn't it, and how they fit in under the Civil Contingencies Act, for example,

if they were a responder under that remit or within that structure.

So I'm not saying that -- I think what I am saying is that the UK IPC cell evolved over time and the membership was specific to the role that we were carrying out, that it was infection control leads with the expertise in infection control that were pulling together the evidence, taking the outputs from SAGE, NERVTAG, translating a lot of the science into practical guidance for frontline staff. But, you know, if the membership is something that we need to review, there's always lessons to be learned.

Q. Thank you.

The one area then I suppose that you would confirm you were on top of, from the perspective of the representatives of the UK IPC cell, was having direct involvement in clinical work; is that right?

A. That's correct.

Q. So there were members who were actually directly involved in putting into practice the guidance that was being formulated?

A. Yes.

Q. Another issue that has been raised with the Inquiry is that of stakeholder engagement. On reflection, I appreciate you have been very candid about the

potential benefits of physical science and engineering, what about the fact that there were concerns from the Royal College of Nursing and the British Medical Association about them being engaged? On reflection do you think there would be benefit for any future IPC cell, if it was convened, to have a representative from one of those union organisations attending?

A. It felt like there was a couple of questions in that. I think, first of all, in terms of stakeholder engagement, we were working at pace, we had -- I know that, as individuals and collectively as an IPC cell, we were seeking feedback and making ourselves available to people to give that feedback. In terms of the updates to the guidance, there were often times, where I would make a phone call to RCN or to the Infection Prevention Society or the president of other organisations to say that we had to get this guidance out quickly but, if I sent it over, would they have a look at it and come back with any concerns. So we were working at pace so it was often difficult to take stakeholder feedback.

When there was what we would consider major changes to the guidance, so when we'd change the guidance for remobilisation, when care pathways were brought in to get the NHS back up and running and, equally, when we were preparing winter guidance for 2020 to 2021, we did

more formal consultation. So stakeholders were involved in that process because we had a bit more time to get the feedback and take their input.

I know that my Chief Nursing Officer and other colleagues were out and about, you know, and they had direct contact with the royal colleges, with very many meetings, we put on lots of webinars --

Q. Can I just pause you there and just ask you about the principal basis for my question, which was: what about having a representative regularly attending the UK IPC cell from the Royal College of Nursing or the BMA?

A. I think the challenge is the number of different representatives from all of those various groups. So I think it's important and, again, I think it goes back to the structure, about setting that in place, about what the consultation looks like, what is the communication and engagement strategy and having something like that proactively built in, rather than it being something reactive. And I accept that, you know, it wasn't always easy to take all of the feedback that was coming from stakeholders, given the pace at what we were working.

Q. I think that then leads on to the criticism which the Inquiry heard last week about the suggestion that, from some of the members of the BMA and Royal College of

Nursing, they felt like they were being managed and pushed away. I presume that, based on what you've just said about stakeholder engagement and the steps you did take to consult, you would at least make clear that wasn't your intention and, indeed, probably not what you consider actually occurred; is that right?

A. Absolutely and, if that was the perception, it couldn't be further from the truth because we did want to get feedback from people. But, as I say, when we were pulling or drafting guidance and reviewing the evidence and updating we were working to very tight timelines.

Q. All of these points are relevant, of course, because what I want to ask you is whether, in fact, you consider the membership of the cell, as it was during the pandemic, the Covid-19 pandemic, was sufficiently broad to ensure that a range of expert opinion was brought to the table; do you consider that was the case?

A. I do.

Q. One of the points which arises from review of the IPC minutes is this concept of cell reaching a consensus. Can you explain what the process was by which the cell reached a consensus and then made a decision on how to proceed?

A. So it was, as chair -- when I was chair and as a member, the decision-making did rely on consensus, it was

ensuring that we had broad agreement among the members, though not always unanimous, and we provided recommendations to national governance bodies, to each of the countries, for their final approval. So it was making sure that we had open discussion, as I say, that we came to a recommendation at the end of that which would be broad agreement and those -- if there was any doubt or we didn't feel that we had come together and reached consensus, then that would have been escalated to senior clinical colleagues.

Q. I sense from what you're saying then that there weren't actually formal votes taken during the meeting?

A. No, there was not.

Q. So then did it rely, essentially, on whoever was chairing the meeting, in many of the instances you, getting a broad flavour of what the discussions were and then summarising that as the consensus?

A. Yes.

Q. If we can then look at one of these documents that's relevant, which is the minutes of the IPC cell from 18 August 2021.

This is INQ000398186, and it's the third -- I think it's the third page of that document, if it could come up on screen, please, if possible.

But don't worry if not, I can just summarise what

you say in it. In August you say that you were still working with a consensus view, however escalation of any disagreement may need to be included in the next terms of reference.

So this is in August 2021, some time into the pandemic, and it seems that still at this stage the terms of reference and the lines of reporting were still being ironed out; is that a fair summary?

A. I mean, we did review the terms of reference for the duration of the cell. I mean, I think it's important to say here that we could have been disbanded at any time. The cell was given authority by others. We didn't have a direct route to publication. The guidance could have been pulled that we put out or the consensus decision could have been pulled by any of the public health bodies across the UK. And I'm sure our senior leaders would have been clear about the decisions that we made, whether they were right or wrong.

Q. To be absolutely specific, I know you have mentioned public health leaders but who would any disagreement or ambiguity have been escalated to? Who were the individuals or professionals who would have had oversight of that?

A. So the UK senior clinical leads.

Q. In which departments?

A. In each of the four nations.

Q. In a related question, would that mean, then, that Public Health England, for example, who published the guidance on behalf of England, at least, would they have had the ability to have come back to you on anything that was agreed during the IPC cell minutes and, say, objected to it or required an amendment to be made to that piece of guidance that was proposed?

A. As a lead organisation for public health and infection control in England, they could have come back at any point and made amendments.

Q. Would this still apply if Public Health England themselves, who were obviously members of the IPC cell, had not in fact agreed with the consensus view that was reached at the IPC cell meetings?

A. Yes.

Q. Can you recall any occasions on which, whether that be the CMO within each nation, the CNO within each nation, or public health bodies, actually came back and said "You need to make a change to this guidance or we're not going to approve it in its current form"?

A. So I don't recall specifics, but I do recall conversations with Public Health England colleagues on draft guidance content.

Q. In practice, then -- I appreciate that you may not have

been responsible for the reporting lines, but in practice, was it the case that recommendations reached at the UK IPC cell were routinely incorporated into national guidance?

A. That's correct.

Q. The Inquiry has been provided with several of the UK IPC cell minutes, indeed I think all of them now, I think that's clear, but the minutes weren't actually published, and I don't think they ever have been published. Why is that the case?

A. The decision not to publish the minutes was never formally addressed. As I said at the beginning, the UK cell, IPC cell, evolved from what was the NHS England cell, and none of those incident cells were publishing minutes. So our primary focus was on producing timely evidence-based guidance that aligned to national and international recommendations.

But I think had the conversation come up, I don't think there would have been any objection to publishing the minutes, but it wasn't something that we formally discussed.

Q. Were there ever any requests from, as far as you can recall, any union bodies or any other campaigning groups to publish the UK IPC cell minutes?

A. During the relevant period, I don't recall.

Q. Again, trying to take a forward-looking approach, do you think there would be benefit in publishing these sorts of minutes to allow for a dialogue of challenge to come to the surface?

A. Yes, I mean, I think if publication of such minutes would be helpful, it might be an area that requires to be formalised across the four nations of the UK.

Q. Thank you.

If we can now turn to some key principles of infection prevention and control to try to establish some of the things that you were looking at as a cell, and considering. You've set out in your statement and the Inquiry has heard about standard infection control measures, and that's measures that I think are taken all of the time for all healthcare workers regardless of the threat that is being faced and regardless of the transmission of any particular virus but to protect against generally all threats; is that right?

A. That's correct.

Q. We then have transmission-based precautions, and this is relevant to the nature of the disease that you're trying to protect against, isn't it?

A. Yep.

Q. In order to properly protect against a virus, you need to understand the way in which it's transmitted and

thereafter you need to prepare for and provide for the relevant protections that will protect against the way in which that virus is transmitted.
A. Correct.
Q. We've heard about, and you've set out in your statement, the three established routes of transmission for a respiratory virus: contact, droplet and aerosol. Focusing if we can on droplet and aerosol, because those are the two most pertinent here, you would agree, I suspect, that there are differences in terms of the precautions you need to take when protecting against a virus spread via droplets and one which is predominantly spread through aerosol transmission?
A. Yes, and it does support the -- the definition supports the IPC measures that would be put in place.
Q. I'm not sure -- sorry, would you clarify what you just said?
A. So, sorry, could you repeat the question?
Q. The question is a basic one really, it's just to establish that there are differences between the way in which you protect against a virus that is spread predominantly by droplets and one which is spread through aerosols?
A. That's correct.
Q. That's why we've heard about the differences between

fluid-resistant surgical masks and respirators, respirators being necessary for aerosol protection and surgical masks for droplet protection.
You accept, I think, that FRSM, if I can use that acronym, don't protect against aerosols, do they?
A. No.
Q. We heard last week from Richard Brunt, who explained that from the HSE's perspective, FRSMs aren't in fact deemed to be PPE because they're not, if I can summarise, personally protective; they are, I think, source control or a medical device as far as he is concerned, they're regulated by the MHRA. You say in your witness statement, at paragraph 68 for reference, that you do think that FRSMs are considered to be a component of PPE. Can you accept that because of the issue in terms of them not being approved by the HSE as PPE that some may not consider FRSMs to be PPE?
A. FRSMs have been used in infection prevention and control in healthcare settings for a long, long time, and are part of established guidelines nationally and internationally, the WHO, communicable disease centres in America, so as PPE they have been cited as part of infection prevention and control precautions for many years, in many guidance documents, so it's a well established piece of infection prevention and control

kit or PPE.
Q. When dealing, of course, with a virus that's spread through droplets?
A. Correct.
Q. In terms of the difference between the two modes of transmission, aerosol and droplet, the Inquiry heard last week about historically this having come down to size of the particle. Of course we also heard that larger droplets behave ballistically and fall to the ground relatively quickly, whereas aerosols float and remain in the air for a much longer period of time. Do you agree with that summary?
A. Yes.
Q. Can we, please, have a look at your paragraph 49 of your witness statement.
And this can come up on screen, it's paragraph 49, page 14.
You say this:
"It is my view that the distinction between a respiratory aerosol and droplet in terms of size (micrometres) is an academic consideration that cannot be usefully applied in national guidance or by healthcare workers in 'real' clinical environments."
And you then give your reasons for that, including how difficult it is to measure a particle in practice.

A. Yeah.
Q. Can I just try to clarify what you're actually saying here. You aren't suggesting, are you, that in fact a healthcare worker would need to take a moment to try to assess the exact size of a particle that's just been emitted, because of course that would be impractical, but it is the case, is it not, that it's important that those who set the guidance understand the difference between the size of particles, because that then informs the guidance that you set?
A. Correct, yeah.
Q. So when you say academic distinction, it's not fair, is it, to call it simply academic, because the understanding is directly relevant to the guidance that's then used in practice?
A. I think I was meaning academic in the sense that research that is done in laboratory conditions or in academic institutions then has to be translated into practicable IPC guidance. So understanding a cut-off point is helpful, and having a definition, again, which has been long established in infection prevention and control guidelines, be it contact, droplet or airborne transmission, have been the known and established IPC transmission measures that have been in the guidance for many -- a long time.

Q. So you do accept that there is a use to it; you're drawing a distinction between the scenarios in which it's useful?
A. Yes.
Q. Okay. Professor Beggs gave evidence last week about the size of microns that he considers to be aerosols and that he considers to be droplets, and the cut-off point that he gave was 100 microns: he says anything less than 100 microns is an aerosol and anything above that is a large droplet.
I suspect you don't necessarily agree with that. Is that right?
A. I respect that that is Professor Beggs' opinion. I am not a physical scientist.
Q. So you aren't in a position to say what your view is on the size of particles and the distinction between aerosols and droplets?
A. I think the distinction that I would say is that airborne transmission occurs by small droplets, aerosols are particles that remain suspended in the air and that the airborne transport of those particles may carry pathogens long distances, unlike a droplet, which involves larger size droplets that requires closer contact for transmission to happen.
Q. It might be helpful if we look at this in practical

terms and consider how this was then translated into healthcare worker infection prevention and control guidance.
If we could go to INQ000251675.
This is a passage from some of the guidance, this is page 13 and 14, it should come up on screen soon. Yes, here we go.
If you look at the bottom part of that, it says "Droplet precautions" and it says:
"Used to prevent and control infection transmission over short distances via droplets ..."
And there it says above 5 microns.
So just to clarify, this guidance, is this likely to have been something that was formulated or agreed upon in an IPC cell meeting?
A. No, this guidance existed well before that.
Q. Is this guidance which was -- the guidance that was adapted from the pandemic influenza guidance?
A. Even before that. I think back in 1997 HICPAC, which is an advisory group to the WHO, came up with these routes of transmission, contact, droplet and airborne transmission, and they described these droplet sizes.
Q. Those droplet sizes as they were described all the way back then have maintained and made their way into infection prevention and control guidance, including the

guidance that was issued during the pandemic?
A. That's correct.
Q. So it is the case, isn't it, that, for the purposes of the guidance that was issued during the pandemic, the cut-off point was deemed to be 5 microns, which is obviously markedly different to the cut-off point that Professor Beggs uses?
A. Indeed.
LADY HALLETT: Can I just ask you a question, Dr Ritchie. Things that are well established aren't necessarily always right. Science moves on, understanding moves on. Were you aware of any debate about the size of droplets and whether the science had moved on or understanding had moved on?
A. I think as we came through the pandemic, those discussions were taking place and scientific individuals were putting those cases forward. At the beginning of the pandemic that wasn't the case.
MR FIREMAN: I suppose, thinking about it in practical terms, if we go back to those cut-off points, if we look at a section -- I can take us, please, to a section of Professor Beggs' report.
This is INQ000474276, page 48, and page 49, paragraph 122.
He summarises here what he considers to be the

issue, as a result of different spheres using different cut-off sizes, and he says:
"One of the unintended consequences of the inappropriate [that's his words] 5-micron threshold, was that scientists from completely different disciplines used completely different terms to describe the same objects. So, for example a 23-micron diameter respiratory particle might be called a droplet by clinicians and microbiologists, whereas the same object would be an aerosol particle to an engineer or physicist."
So is that, Dr Ritchie, the nub of the distinction between the two disciplines and, indeed, a potential cause of concern where you have the established science, as it was, in the infection prevention and control guidance and, in fact, another reasonable body of scientific evidence that says, in fact, you're describing these particles in the wrong way and, as a result of that, you're devising infection prevention and control measures that are incorrect?
A. I think the challenge for us was to translate a lot of this scientific evidence into infection prevention and control guidance and I respect, as I say, Professor Beggs' view and acknowledging that transmission can occur along a spectrum and airborne is

possible -- I'm talking about airborne generating procedures -- that airborne spread is possible, particularly in crowded and ventilated settings. But the epidemiology and the scientific literature did not support that airborne spread as the predominant mode of transmission and, indeed, the WHO guidance has not stated a change in a predominant mode of transmission for SARS-CoV-2.

Q. But is that using the 5-micron cut-off or the 100-micron cut-off?

A. The WHO have recently looked at and published revised terminology for respiratory viruses and that still -- I don't think -- they've spoken about a continuum now, as I've just said, and the cut-off, I think, is part of a risk assessment.

Q. Okay, I'm just struggling to follow because I think, ultimately, the question would be: it could have been that both you and Professor Beggs agreed entirely on the size of the particles that were causing the infection, you both look at a 12-micron particle, but he says that's aerosol transmission and you say it's droplet transmission and, as a result, you say airborne transmission is not predominant because we've got 12-micron particles which are droplets.

When you say that airborne transmission has not been

recognised as being predominant, do you know on what basis you're saying that with respect to particle sizes, or are you not able to say that?

A. I'm probably not able to say that in terms of particle sizes but, in terms of the epidemiology and the scientific literature, and the outputs from those scientific groups that we were taking advice from.

Q. I suppose, trying to follow this up, then, just to tie things up, those scientific groups that you were taking advice from, saying that airborne transmission was not a significant threat, were they doing so on the basis of a 5-micron cut-off; do you know that?

A. I don't know that.

LADY HALLETT: Sorry, can I just make sure I've understood. I thought you said, just a moment or two ago, that the World Health Organisation has not even now said that aerosol transmission is the most dominant route; is that what you said?

A. Yes.

LADY HALLETT: I thought they had.

A. They haven't changed their guidance --

MR FIREMAN: My Lady, I'm not sure if they said "most dominant" or if they've just acknowledged it as a route.

Do you know the answer to that, Dr Ritchie?

A. They've acknowledged it as a route but they've not said

that it's the predominant mode of transmission.

LADY HALLETT: Thank you, I had misunderstood.

A. Apologies.

LADY HALLETT: Thank you. No, it's my fault, I misunderstood.

MR FIREMAN: I suppose this leads on to a point you make in your witness statement, which is that you say that the established modes of transmission as defined before the pandemic, ie with specific infectious particle cut-off sizes, is, in fact, not as delineated as first thought prior to the pandemic.

I suppose, first of all: what do you mean by that?

A. So I again accept that airborne spread is possible and I think what we learned through the pandemic was that, rather than these distinct cut-offs, that there was more of a spectrum of airborne spread was possible.

So having distinct cut-offs probably now is not a helpful thing to have, and I think there's been many reports of nosocomial infection, like hospital infections, where other routes of transmission can't be ruled out.

Q. That can come down, that document.

I suppose there are two questions which arise from that. The first is: if that is the case and that's the view you've come to now, when did you come to that view?

A. Could you repeat the question, sorry?

Q. I think you said that you accept that there are multiple routes of transmission, airborne was possible, there's a spectrum of different ways in which a virus can transmit, if I'm summarising what you said, I think.

A. Yeah.

Q. So I suppose what I'm asking you is when did you reach the conclusion that that was, in fact, the appropriate way to assess the risk?

A. I think when the cut-off measures of the particle sizes were not seemed or deemed to be helpful within clinical guidelines and that the awareness of airborne transmission became more apparent --

Q. Can I push you to try and identify a timeframe?

A. I don't recall.

Q. Was it during this module's relevant period of March 2020 to June 2022 or after it?

A. Probably more towards the end and after.

Q. Just to tie this area up before we break, does your understanding that things are perhaps more nuanced than was previously considered to be the case, and that in fact there's a spectrum, does that not reinforce the need to protect against a variety of different modes of transmission and perhaps be more precautionary and protect against all of them at once, rather than just be

specific and say "This is the way in which it was transmitted"?
A. Indeed.
MR FIREMAN: Thank you.
My Lady, I don't know if that's an appropriate time.
LADY HALLETT: Yes, certainly. I shall return at -- I hope you were warned that we would be taking a lunch break. Thank you, I shall return at 2 o'clock.
(1.00 pm)
(The short adjournment)
(2.00 pm)
LADY HALLETT: Mr Fireman.
MR FIREMAN: Thank you.
Dr Ritchie, I want to, before I actually begin, I just need to make one point of clarification. Prior to starting -- earlier on I referred to a document INQ000 -- well, in fact, I'm going to give you the correct reference for the document I should have referred to. I can't remember the wrong one because I don't know which one I did refer to incorrectly, but I can tell you --
LADY HALLETT: You're getting confused here, Mr Fireman.
MR FIREMAN: I got confused. The correct one is INQ000398180, and if just for formalities we could have that on the screen for a second or two and then take it

down and it will be corrected for the purposes of recording it. Thank you.
Turning then back to your evidence, Dr Ritchie, I want to deal with the issue of the role of high-consequence infectious diseases, HCID, and the classification as an HCID, and how that plays a part in infection prevention and control, if it does at all, and how it in fact did play a part during the early part of the pandemic.
So, starting point, it's right, and I think you acknowledge, in January 2020 Covid-19 was designated as an HCID, if I can use that acronym?
A. That's correct.
Q. Generally, is it right that HCIDs are divided into two categories, contact and airborne?
A. That's correct.
Q. What is the difference between a contact and an airborne HCID?
A. So the difference is how they are transmitted. So a contact HCID spreads primarily through direct contact with an infected person, their bodily fluids, tissues or contaminated materials. An airborne HCID spreads via respiratory droplets and aerosols and may also involve contact routes.
Q. So the key point there is that in the context of

an HCID, the categorisation of airborne encompasses both respiratory droplets or droplets, let's use droplets for the sake of clarity, and aerosols?
A. That's correct.
Q. Do modes of transmission, other than in the way you've just described in terms of distinguishing between whether something is an airborne or a contact HCID, have any bearing on the fact that something is designated as an HCID?
A. So the mode of transmission of an HCID classification does not differentiate between transmission modes.
Q. Put another way, then, just trying to clarify this, are the implications from an infection prevention and control perspective, in terms of the requirement to wear respiratory protective equipment and I think using negative pressure rooms, the same if you're dealing with a contact HCID and an airborne HCID?
A. That's correct.
Q. So in January and until March 2020, because of the fact that Covid was designated as an HCID, it was a requirement for all healthcare workers to wear respiratory protective equipment and also to be dealt with in negative pressure rooms; is that correct?
A. That's correct.
Q. The decision was then taken to declassify Covid as

an HCID and, following that, is it right that the stringent requirements about how to deal with the virus, because of the fact it was designated in such a way, fell away and there was no need to at that point necessarily to deal with what actually happened, but once it was not categorised as an HCID those requirements were not -- you didn't need to abide by those requirements necessarily?
A. That's right. So when something is classified or a pathogen is classified as a high-consequence infectious disease, be it contact or be it airborne, there is one PPE kit ensemble, as we refer to it, that includes a respiratory -- sorry, which includes an FFP3 respirator, RPE, so it does not matter how that HCID is classified, the PPE ensemble or kit is exactly the same for both contact and airborne.
Q. So it may well have been, and it may be that your evidence is that this is the case, that whilst Covid was designated as an airborne HCID, it was not thought necessarily that it was airborne but it may have been thought that it was spread by droplets, and as a result, because it was an HCID, it was designated as an airborne HCID and requirements to wear respirators applied?
A. Correct.
Q. On reflection, I think you recognised that this is

an area where there is quite a great deal of scope for confusion, isn't there?
A. Indeed.
Q. There are a number of terms that are used in different contexts which, from a layperson's perspective, seem very similar. I can mention some of them. Is it right that in this context, of course, airborne means both droplet and aerosol, but in other circumstances airborne is essentially synonymous with aerosol?
A. Correct.
Q. It's also right that there is a term used to describe an aerosol that's often used I think scientifically but also in clinical circles as droplet nuclei?
A. That's --
Q. That refers to an aerosol, doesn't it?
A. It does.
Q. Not a droplet?
A. No.
Q. You recognise quite clearly then that there is, without even going to the detail, immediately a challenge in understanding what's being spoken about, given the way in which these terms are referred to?
A. Yes.
Q. And is it right that NHS England has looked to undertake some work to try to assist with clarifying these things,

and do you think that it is important that definitions of these terms can be clarified in a way that it is clear, without any ambiguity, what each of them refer to?
A. Yeah. I think there's definitely scope to be clear on definitions and what they mean. It's really important that we make things clear to our frontline healthcare workers so they know exactly what to do and that we are speaking a common language which when we talk about different terms that people understand exactly what we're talking about.

The work that NHS England is looking at currently is almost going back to the history in a way of how did we end up with those three contact -- those three definitions of contact, droplet and airborne, and just bringing that information forwards and understanding the terminology. We have had a publication more recently from the WHO, who have looked at terminology and again have given some different terms to describe contact, what effectively would have been droplet and airborne, both short and long range.
Q. So is that something that you think the WHO are doing and that should then be adopted worldwide, or is it something which you think we within the UK can define ourselves and ensure that is consistent nationally?

A. I do think it is important to have some -- if the WHO have made those inroads, and I know that the work they have recently done in the publication and the terminology that they've looked at has included some professionals from the UK, so it is a global document that they have looked at and come up with terms, and I do think it's important going forward that international and national guidelines are aligned, and we did aim to do that throughout the duration of the pandemic.
Q. At the outset of the pandemic, once Covid was no longer designated as a high-consequence infectious disease (HCID), is it right that the starting point for understanding likely modes of transmission of the virus SARS-CoV-2 was what was known about SARS-CoV-1? In other words, what was known about Covid was informed by what was known about SARS; is that right?
A. That would be correct.
Q. In 2013, do you recall that you co-authored a paper alongside some other medical experts including Sir Jonathan Van-Tam, who was the Deputy CMO for part of this relevant period, and that paper was aimed at giving guidance to healthcare workers on how to protect against various different viruses?

Can I call that document up, please. It's

INQ000130561, and I want to go to page 5 in particular, please.

So this is an article -- as I said, you were one of several authors too. We can see that this is a table which has various different viruses. In the middle there is "Main route of transmission" and then further along we have "Respiratory personal protective equipment for healthcare workers" and "[FFP] required". We can see first of all, with tuberculosis, it's described as "Aerosol" under "Main route of transmission". And then we have "FFP3 required" and then it has a tick there and some language underneath that -- some text underneath that, sorry.

If we look at SARS coronavirus, that's SARS, it describes main route of transmission for SARS as "Droplet/aerosol", and in terms of "Respiratory personal protective equipment", it says "(recommended to be worn until patient is no longer considered infectious)" with a tick next to it.

Given that SARS was the starting point in terms of informing the way in which Covid was to be protected against, and SARS was described as "Droplet/aerosol", and indeed recommended that an FFP3 be required when caring for SARS, can you explain why that didn't apply when providing guidance as to how to deal with Covid,

despite the fact they were so similar?
A. So the SARS-CoV-1 which would have been the SARS outbreak in 2003 -- and I think you're correct in saying that the principle of this paper was to help guide personal protective equipment and particularly respiratory and facial protection, what it didn't do was specifically look at individual pathogens, but SARS-CoV-1 that -- in the 2003 outbreak was predominantly found to be spread by droplet contact with the potential that it could be airborne, but it was never confirmed that that was the predominant route of transmission for SARS-CoV-1.
LADY HALLETT: Sorry, I don't think that's answered Mr Fireman's question.
A. Sorry.
LADY HALLETT: Well, if SARS-1 was meant to be guiding you, why didn't it?
A. Because this paper wasn't specifically targeted towards SARS-CoV-2, so this was a paper that was written ten years ago, and SARS Coronavirus 1, I think they did guide us in terms of droplet contact with the potential to be airborne transmitted, so it did guide us in that way.
MR FIREMAN: The guidance said on its face that it -- in fact within the context of the guidance it specifically

addresses the fact that it was based on the reasonable assumption that SARS-CoV-2 would behave in a similar way to SARS-CoV-1.
You say in your -- perhaps it's easier to go to your witness statement, because at paragraph 110 there's a footnote to your witness statement which deals with this, and you say:
"The evidence that SARS-CoV-1 could transmit by aerosol was weak, circumstantial and very limited in volume ... So it was certainly possible and worth noting as a possibility due to the high consequence nature of SARS-CoV-1, but there wasn't evidence (certainly not with any certainty) to say that the airborne route was common/dominant."
So that's obviously a different explanation, isn't it, to -- if we just look at this document, which does seem to describe the main route of transmission as being at least partially aerosol?
A. Correct.
Q. But it seems that you're drawing a distinction in your statement between the two viruses, not based on routes of transmission but based on the case fatality rate, or the extent to which a higher proportion of patients die when they catch SARS, as opposed to when they catch Covid?

A. Yes.
Q. So was that what guided you? Or not you. When I'm saying "you" here, I don't mean you personally, I should be clear. Was that what you think guided the guidance, or guided those who were making the guidance, the fact that Covid wasn't going to kill as many people, proportionately, of those who were infected as SARS?
A. Sorry, could you --
Q. Was the fact that a higher proportion of people who catch SARS die part of the reason that you recommended that airborne precautions be taken against SARS than with respect to Covid?
A. So part of the declassification -- so more information was coming out with regards to how SARS-CoV-2 was being transmitted and, with that information, we were using that from NERVTAG, from SAGE, the bodies who were looking at the science, to inform or translate that science in what would be infection prevention and control guidance.
Q. Sorry, just because I think this is important, I'm trying to understand from what you're saying whether or not, in fact, you did look at SARS to inform the way in which you dealt with Covid but, in fact, you thought SARS was predominantly droplet based and that was why that influenced the way in which the guidance was

produced for Covid, but the difference with SARS is that it's deadlier, essentially?
A. Yes.
Q. Is that the distinction that was being drawn by those who were producing the guidance, do you think?
A. Yes.
Q. Thank you.
That can come down, that document.
The Inquiry has also heard criticisms, I think in Module 2, from Professor Catherine Noakes, who was, I think, on the Environmental Modelling Group, and she said, to summarise, essentially, that she considered that there may have been a belief or a consideration that we needed a higher threshold of evidence to be confident that airborne transmission was occurring, whereas, with respect to droplets and contact, it was sufficient to make assumptions based on what was reasonably known previously.
Do you think that's a fair criticism?
A. Sorry, could you --
Q. Put another way, was a higher threshold of evidence required for airborne transmission, as opposed to droplet and contact transmission?
A. So the infection -- the UK IPC cell was basing the guidance on the evidence that we were being given from

outputs from NERVTAG, SAGE and aligned to what was in WHO guidance. So the early IPC guidance was based on the available evidence on transmission routes which aligned with the WHO recommendations.

LADY HALLETT: The question was: were you looking for more evidence?

A. I don't think it was looking for more evidence. We were translating the science that we were being given. So, had our science evidence groups, such as NERVTAG and SAGE, said that that evidence was available in the literature, then we would -- or that was the mode of transmission, it was airborne, then that is what we would have put into the IPC guidance.

MR FIREMAN: Just following up on that, I thought that the reason that you looked, or the guidance looked, at what happened with SARS to inform how to protect against Covid was because there wasn't evidence of the way in which Covid specifically transmitted and so, in order to do that, you look at SARS to inform and make reasonable assumptions.

Is that right, first of all?

A. Yes.

Q. If that's right, you didn't have evidence about the mode of transmission with respect to Covid either, did you? You didn't know whether it was droplet or contact, you

just knew that it was likely it may have behaved in the way that SARS did?

A. Correct.

Q. So, given that you didn't know that, the obvious question is to say: why wasn't it presumed that we don't know about the way in which this virus transmits at all and we're going to protect against all three established modes of transmission?

A. Well, we were taking our lead from the expert science groups to translate that, as I've said before, into the infection prevention and control guidance.

Q. So was it essentially a risk assessment that you considered, based on the evidence it's likely that it's droplet based?

A. Correct.

Q. Can we go, please, to a document now, which is INQ000130506, and I think it's the third page. We can start with the first page, just to orientate ourselves. So this is a letter from Professor Stephen Powis, I believe, on 28 March 2020, and it was sent to all of these various groups. We can see here all chief executives of all NHS trusts and foundation trusts and to lots of those interested parties in the NHS, including the royal colleges, the BMA and the RCN.

If we can go to page 3, please, if we can look at

the second paragraph under "Comparison with WHO guidelines", just about four lines up from the bottom, it says this:

"Covid-19 is not airborne, it is droplet carried."

So this was on 28 March 2020, sent by the medical director of NHS England at that time. Of course, do you think that it was helpful to be this definitive about the way in which the mode of transmission was for Covid-19, this early on in the pandemic?

A. That -- if that was what was known as the science at that time and was the information being given by the CMO.

Q. I think this reflects, in fact, a tweet or is similar to a tweet that the World Health Organisation similarly put out saying more or less the same thing, but let's take it back to your perspective. You were obviously involved heavily with the IPC cell, you chaired it for some time. Did statements such as this, that were so definitive, make your job harder in terms of changing the approach as the IPC cell because to do so would mean going against statements that had been this definitive early on?

A. We were working to keep the guidance updated with the information that we were being given, so --

Q. If you could answer the question: did this make it

harder for you to go against what had previously been said and decide in fact that there was airborne transmission?

A. There is a possibility that it could have been airborne transmitted.

Q. No, no, the question is: did statements such as this influence you on the IPC cell and make it more difficult for you to say, "Actually, this is an airborne virus, notwithstanding what's been said previously"?

A. No.

Q. Thank you.

Can we go now to a different document, so this is a passage from Professor Beggs' report, INQ000474276, and this is paragraph 139.

If we can just increase the size, here we go, here is the bold section. We've looked at this before in the Inquiry but, just to orientate yourself, this is basically Professor Beggs' view, where he sets out that he considers by September 2020 there was enough moderate certainty evidence to strongly suggest that SARS-CoV-2 could be transmitted via the airborne route, and to justify precautionary measures being taken by health authorities to prevent this route of transmission in hospitals and elsewhere.

Do you think that that is right? Was it the case

that, by September 2020, you felt there was sufficient evidence, or is that unfairly early in terms of the history of events?

A. So the weight of evidence that we were being advised with, I mean, the guidance was approved by Public Health England, UKHSA and the recommendations that were in the UK IPC guidance was consistent and aligned with the World Health Organisation.

LADY HALLETT: Sorry, I think Mr Fireman's point is getting to the timing. Do you agree there was enough, what the professor called, moderate certainty evidence, I think he means moderately certain evidence that SARS-CoV-2 was aerosol transmitted by September 2020?

A. It could be aerosol transmitted if there was aerosol-generating procedures being performed.

MR FIREMAN: Right, that's a different point but thank you. So, other than outside of aerosol-generating procedures, you didn't think in September 2020 that was the case?

A. And potentially, if people were in poorly ventilated and overcrowded situations, then again that had been raised as a possibility that it could be airborne spread.

Q. Bear with me one second.

With respect to poorly ventilated areas, is it not the case that ventilation is only a relevant precaution if you are guarding against an airborne transmitted

disease? There is no point in opening the windows in terms of trying to protect against a contact disease or a droplet disease, is there?

A. Potentially, yes, skin scales, you know, things like that to get into the air potentially.

Q. So you consider that ventilation is helpful both for all modes of transmission?

A. Yeah, specific air conditioning units and specialised ventilation are necessary for airborne or preventing airborne transmission.

Q. So you agree predominantly it's an airborne measure but it's also beneficial in your view --

A. Yes.

Q. -- for other measures?

Just dealing then, first of all -- we'll come back to that -- with the timeline, because here we're talking about September 2020, are you aware that there are other organisations involved in the Inquiry, such as the BMA, the British Medical Association, who do support the view that Professor Beggs espouses about the IPC cell being too slow to acknowledge airborne transmission?

Just trying to get down to timing, I know you said earlier that you, latterly, towards the end of the relevant period, you started to acknowledge that actually there was a genuine threat of airborne

transmission and you appreciated that. From the IPC cell's perspective was there ever a point where you collectively reached the view that it was a significant threat and needed to be guarded against with, for example, routine respirators being used?

A. No.

Q. Did the level of things like nosocomial outbreaks impact your assessment of whether or not airborne transmission was a significant threat?

A. Yes, they did.

Q. Why then, when there were some instances -- I think, particularly in the first wave and sometimes in the second wave, there were instances of nosocomial outbreaks -- why did that not cause you to reconsider and think about the threat of airborne transmission?

A. So we did investigate or we enquired about the different nosocomial outbreaks of infection that had happened. What we tended to see was that, when community prevalence went up, so when there was more Covid in the community, then the hospital admissions increased.

In terms of those outbreaks, infection control is -- there seemed to be -- the FFP3 respirators became almost like the silver bullet, if I could use that term, and there are many other precautionary measures that do need to be put in place. So I think some of the publications

that came out, and there was a rapid influx of Covid-19 related scientific information, much of that was disseminated through pre-prints or press releases and it posed difficult in sustaining a well considered scientific narrative, and information was often taken out of context.

Q. Sorry, so just to try to understand what you're saying, are you saying that it wasn't possible to sort of disentangle the causes of nosocomial outbreaks --

A. Correct.

Q. -- in order to say it was caused by --

A. Correct.

Q. -- route of transmission as opposed to all of the other factors which may have been contributing?

A. Because infection prevention and control is multi-interventional, so it's multifaceted, so it means many things need to be put in place, and it's very difficult to extract one thing to say that was the thing that made a difference or caused this outbreak.

Q. I just want to explore this point about ventilation slightly further, seeing as you mentioned it before.

Can we go, please, to INQ000203993.

This is a paper from September 2020 which SAGE produced, and it says:

"Role of Ventilation in Controlling SARS-CoV-2

Transmission."

In this executive summary, just to deal with this point, it says:

"Ventilation is an important factor in mitigating against the risk of far-field ... aerosol transmission, but has no impact on other transmission routes (high confidence)."

So that's SAGE's view, that's the view of the EMG. That's inconsistent with what you've just said, isn't it, about ventilation being a good measure generally to take in infection prevention and control?

A. In the context, so this is set in the context of SARS-CoV-2. I think what I was saying earlier was other pathogens have the potential and ventilation is important.

Q. But you would accept then, would you, that with respect to SARS-CoV-2 or Covid, ventilation is only a useful precaution measure if in fact you are accepting as a prima facie standpoint that in fact there is airborne transmission outside of aerosol-generating procedures?

A. Okay.

Q. I'm asking you the question: is that not -- I'm not telling you that, it's your evidence, but what is your position on that?

(Pause)

A. So I think that what that's saying is that the aerosol transmission depends on the interaction of multiple factors.

Q. It does, yes, but the starting point is that in terms of recommending ventilation as a measure of protecting against the virus, it's only worth ventilating -- and this is something that Professor Beggs said last week, he said that people generally think ventilation is a good thing, but they don't necessarily acknowledge that it's -- the virus may be airborne. But they think ventilation is a good thing. But this paper seems to be saying that ventilation as an IPC measure is only worth taking if in fact you're protecting against an aerosol-borne disease -- or an aerosol -- against aerosol transmission.

So I'm just trying to understand why you think ventilation was good if you didn't think there was aerosol transmission as of earlier on in 2020 and into 2021?

A. Sorry, I don't think I'm disagreeing, I think I'm agreeing, saying that ventilation is an important factor to mitigate against that far-field aerosol transmission.

Q. I understand that you're saying that, but what I'm trying to understand is, if you didn't think there

was a significant risk of far-field aerosol transmission, what did you think the benefit of ventilation was? If you didn't think that the virus was airborne, why were you recommending that people --

A. But we weren't just recommending ventilation, there was multiple measures.

Q. Sure, but just focusing on ventilation.

A. If there was aerosol-generating procedures being undertaken in those areas, then it was important to have good ventilation. There are -- infection control sits within a complex framework of many other regulatory documents, including health building notes and health technical memorandum, so ventilation is an important part of healthcare buildings.

Q. So any recommendations that you made about ventilation weren't necessarily indications that you thought that there was aerosol transmission, they were just general tips as to how to deal with the virus and all viruses?

A. Yeah.

Q. Okay, thank you.

That can come down.

Can I just ask you, then, just to conclude this area of questioning, about what you say in your witness statement, which is that your view is that aerosol transmission is -- you say this at page 31:

"My view ... that aerosol transmission is significant compared to other routes is that this is not sufficiently strong to recommend that FFP3 respirators are routinely used in locations other than high-risk clinical areas where AGPs take place."

A. That's correct.

Q. Does that remain your view today?

A. Yes.

Q. What would have been sufficiently strong evidence to justify, certainly during the pandemic, routinely using FFP3 respirators for healthcare workers?

A. So that would have been the scientific evidence that would have come from the expert bodies who were providing that information during the pandemic, and from international organisations such as the World Health Organisation.

Q. So a conclusive statement that Covid-19 was airborne?

A. Yes.

Q. Would it ever be practical, ever, at all -- a slightly different point, but would it ever have been practical to advise that FFP3 respirators would be used on patients, or is that simply impractical given the need to fit test?

A. It's not recommended to put FFP3 respirators on patients because they -- they're not -- they're protective when

wearing but they can exhale, if they have a valve, actually leak the pathogen you're trying to protect against. So you would never -- the recommendation is, and as I understand it, put an FFP3 respirator on a patient.

Q. That includes a very vulnerable patient, for example?

A. Yes.

Q. We were speaking earlier about the March 2020 guidance and what informed it. The guidance itself was also adapted, I think it says on its head, from the pandemic influenza guidance; is that right?

A. That's correct.

Q. You've described in your statement that while you were at Health Protection Scotland you led a working group commissioned by the Department of Health and Social Care to review pandemic influenza control guidance; is that right?

A. That's correct.

Q. Does it follow that of course Covid-19 was a different virus to pandemic influenza or influenza generally, but the principles that were derived from that review on how to deal with a pandemic and the pandemic influenza virus also applied to the way in which you would approach Covid-19, given that that guidance then was adapted for the Covid-19 guidance?

A. Yes.

Q. You say in your statement at paragraph 89 that one of the conclusions of the review was that, during a pandemic, supplies of RPE and PPE may become scarce, making it essential to avoid unnecessary or inappropriate use.

This is a principle that it appears to apply to all pandemics; is that right?

A. Correct.

Q. You go on to say in your witness statement that the supply of PPE did not influence the IPC advice provided by the UK IPC cell?

A. That is correct.

Q. Can I try to understand the two points you're making there: are you drawing a distinction between being guided generally by a principle that it's important to avoid inappropriate and unnecessary use of PPE and RPE, with the fact that you weren't monitoring the numbers of supplies of PPE to inform the guidance that you gave?

A. Sorry, could you --

Q. You say as a general principle it's important to avoid unnecessary or inappropriate use of PPE but you then say that the supply of PPE didn't influence the advice you gave. Are you saying that you were informed by the general principle that you need to avoid inappropriate

use of PPE but you weren't informed by the actual level of supply of PPE?

A. That's correct.

Q. Can we look, please, at INQ000489907, page 31, paragraph 6.33. This is a passage from Dame Jenny Harries', who was the Deputy Chief Medical Officer, witness statement, and she is discussing the selection of aerosol-generating procedures in March 2020.

She says, four lines up:

"The list of AGPs included chest compressions."

Don't worry about that:

"There were, at that time, extremely constrained supplies of respirators, and so they were prioritised for staff performing the highest risk activities. Alongside this, there was a recommendation that FFP2s also be sourced."

Okay. So she seems to be saying here that the constrained supplies of respirators directly impacted on the designation of aerosol-generating procedures, which would suggest that supply did influence IPC advice. So she seems to be saying that she has a slightly different view to what you say the UK IPC cell's view was; is that correct?

A. So the recommendation in the guidance at that time was not to do with supply but the recommendation was to wear

a respirator if aerosol-generating procedures were being performed and, of course, they would be the highest-risk activities, in terms of airborne transmission. That was a decision that was endorsed by NERVTAG and ACDP, as stated there, and the Health and Safety Executive.

Q. But she seems to be saying here that what happened, because there were constrained supplies, it was necessary to prioritise the highest possible risk areas as being aerosol-generating procedures. The logical inference from that is that, if you had more supplies, you may not have needed to do that?

A. That --

Q. Is that right?

A. That was not the case.

Q. So you disagree with her?

A. I think it's a different context. I'm not disagreeing. I think what she's saying there, that if we had got to a point -- and I recognise that -- that supplies were limited, then they might have had to prioritise and what she, Dame Jenny is saying in that regard is that staff performing the highest risk should have those supplies made available to them. I don't recall us ever being in that position and the -- and that was not what was recommended in the IPC guidance.

Q. Thank you. Of course, we do know that the way in which

the guidance -- that can come down -- was approached was that the highest risk aerosol areas, if I can put it that way, were aerosol-generating procedures and where you were dealing with those, or in AGP hotspots, you needed to wear respirators?

A. Correct.

Q. So this, I think, reflects the understanding, does it not, that AGPs were thought at that time -- and they may well be thought by you to continue to be the case -- to generate a higher number of aerosols than activities such as breathing or talking or coughing or sneezing; is that right?

A. Correct.

Q. The Inquiry has received evidence from organisations such as the Royal College of Anaesthetists, the Faculty of Intensive Care Medicine and the Association of Anaesthetists, and I just want to take you to a passage from their witness statement that they've set out, it's INQ000389244, paragraph 291 to 292. They talk about here that frontline healthcare workers in general were at higher risk of infection, but:

"... anaesthetists and intensivists seemed relatively less affected, both in terms of infection and Covid-19 related mortality."

They then cite a study from April 2020 -- and

I appreciate that's very early on and perhaps not the most comprehensive in terms of how lengthy it is -- where they talk about 119 deaths of healthcare workers and no deaths found among anaesthetists and intensivists. Then in the reasons being explored they talk about the use of higher performing PPE.

So I suppose the question is this: if it was the case that those using higher performing PPE were dying at lower rates and were infected at lower rates, did that not indicate that, in fact, it was necessary to spread the use of higher performing RPE and PPE more widely among other areas?

A. No.

Q. Why?

A. Because the risks are not the same in different areas, the risks were clearly different in those AGP hotspot areas and intensive care units but providing routine care did not -- may not provide the same risk. But I think risk assessment is the approach that we also put within the guidance for healthcare organisations who are well versed in performing risk assessments on a day-to-day basis. Covid-19 is not the only pathogen that we deal with in our healthcare settings, we are dealing with infections all of the time, and clinicians will make risk assessments depending on the tasks that

they are performing, how ill the patients are, the severity of the pathogen, in terms of the approach that they take. So we were giving guidance in terms of what infection prevention and control measures to put in place.

Q. I understand what you're saying there but, if those working in ICU and HCU and performing aerosol-generating procedures were actually being protected to a greater extent -- in terms of infection rates, there were less infection rates among those than those who were working on wards, for example, with Covid-19 patients -- would that not indicate that maybe the protective factor of the PPE that they were using was part of the contributing factor to them being better protected?

A. I go back to the previous discussion response. Trying to extrapolate out that that was a defining factor that they were wearing an FFP3 respirator is quite difficult, it's --

Q. Thank you, that's clear, can we take that down, please. A linked issue is really the distinction that is drawn between aerosol-generating procedures and other procedures. We've heard the evidence of Professor Beggs, who doesn't think there is a huge distinction to be drawn between them, and I think the British Medical Association in their witness statement called it a false

dichotomy. So do you accept that there is or began to be, at least, some way into the pandemic, a reasonable body of scientific evidence which said, in fact, there isn't a distinction between the activities that do and don't produce aerosols in terms of aerosol-generating procedures. You accept that as a reasonable body of --

A. Yes.

Q. I suppose then, of, course, the obvious question is: would it then have been appropriate, if that was the case and you accepted that to be the case at the time, to have more widely recommended the use of respirators?

A. Sorry, I don't follow.

Q. If, in fact, you accepted there is a reasonable body of scientific evidence that says aerosols are generated in a number of different circumstances, not just aerosol-generating procedures; if that's an accepted scientific view, does it follow that respirators should be more widely used?

A. No.

Q. Why not?

A. Because I think respiratory droplets or respiratory particles that come out of your mouth, they do vary, so, you know, and we go back to that, the droplets, you know -- so there are multiple different sizes. I think what we recognise is that there is now probably

a continuum of those droplet sizes and not the demarcations that we had before. So, again, it doesn't follow that FFP3 respirators should be worn for routine activity when there are other measures that can be put and source control, so patients wearing an FRSM, the staff are wearing an FRSM, and other infection prevention and control measures are put in place. I don't -- the FFP3 wearing is not the silver bullet to prevent an infection.

Q. I understand what you're saying about other measures but, of course, you acknowledged earlier on in your evidence that using an FRSM won't protect against the inhalation of aerosols and so, if aerosols are generated in lots of other areas, using that won't protect you in the way that a respirator will, so why not use a respirator in those circumstances, if there is aerosol risk of transmission?

A. We're trying to control all of the factors, it's not just down to the PPE, so the kind of environmental factors and other, and when, you know, viral load is important as well and there's likely more viral load in a heavy droplet that comes out of someone's mouth, that will fall quite quickly, rather than fine aerosols that will remain suspended through the air, and FFP3s are not a comfortable piece of kit to wear and, in certain

circumstances, you know, we had frontline nurses telling us that they found it difficult to breathe.

So I think it's important that we look to those other hierarchy of control measures that the Health and Safety Executive are set out about, you know, how we -- processes that we put in place, the environment, the ventilation, notwithstanding that PPE is important, but it's not the silver bullet.

Q. If, however, we are going to distinguish between the procedures which do generate aerosols and those which don't, and I know what you say about respirators not being the only way of protecting against aerosols but, if we are going to say that some procedures are aerosol-generating procedures and, therefore, recommend a higher level of respiratory protection in those areas, do you agree that it's important that those procedures that are designated as AGPs are correctly so identified?

A. Yes.

Q. There are two disadvantages, aren't there, both in terms of wrongly categorising a procedure, which is, in fact, not aerosol generating and failing to designate one which is, in fact, aerosol generating?

A. Sure.

Q. Do you recall being involved separately perhaps to your role in the IPC cell, or in fact in addition to, in the

initial identification of aerosol-generating procedures for the Covid-19 guidance?

A. The initial AGP or aerosol-generating procedure list was published, as I recall, in the first UK IPC guidance document by Public Health England and that AGP list was based on the aerosol-generating procedure list that was in the national manual for Scotland.

Q. I think that's correct. I think can we have a look at -- I think that guidance was 13 March or something around then --

A. Around.

Q. -- that was issued. Can we look at an email chain, INQ000381163. This is an email chain which you're involved in, in early March 2020. If we start, you can see right at the bottom there, there's an email from Susan Hopkins of Public Health England, Dr Susan Hopkins -- Professor Hopkins I believe it is. If we go down to the next page on page 6, we can see what she said. Sorry, apologies, yes, here we go, it says here:

"The list I submitted to Keith [I think this is Keith Willett of NHS England]", is as follows, and we can see a list of them, non-invasive ventilation, et cetera.

The one I want to ask you about is there is cardiopulmonary resuscitation, CPR, included on her list

and then, if we go back to the email chain and we can see that you then provided a list above. This was a subsequent email from you later that evening, where you list out a series of procedures that were in the, I think, NIPCM in Scotland?

A. Correct.

Q. The National Infection Prevention and Control Manual. We can see here, omitted from this list is CPR; is that right?

A. That's correct.

Q. We can see then that Dr Hopkins subsequently says thank you and you use that list, and that's the list that then makes its way into the guidance, isn't it?

A. Yes.

Q. So can I just understand, do you know if this conversation where Dr Hopkins proposed one list of procedures and you then proposed another, as was reflected within the NIPCM in Scotland, was in fact the genesis of the list of aerosol-generating procedures that ended up on the guidance?

A. Yes.

Q. If we can then also go to another document, which is INQ000381182.

This is an email of 25 March 2020, and there are a number of individuals, senior clinicians and -- in

senior roles in NHS, I think in Public Health England at least.

Then if we go to page 3 of this document, we can see it says "Dear All" and there's a read-out of a meeting "this morning". Then if you just go to the bullet point that is just second from the bottom, this is 25 March 2020, here it says:

"Chest compressions also represent an aerosol generating procedure."

So what I want to clarify, first of all, with you, is that chest compressions and CPR didn't end up in the guidance, we know that, but as of 25 March 2020, and indeed of Dr Hopkins' initial list, there were senior clinicians who did think that CPR or chest compressions were procedures that should be designated as AGPs. Do you agree with that statement?

A. Yes.

Q. Ultimately, you're right, the situation was reviewed by NERVTAG, and they said essentially that whilst chest compressions could produce aerosols, that was just in the same way as breathing or coughing; is that right?

A. Correct.

Q. So they considered it wasn't appropriate to designate it as an AGP?

A. Correct.

Q. That can come down, thank you.

I just want to just tie this up with one more document, if that's okay, and go to a document of -- INQ000189351.

This is a review that was done by Health Protection Scotland of the comparison between different countries and different guidance providers and the way in which they approached things.

If we look at page 13, please.

This is the guidance that was given by the European Centre for Disease Prevention and Control. I think it says last accessed there, 4 May 2020.

Under guidance on AGPs, at the bottom, they do include cardiopulmonary resuscitation in an AGP in their guidance.

So I just want to understand, this is an area that caused quite a lot of controversy, wasn't it?

A. Yes.

Q. Given that there were a number of clinicians and indeed the European guidance classifying CPR as an AGP, was it perhaps not precautionary enough to have not included CPR as an AGP within the UK guidance?

A. So that was a decision made by NERVTAG, as you correctly say, and Public Health England, as I recall, then published the outcome of the NERVTAG review with

a caveat that the interpretation and the application of that AGP list was ultimately to be determined at a local level where specific risks and exposures were better understood.

So I think the first time we ever had an agreed -- well, not an agreed, but we had an aerosol-generating procedure -- or a list of aerosol-generating procedures was that that was published in 2016 in the Scottish infection control manual, and they teased out those parts of the procedure that could be aerosol generating, so I suppose they dissected CPR whereas the WHO and others just put cardiopulmonary resuscitation down as one procedure.

Q. And that would include chest compressions, would it?

A. Yes.

Q. Okay, that can come down.

Just to summarise, this issue, as I said, caused some controversy. There was a statement put out by, I believe, the Resuscitation Council, and they essentially said that their guidance, contrary to national guidance, was that you should wear a respirator and respiratory protective equipment when doing chest compressions and CPR in its entirety.

Can you recognise that the conflicting guidance between the bodies and the national guidance was an area

that was unhelpful and perhaps damaged trust in guidance from healthcare workers?

A. Yes. But, as I say, I think Public Health England, as I recall, then put out a published -- you know, a statement on the back of it then giving local determination, and I do recall that UK Resuscitation Council did reply saying that that was a helpful thing for Public Health England to have done.

Q. Can I ask you about the way in which the cell approached evidence generally, and emerging evidence about Covid-19 being transmitted through various different means -- modes, sorry.

What was the role of the ARHAI rapid review process that you relied on, at least partially, during the IPC cell discussions?

A. So Scotland had a National Infection Prevention and Control Manual, and that manual was underpinned by evidence, reviews on standard infection control precautions and the basics of transmission-based precautions, so they had a well established scientific evidence base for the manual in Scotland. So that provided a really good foundation for what was then the pandemic flu guidance for 2019 and was the document that we adopted.

Because Scotland had that infrastructure, it was

helpful to the cell because we did not have that structure in England. Initially when I first came into post in April 2020 that structure wasn't in place, and Wales were using -- they had adopted Scotland's manual, and Northern Ireland had something slightly different. So Scotland were in a good position to support us with some rapid reviews.

It wasn't the only place that we were taking evidence from. So, as I say, they had the mechanism and the structure in place to do that. We were also looking at the outputs, as I say, coming from SAGE, NERVTAG and the other scientific groups and using that to support and translate that evidence into infection prevention and control practice, and always making sure that we were aligned with WHO guidelines.

Q. So did relying on this rapid review process reflect a process that you would use both pre-pandemic and during the pandemic of it being one of a number of different ways in which you were assessing evidence?

A. Correct.

Q. Do you recall a specific meeting of the UK IPC cell which took place on 22 December 2020, and a discussion at that meeting about potentially extending the use of FFP3 masks that wasn't ultimately proceeded with? I think that's right, isn't it?

Can we just as a starting point in fact go to INQ000398244. I want to actually go to page 3 of this, if that's okay.

If we can look at some of the discussions that were had at this meeting -- as I said, this was a meeting where you were discussing the potential to extend FFP3s, and you start the conversation on this page and you're saying:

"If patient and staff face mask wearing and other IPC measures e.g. decontamination of environment/equipment are not being reliably implemented as they should be, it does not seem appropriate, in the absence of evidence regarding any change in mode of transmission, that a change to PPE should be recommended ..."

So that goes back, I think, to something that you're saying today about how it's difficult to disentangle the causes of increased transmission --

A. Correct.

Q. -- and that you need specific evidence that, in fact, the reason for that cause is the increased aerosol transmission before recommending FFP3s be more widely used?

A. Or a change in the mode of transmission.

Q. Then a fourth line down it says -- or fourth comment

down, it says:

"If we increase the use of FFP3 masks we need to consider stock availability ..."

We touched on supply earlier but is this a comment more about examining, if we do extend the use of FFP3s, we need to just make sure that that's not going to have an impact on putting trusts under additional pressure, rather than saying we don't have the stocks?

A. Yeah, so that wouldn't have been a decision that we had -- would have made but, if we had come to a consensus agreement that there had been a change in the mode of transmission and we were going to move to FFP3 masks, then that's something that we would have required to escalate across all the UK nations to senior clinical leaders, if that was the position to say that we think there's a change here this is going to impact on use.

Q. Thank you. Then two comments down, CB there, I think that's Colin Brown of Public Health England, he says:

"Our understanding of aerosol transmission has changed. A precautionary approach to move to FFP3 masks whilst we are awaiting evidence should be advised."

So this is, it seems, one of the first points, I think, in the IPC cell meetings where someone is saying in fact we need to take a precautionary approach

and extend the use of FFP3s. Can you explain, were you able to reach any sort of agreement on this during this meeting, can you recall?

A. I do recall that we did come to a consensus or an agreement, after which we pulled together a position statement setting out what our recommendations were, and that --

Q. I apologise, I think there's two meetings, there is the 22nd and there is the 23rd.

A. Yes.

Q. If we carry on to the next page we might be able to see what happens in this particular meeting. You say here that there's then a comment about fit testing by LI, I think that's Laura Imrie, and then I think you say:

"We appear to have consensus."

You've listed what you have a consensus on. But you don't appear to say you have a consensus, or at least it's not within the bullet points on the question of whether you need to change the level of PPE/RPE?

A. That's correct.

Q. So was this the point, a point at which the UK IPC cell wasn't able to specifically agree how to proceed with this issue, and I think you then met again the next day; is that right?

A. So there was a consensus, and based on the information

and the discussion that we had, as I recall, was that the new variant that we were discussing and whether that was going to have an impact on control measures was or seemed, to be more transmissible, but what hadn't changed was the mode of transmission. So what that meant for the cell, in a way, was to be clear that all those other precautionary measures were being put in place to make sure that infection wasn't being transmitted. So again not just down to the FFP3 respirator, but were organisations checking that those precautionary measures that they had in place were reliably being applied and monitored actually have been followed.

Q. What you didn't agree with then, at this stage, if I can summarise, is that a precautionary approach to move to FFP3 masks, whilst awaiting further evidence, should be advised; you didn't agree that that was the way to go at this stage, did you?

A. That was a consensus across the UK IPC cell and that was what we put into a position statement that we then took or it was discussed. I then discussed it with my CNO, and that paper was discussed at the UK senior leads meeting. So it would have been them that would have made a final decision on whether any change should have been made.

"LR confirmed today's meeting will be a further discussion to reach consensus regarding the IPC/PPE guidance following the meeting yesterday to discuss [the] new variant", because you were discussing it in light of the new variant and the potential transmissibility of that variant, I believe; is that right?

A. Yeah, that's correct.

Q. You then summarise that you think the consensus from yesterday was that you don't need to change the recommendations. Again, I suppose this goes back to what you were saying earlier about the way in which you got that assessment of there being a consensus, that was your assessment of the way in which the discussions had gone; is that right?

A. That's correct.

Q. We then see, I think, just further discussion of this issue to try and reach a formal view from the IPC cell; is that right?

A. That's correct, and I think what that minute draws out is that every nation and the leads, the representative leads from those nations all were given the opportunity to put their position forward. So everybody got the opportunity to put their discussion in and we came to a general agreement at the end of that.

Q. But, of course, you say consensus but that's consensus not including Public Health England who had proposed a precautionary approach of extending FFP3 masks; is that right?

A. General agreement but, of course, there was the checks and balance in place that, when it went it the UK senior clinical leads to discuss, they could have decided that that was not the right approach and that we should take a precautionary approach, in which case we would have changed the IPC guidance to reflect that.

Q. Well, when you say "clinical leads", do you mean after this discussion, this was escalated to any particular individual?

A. Yeah. So there was a UK senior clinical leads group, which was CMOs and CNOs, and other national clinical directors from across the UK and UKHSA Public Health England were a member of that group.

Q. Then I think do you remember if this happened, the escalation, after this meeting or after the next meeting? Because I want to go to the next meeting that happened the next day, and that's INQ000398242. Here's page 2 of this.

So we've just seen what you were summarising before. You said that you considered there was a consensus. You start this meeting saying, this is three lines down:

Q. So if we look at the bottom of the page there, it says Northern Ireland were invited to present their position, and it says:

"In the absence of robust evidence to support the move, CM felt that colleagues might think that they have not been appropriately protected with what has been previously recommended."

Two points there: again, does this not come back to the issue of requiring robust evidence to justify a change in a way that perhaps wasn't the case earlier on in the pandemic for other modes of transmission?

A. I can't speculate as to --

Q. What was meant by --

What about the fact that colleagues might have thought that they might not be protected with what had previously been recommended. Do you think that influenced the way -- was the fear that colleagues might have thought they weren't protected influential in terms of any decision-making you made.

A. Absolutely not, and I come back to there was checks and balances in place and that if our UK senior clinical leaders had thought or Public Health England, UKHSA had thought that the guidance that was drafted out in the document was incorrect, then I'm sure that they would have made us aware of that.

Q. If we can just continue through some of these comments, we can see there's more discussion, PHE are invited to present their position and they then continue to say they're recommending FFP3s in all medium/high-risk pathways, irrespective of AGP. So they're continuing to make that statement.

To summarise, in essence, the cell doesn't agree with that decision and the consensus you then take is that everyone else, I think, except, predominantly PHE, considers that that shouldn't be the case; is that right?

A. So there was general agreement, there was a paper produced, which was discussed at the UK IPC senior leads group, and the decision was made there.

Q. The way in which this was resolved though was that the IPC cell didn't endorse the PHE position, did it?

A. I don't think it was about endorsement. We had a discussion, and the consensus agreement; the broad agreement was that we didn't need to -- the mode of transmission had not changed and, therefore, we weren't going to recommend the use of FFP3 respirators more broadly than what was already stated in the guidance. But what we did do was strengthen some of the information round about risk assessments and pointing to the other precautionary measures to make sure that they

were being robustly implemented.

Q. Ultimately, did Public Health England, despite their position in this cell meeting, where they are there pushing for just to put it in colloquial terms a move for FFP3 masks to be used more widely did they ultimately still publish the guidance that was proposed as a result of the consensus?

A. That's correct.

Q. So they didn't decide to take a different view and perhaps overrule the IPC cell but your view is they could have done if they had wanted to?

A. Correct.

Q. You mentioned just before the role of risk assessments and you spoke about that and you say that they had an important role in terms of properly applying infection prevention and control measures within healthcare settings.

I want to just quickly look at the guidance that directly refers to risk assessments.

This is INQ000271659 and the fifth page.

At the bottom there it says -- this is June 2021, to be absolutely clear -- it says:

"To ensure maximum workplace risk mitigation, organisations should undertake local risk assessments based on the measures as prioritised in the hierarchy of

controls. If an unacceptable risk of transmission remains following this risk assessment", et cetera, et cetera for now.

Can we just deal with hierarchy of controls. You've mentioned it before. What is the importance of the hierarchy of controls?

A. I think the key thing with the hierarchy of controls is that we try -- or the aim is to maximally mitigate risk for as many people as possible without it getting down to an individual level where it comes down to personal protective equipment. So it's dealing with the engineering controls, process --

Q. It may help -- you've put a diagram in your witness statement, if I put it up it might help you.

A. Thank you.

Q. It's at paragraph 60 of your witness statement. You can then talk us through, I think, how that assists. Yes, there we go.

A. Yeah. So the whole point is system wide to try to "eliminate or reduce exposure to risks", as stated there. Elimination with a respiratory virus, not always possible, but measures were put in place, for example telemedicine, which could be, you know, administrative controls as well, so that people weren't actually coming into healthcare environments, and engineering controls

we've talked about such as ventilation.

So by putting different things in place and different administrative controls, the way that people work, and trying to maximally mitigate the risk for all healthcare workers and patients in that environment is far more conducive to health and safety and the wellbeing of everyone than you having to use PPE. But I do recognise that -- what we said about residual risk, individual risk assessments are important --

Q. Utilising this framework?

A. Use -- yeah.

Q. Of course I think you do also recognise that some of these steps, elimination perhaps even substitution --

A. Yeah.

Q. -- is simply not possibly, especially if you are providing close quarters care as a healthcare worker. In those circumstances it is going to be necessary to use protective equipment, isn't it, personal protective --

A. Yes.

Q. If we go back to the guidance that we were looking at before, it's a similar point that we touched on earlier but I just want to understand it in this context, one of the things that was suggested, again in doing a risk assessment, it says:

"If an unacceptable risk of transmission remains following the risk assessment, it may be necessary to consider the extended use of RPE for patient care in specific situations. The risk assessment should include an evaluation of the ventilation in the area ..."

We spoke earlier about ventilation being a measure that was relevant to airborne transmission but certainly in at least a paper from SAGE they considered it was only that mode of transmission that it was relevant for, so was this guidance an acknowledgement of the growing risk of airborne transmission, because it's directly pointing to ventilation as a measure that might need to be taken?

A. So local -- sorry, do you mean in terms of the hierarchy of controls?

Q. In terms of directing a risk assessment that looks at ventilation, was that because there was, by this stage, in June 2021, an acceptance that there was an increased risk of the virus existing in the air?

A. I would say not specifically. I think the hierarchy of controls and risk assessments are something that should be inherent in healthcare organisations. No healthcare facility is free of risk and therefore risk assessment and local risk assessments are vital to adapt infection prevention and control measures to specific environments

and specific healthcare settings, so you're looking to identify what are the unique infection risks in this area and then ensure compliance with the recommendations and guidance and that those are being reliably applied.

Q. In terms of directing the need for risk assessments, was this something that was directed at organisations, employers or individual healthcare workers?

A. At different levels -- I mean, for employers, the Health and Social Care Act for healthcare premises includes within that risk assessments. I mean, our clinicians do risk assessments probably every day when they are seeing their patients and managing their patients. I think risk assessment of the environment will include many people. It's an employer's responsibility to ensure health and safety in the workplace. So the risk assessments would be carried out by a multidisciplinary team of individuals including ventilation engineers and ensuring that that approach was taken.

Q. The Inquiry's heard some evidence and has received some evidence that there are challenges in terms of actually conducting risk assessments and that sometimes guidance that requires an additional step to be taken in terms of then doing a risk assessment can be difficult for healthcare workers to actually implement. Do you accept that directing an organisation to do a risk assessment

is essentially making them make the decision about the level of risk rather than guiding them as to how to protect against the virus?

A. I don't think it's directing them to do it on their own. I think there is guidance there to do it. Risk assessment is something that is, you know, ingrained within healthcare systems, it's set out in the Health and Social Care Act for infection prevention -- the code for infection prevention control risk assessment is fundamental within all of that and in the day-to-day business and work of organisations.

What we did do, recognising that it seemed to be a challenge, was we developed tools for various different settings, be it acute care settings, GP practices, dental practices, to support organisations or employers to undertake a risk assessment in accordance with the hierarchy of controls.

We also had teams within or personnel, colleagues within the national IPC team who were part of a support mechanism who would go out and help organisations where they were struggling or where they had outbreaks of infection to help them undertake some of the risk assessment and put mitigating measures in place.

Q. Thank you. Just in terms of these risk assessments, they appear to be -- this is a general recommendation

and one of the things the Inquiry has heard about is the disproportionate infection rates among some healthcare workers, including those from ethnic minorities. This wasn't a particular risk assessment that was specific to them or those particular workers or any particular workers, was it; it was a general risk assessment?

A. A general risk assessment.

Q. The IPC cell didn't, did it, delve into providing specific advice about how to account for specific inequalities or anything like that, that wasn't the remit of the IPC cell, was it?

A. No, but we did, with the guidance, what we did do was a complete Equality Diversity Impact Assessment, an EHIA -- they call it Health Impact Assessment -- for the guidance initially and then we would review that when we were updating the guidance documents.

MR FIREMAN: Thank you, I think that might be an appropriate time.

LADY HALLETT: Certainly, I shall return at 3.30.

(3.15 pm)

(A short break)

(3.30 pm)

LADY HALLETT: Mr Fireman.

MR FIREMAN: Thank you.

Dr Ritchie, can I just clarify something on the

basis of evidence you gave earlier on. You said in your evidence, when you were talking about the need to control environmental factors as well as others, and you talked about viral load is also important, and you said that it's likely more viral load is in a heavy droplet that comes out of someone's mouth that will fall quite quickly rather than fine aerosols that remain suspended in the air. Can I clarify, that's your view, is it, that it's more likely that there will be more viral load in a heavy droplet than there will be in an aerosol?

A. Correct.

Q. Are you aware that Professor Beggs told the Inquiry that he considers the majority of exhaled viruses are in fact found in fine aerosols?

A. I respect that opinion and I am not an aerobiologist or scientist.

Q. It's an area where you disagree, though, is it?

A. Yes.

Q. On what basis did you come to the view that a heavy droplet contained a higher level of infectious particles than an aerosol, given you're not a physical scientist expert?

A. My understanding would be that in a larger droplet and in a heavy droplet there is likely to be more viral particles, whereas in a finer droplet it's going to dry

out quite quickly, so the viability of that causing any kind of infection subsequently is less so. But I think going back to the other environmental factors, those droplets and aerosols that, you know, do finally settle on surfaces, it's important that cleaning of equipment and the environment is just as important as other measures.

Q. If you are wrong about your assessment of which particles contain a greater amount of viral load in them, and in fact it's the case that aerosols contain the highest number of viral load, or the highest level of viral load, would that influence the guidance that you would give in terms of use of respirators, if in fact they are in aerosols to a higher -- infectious particles are in aerosols to a higher degree, would that influence the guidance as to when to use FFP respirators?

A. I'm understanding then -- it's almost confusing two separate things. So the guidance currently for droplet protection is FRSMs.

Q. Yes, if in fact -- this is probably my fault, I didn't phrase that brilliantly, but if in fact it's the case that there is a higher viral load in aerosols than in droplets, would you recommend that FFP3 respirators be used more widely, if you're wrong about your belief?

A. I'm not sure that I can answer that.

Q. Okay.

Can I ask you about the changes to guidance, healthcare guidance, and the language that was used within healthcare guidance, and just taking an example, but it's cited within Professor Hopkins' statement, if we can go to that.

It's INQ000410867, and it's paragraph 353.

So here she's describing a change that was made to the IPC guidance where it said:

"... where a risk assessment indicates it, RPE should be available to all relevant staff. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area. Staff should be provided with training on correct [route]."

Then it goes on to describe other additional edits that were made, including:

"... removing the word 'wholly' in relation to transmission and use of RPE as follows ..."

And if we look at the next paragraph, please, if we could find that -- yes. If we could just -- the top bit, "A respirator". It says:

"'A respirator with an assigned protection factor

(APF) 20, that is, an FFP3 respirator (or equivalent), must be worn by staff when: caring for patients with a suspected or confirmed infection spread ..."

And then what was "wholly" removed:

"... by the airborne route ..."

So it previously says, does it not, that you should use a respirator where you're caring for a patient with a suspended infection that is from a virus spread wholly by the airborne route; is that right?

A. Yes.

Q. So with respect to Covid-19, it wasn't the case at any point, I don't think, that it was said that it was wholly spread by the airborne route, and so it wouldn't be the case, interpreting this guidance, that you're supposed to use a respirator?

A. Correct.

Q. But by removing the word "wholly", Professor Hopkins explains that this caused confusion because then it just said "spread by the airborne route" and it could be interpreted that Covid was spread by the airborne route and so you should use a respirator when caring for Covid-19 patients; is that right?

A. That's correct.

Q. Simple question: was it confusing to use language such as "wholly" and then to remove it entirely?

A. I accept that it probably was confusing. Again, that was wording, "wholly", being a predominant mode that we had used in earlier guidance. We had feedback from frontline staff, other stakeholders saying that that word wasn't helpful, so in response to that we removed it, and then that caused more confusion.

So, yes, I accept that terminology/language, is something -- having a standardised and consistent language base will be important going forward, absolutely.

Q. I think in fact what happened was the word "predominantly" was in fact added in to replace the fact that there was no word, but "predominantly" -- I mean, how did you expect a healthcare worker to know whether or not Covid-19 was spread predominantly by the airborne route? Is it for them -- if the guidance doesn't expressly say that it is, how are they to know whether or not it is?

A. Well, I don't think the guide -- the guidance didn't express that it was predominantly spread by the airborne route, so it did cover other contact measures, so the guidance wasn't just about the airborne route, the guidance covered contact, droplet and airborne. So invariably those transmission routes do not happen in isolation. And we talked earlier just about the

environmental impact, that if you've got droplet spread or airborne spread you invariably will have contact spread as well, if you don't keep the environment clean. So it's a very complex number of procedures, so the standard infection control procedures and the transmission-based precautions.

Q. What happens is that there's the -- the chain of events, as I understand it, is it goes from -- in fact it might help if we look at INQ000502072, which is a document that's been produced by the Inquiry's trio of experts, Shin, Gould, Warne, who summarise changes to the guidance.

If we just look at what happens afterwards, if we go down and look at 15 March 2020, it says that what happened was it was then changed to saying "predominantly by the airborne route".

So if I can just summarise this, what happened is it started off from January 2020 saying "wholly spread by the airborne route", it then changed to be removed and there was no word at all there, it just said "spread by the airborne route", and it then said "predominantly spread by the airborne route". Is that right in terms of the chronology?

A. So just to clarify, so the highlighted 15 March document is a UKHSA guidance document. I don't think that's the

UK IPC guidance.

Q. Okay. Can you then -- just generally speaking, talking about the fact that in guidance and healthcare-wide guidance generally, the phrases such as "wholly spread by the airborne route", "predominantly spread by the airborne route" and no phrases at all about how it was spread were used -- understand how that of course caused issues in terms of interpretation with respect to Covid-19?

A. Sure.

Q. Do you have any thoughts about how to avoid that sort of thing in the future?

A. I think that it's agreeing the terminology and the definitions and being as clear and give clarity as much as we possibly can going forward in guidance documents. As I said, earlier, WHO have made a start on that by their published document on airborne transmission risk where they describe new terminology. I don't believe that that has been signed up to by the UK as yet, but I do think it's important that the national and international guidance is aligned with the language that we use, because it's important that, you know, healthcare workers understand what they need to do to keep themselves and their patients safe.

Q. Would one way through this be to have clarity in terms

of the guidance making clear exactly how it is considered that a virus is spread so that when interpreting whether or not something is or isn't spread by the airborne route we know what the guidance says about how the virus is spread?

A. Yes.

MR FIREMAN: Thank you.

Those are all my questions, my Lady.

Questions from THE CHAIR

LADY HALLETT: Just before we turn to the core participants.

Going back to the routes of transmission, Dr Ritchie, you've been asked a little about this, but where there is uncertainty, would you agree that the precautionary principle should be applied?

A. I do agree that the precautionary principle should be applied. That is a number of measures, in its broadest term, so again I don't think it's just one thing. So the silver bullet of the FFP3 is the answer and the precautionary measure to SARS-CoV-2, I think there are multiple other interventions from an infection prevention and control perspective that need to be put in place, because none of these transmission routes function in isolation or act in isolation.

LADY HALLETT: I understand that. It's just that, if you have uncertainty and there's a possibility and you don't

know yet that the pathogen could be airborne, aerosol -- sorry, aerosol -- we say aerosol because of the confusing nature of the HCID classification.

So you have a possibility it could be aerosol. Amongst the package of measures, if you're going to exercise a precautionary principle, wouldn't it be best to advise the highest level of face mask protection that is reasonable, in other words the FFP3? Wouldn't it be best to advise the highest reasonable measure of face mask?

A. But not every situation is the same, so in those higher risk areas then where people are exposed to aerosol or aerosols, so you need aerosol precautions, then absolutely, but in other given routine care, when the predominant mode was understood to be droplet and it could be aerosol, if aerosol-generating procedures were performed, then FFP3 respirators might not be required.

And I think this goes back to risk assessment, it's putting in place things that are risk based and proportionate to keep healthcare workers safe and patients safe, but FFP3 respirators are not comfortable to wear, and if you -- in setting that position with FFP3 respirators, it's then saying, well, when do you step down from that? And we're now living with Covid-19 as well.

So I think there are many, there are multiple factors that need to be considered rather than just moving to that position, in the absence of that evidence that it is airborne to put everyone in an FFP3 respirator, or all our healthcare workers.

LADY HALLETT: But the premise of my question was there is uncertainty, so the uncertainty means we don't yet know the source of transmission, and what I don't really understand is that the IPC cell seems to have become wedded to the idea that it was droplet and hadn't really thought about whether they should be exercising the precautionary principle on the basis it might be aerosol.

A. But I don't -- the IPC cell, with respect, I don't think was wedded to the idea. So initially when it was high consequence it was declassified, so we were using known established frameworks. If we had been advised by the scientific advisers from SAGE, from NERVTAG, that there was a potential of airborne and that actually we needed to move, then we would have moved to that position. So our responsibility and our role and function in the IPC cell was to translate the scientific evidence and advice, the outputs from all of those scientific groups into practical IPC guidelines. If our senior clinical leaders had not agreed with that position and said

"Actually, there's science there or there's evidence there or we are telling you as experts, IPC cell, that you are wrong", we would have moved to a different position.

LADY HALLETT: In December 2020 when you had that meeting to which Mr Fireman took you, you had advice from the Public Health England representatives on the cell that the -- I'm going to call them "F3 respirators" should be used, and that advice was not accepted, the consensus that the cell reached was not to go with that recommendation. I mean, Public Health England has some highly qualified scientists who work for it, doesn't it, or it did have some highly qualified scientists; on what basis did the cell not accept that advice from Public Health England?

A. So we had a discussion across all four nations. If Public Health England had felt strongly that we, again, were wrong with the broad consensus that we had come out with, and that the position statement that we put together with recommendations of not to move to FFP3 respirators for all, they could, as the lead organisation for infectious diseases in England, have trumped our decision and said "We're moving", and that consensus statement and position statement that the cell put to the UK senior leads group has Public Health

England, UKHSA representation on that group.

That document went there, it was discussed and it was approved. Had they not approved it and come back and said "Actually you guys are wrong", we would have changed our guidance. So we weren't there building the science, we were taking the outputs and the science and translating that into what would be, as much as possible, and I accept the terminology, but into practical guidance for frontline healthcare workers to put into action.

LADY HALLETT: On that point, can I go back to something again Mr Fireman asked you about, which is membership of the cell. Given you were trying to interpret what was at times quite complex science and some top notch experts on SAGE, and the like, and NERVTAG advising you, do you think now, looking back, that it would have been better if you had had different experts on the cell?

A. Potentially now, in hindsight, there is always room for improvement and I think that goes back to what I initially said about, had I come in and there had been a structure, it would have been helpful to know where everyone was placed in their roles and functions.

I think, given the role that we were performing at that time, we were senior infection prevention and control clinicians and our role was to translate that

evidence into IPC practical guidance. I think we were qualified to do that, and we had our senior clinicians who would have advised us, had that not been right, to change that guidance. But, yes, in future, I think it would be really helpful to have more of a structured: what should the membership look like, where does the evidence come from. So yeah, lesson learned, thank you.

LADY HALLETT: Thank you.

Finally from me, as you may know, there's one issue that's particularly concerning to a number of families, bereaved, pregnant women, and the like, about visiting restrictions to hospitals. They obviously caused really serious concern and, given that visiting restrictions were imposed in the name of infection prevention and control, did the cell get involved with visiting restrictions?

A. No.

LADY HALLETT: Not at all?

A. We would have been asked -- and I wasn't personally asked, but colleagues in the national IPC team would have been asked to comment possibly on those visiting guideline restriction document, but it wasn't a document that came from the IPC cell.

LADY HALLETT: Is there a reason for that, given, as I say, they were imposed in the name of infection control?

A. Many things are imposed in the name of IPC and, you know, it's trying to balance protecting healthcare workers and staff from infection and being proportional, in that respect. Not always an easy balance to make and, hence, the risk assessments are so important in situations like that because local organisations have unique situations and can make decisions based on, you know, what they see and what they think will be right for their organisation.

LADY HALLETT: Particular patients may have particular needs, like a disabled patient --

A. Sure, absolutely.

LADY HALLETT: -- and they need a support --

A. Agreed.

LADY HALLETT: -- person.

Right, Ms Morris, I think you have a couple of questions for the Royal College of Nursing?

Questions from MS MORRIS KC

MS MORRIS: Thank you, my Lady.

Good afternoon, Doctor.

Could we have up, please, document INQ000271659 and, within that document, page 36. This document represents IPC recommendations produced by Public Health England. We don't need to look at it but the preceding page makes it clear that this table relates to healthcare settings.

You can see a chart on this page, which is headed "[PPE] suspected/confirmed Covid-19 patient/individual". Then in the top left-hand corner, you can see:

"PPE required by type of transmission/exposure."

Then if you look in the bottom row, bottom left, there is a reference to airborne PPE, and then there's a sentence at the end:

"If an unacceptable risk of transmission remains following rigorous application of the hierarchy of control."

The RCN is concerned that it wasn't appropriate to apply the hierarchy of control in this type of healthcare setting, given the importance of having to provide care which meets individual patient need. In the light of that, our question is whether use of this language, of the hierarchy of control, created a risk that decisions about granting access to PPE would be made wrongly and, in particular, would allow the rationing of PPE?

A. So that would not have been the intent of guidance. The hierarchy of controls and risk assessment, as I said earlier, is something that organisations would be performing and, as part of the infrastructure of infection prevention and control, and by saying, you know, an unacceptable risk remains, goes back to that

individual organisation identifying unique risks for their staff in that situation and making a decision based on that risk assessment, and an individual risk assessment as well, if there were particular healthcare workers who felt that they were going to be at risk, then having those appropriate occupational health assessments.

Q. But do you accept that sticking with, say, trust level risk assessment, that language left it open to a trust to say, I don't know, "We've got all the windows open, we've taken all these other steps, therefore we're not going to provide you with PPE"?

A. I don't think I can answer that question. I mean, I think organisations are, they should -- you know, doing risk assessments all of the time, and the hierarchy of controls is something that the Health and Safety Executive -- you know, the Health and Safety at Work Act, it's not a new document. So, yeah, I don't -- you know, trusts were able to make those individual risk assessments and I would like to think that they made them appropriately and did not withhold PPE from individuals who were risk assessed to need to higher level of PPE.

Q. So turning to my second question, we heard from the Scottish TUC this morning the view that nurses should

have been able to make their own decisions as to whether and what PPE was required by them in a particular setting, and that PPE should have been provided to them on that basis. Do you agree or disagree with that proposition?

A. I think it's challenging when selecting items of PPE on an individual basis is down to personal preference, because I think healthcare workers need to understand the reasons for wearing that PPE and knowing when to wear it, for how long, all of those reasons. So I think those clinicians should be involved in the discussions around risk assessments and, you know, that an organisation or a department come to an agreement about what their risk assessment is and what the level of PPE is going to be, but not down at an individual personal level, because that could land us in places where I choose not to wear it, and put myself at risk, and then someone else chooses to wear it.

So I think the personal preference route is quite difficult and it's not easy to navigate, but I do agree that within certain -- within settings or units then clinicians should be involved in the discussions with regards to what PPE and understand the risks that are in that area.

MS MORRIS: Thank you very much.

LADY HALLETT: Thank you, Ms Morris.

Mr Weatherby.

Questions from MR WEATHERBY KC

MR WEATHERBY: Thank you.

Dr Ritchie, I've got a very short number of questions. I'm asking on behalf of Covid Bereaved Families for Justice UK, which includes families bereaved from nosocomial infection and also healthcare workers.

You've touched twice, I think, on my first point, which is that when you arrived at NHS England in April 2020, you found that there was no national IPC manual and there was no national England IPC team; is that right?

A. That's correct.

Q. Obviously it wasn't your fault that there was neither of those, but did you learn, in the course of the handover or the arrival, why that -- or those gaps had been?

A. I'm not aware what the rationale for that was.

Q. Yes. But obviously you had come from Scotland where you had had a similar role in relation to the manual, and you had a national manual there. Did you not ask your colleagues as to why the structures simply weren't there?

A. I was working in a different NHS organisation in

a different country. That said, the national infection control manual for Scotland was something that was added as an ambition into the 2019 five-year UK antimicrobial resistance national action plan that England would adopt the manual, and we have indeed done so.

Q. That's helpful. It isn't in fact an answer to the question. But would you agree with the summary of the experts that I anticipate will give this on Thursday, the IPC experts, that because there was no national manual, that the IPC guidance in England pre-pandemic was in fact fragmented, it came -- the IPC guidance that people were following or looked to follow came from professional societies with an expertise in infection or professional bodies or PHE, there was a fragmented picture?

A. I can't comment on that, I wasn't working in NHS England at the time.

Q. Okay, but you arrived in April, what did you find? You didn't find a national manual, so the guidance that was there you would be sighted on, you would look at, it was fragmented; is that right?

A. So at the time that I arrived we were working on UK guidance for SARS-CoV-2, Covid-19, so I suppose I wasn't looking at the wider IPC guidance for other specific pathogens that was available, and I -- to currently

and -- then and now, Public Health England are the advisory body on specific pathogen guidance.

Q. Okay. But the work of the cell and your subsequent work on Covid from when you arrived sat on top of the existing IPC guidance that was available, didn't it? It was complementary to the general IPC guidance --

A. Yes.

Q. -- that was there.

Are you able to say what impact the lack of a national manual, what I've referred to, a fragmentation of IPC guidance, what effect that had on your work in terms of Covid?

A. I think that's why we used the foundation of the Scottish manual in terms of standard infection control precautions and the basics round transmission-based precautions and used that as a foundation to base the SARS-CoV-2 Covid-19 guidance on going forward, and then as we developed that guidance, as that guidance evolved throughout the pandemic, we were taking the appropriate scientific advice.

Q. So Scotland had effectively had the lead on it, so, in the absence of joined-up national guidance in England, you looked to the work that you had done in Scotland; is that a fair summary?

A. To give us an initial foundation.

Q. Now, very quickly the second area, would you agree that traditional views about IPC were firmly ingrained and hard to change?

A. I disagree. I think there was established modes of transmission that were set out/defined in international and national guide -- pre-pandemic guidance across many countries, the WHO. I don't think we were wedded to that. Had the science and our expert colleagues, science colleagues, told us that there was a change then we would have followed.

Q. All right, I've lifted that as a quote from the expert report, so we can go back and ask them when they give their evidence on Thursday.

When Professor Noakes, who was referred to earlier, a bioengineering professor, has given evidence, both in Module 2 and in her witness statement, she referred to a simplistic distinction in healthcare between droplet and airborne, aerosol, respiratory virus transmission, and gave the view that it was persistent because it had been taught for years and ran through IPC guidance.

Would you agree with that, that there was this hardwired view which just kept being taught and that's one of the reasons that it persisted?

A. I don't think it's a hardwired view. I think infection prevention and control is very much down the pecking

order in terms of research and good research, and I respect Professor Noakes' position. I accept the science is far from settled, we need studies with improved quality to further understand short and long-term airborne transmission. But I -- we were not wedded to those. They were a foundation that existed in all of the international and national guidance, and had -- and, if evidence demonstrates that that is incorrect, then the guidance will shift.

Q. Okay.

Finally this, then: would it follow, would you agree, that there was a reluctance to acknowledge airborne transmission because there was an emphasis on looking for the evidence of aerosol transmission, rather than the possibility that it would persist, it would exist?

A. I don't -- if the evidence had demonstrated and -- I mean, I go back to the role of the UK IPC cell, we weren't driving the science, our role throughout the pandemic was to take the outputs from the science groups and the evidence that they had discussed, and their recommendations and translate that into the IPC guidance document.

MR WEATHERBY: Thank you very much.

THE WITNESS: Thank you.

LADY HALLETT: Thank you, Mr Weatherby.

I think it's now Mr Odogwu. I'm so sorry, Ms Banton. Well, I was told it was Mr Thomas, so there we go.

Questions from MS BANTON

MS BANTON: I apologise, my Lady, there has been some movement this afternoon. Thank you.

Dr Ritchie, I represent FEMHO, which is the Federation of Ethnic Minority Healthcare Organisations. We advocate for healthcare workers from ethnic minority backgrounds who were disproportionately impacted by the pandemic, and those concerns include surrounding personal protective equipment and fit.

If I may ask a question regarding your statement, you mentioned the recommendation of fluid-resistant surgical masks -- this is in footnote 3, paragraph 16 of your statement -- for GPs triaging suspected Covid-19 cases, despite evidence showing a higher risk of infection when compared to FFP3 masks, especially for those who failed fit tests, including ethnic minority staff.

So, given this evidence, why did you believe that recommending FRSMs provided providing sufficient protection at the time, particularly for those facing fit testing challenges, such as we've heard of before?

A. So on the primary care and the FRSM, the date round about that guidance, as I recall from my statement, that Covid-19 at that point in time was classified as a high-consequence infectious disease and, given that, in primary care settings, FFP3 fit testing was not widely established, then the advice that we were giving in that situation at that particular time was obviously for people who suspected themselves was not to turn up at a GP practice but, if they did, for the GP to basically identify through assessment that there could be a potential that this individual may have SARS-CoV-2, to isolate them and not undertake any intervention, and then to inform their local infectious diseases service to take advice on what to do next.

As the pandemic progressed and evolved, GP services took on quite a different approach where, you know, they were triaging on the phone and, you know, individuals not turning up, so we were looking at more administrative controls in the primary care setting rather than the PPE.

Q. Right, thank you.

LADY HALLETT: I'll just interrupt there, forgive me, Ms Banton. I thought you said that as long as it was classified as a high-consequence infectious disease, all healthcare workers had to wear respiratory protection

equipment.
A. That's correct.
LADY HALLETT: But wouldn't that be more than the fluid-resistant masks that Ms Banton was talking about?
A. At the time, when it was classified as a high-consequence infectious disease, we didn't have many cases or if any cases in the UK, and because we knew that FFP3 respirators was not something fit, because they have to be fit tested, there will not be many GP practices and clinicians in primary care that are fit tested for a FFP3 respirator. So the guidance was to put in place measures that would protect the individual patient but protect the healthcare worker at the same time. So we were not anticipating that those primary care practitioners would come into contact with a high-consequence infectious disease at that time, but if they did and they presented, then it was identify, isolate and inform.
LADY HALLETT: Right.
Sorry to cut across you.
MS BANTON: I'm very grateful, my Lady.
If I may, just a question that arises from an earlier answer which also is relating to my question, just to clarify that something was raised in questioning before the afternoon break on the topic of risk

assessments.
You told us that the IPC cell developed various tools to support organisations and that teams would help those struggling with outbreaks to undertake risk assessments and to put in place mitigating measures.
Counsel to the Inquiry asked whether there was any particular risk assessment specific to ethnic minority healthcare workers, and your response was that it was only a general risk assessment.
However, there was a clear and stark disparity evident in the disproportionate infection rates for ethnic minority healthcare workers which was public at the time. We've heard reference to unequal access to PPE, working conditions, et cetera.
So can you explain why a specific risk assessment tool was not worked on or, indeed, support from IPC teams directed at addressing such specific issues?
A. So in terms of the FF -- the facial protection, respiratory protection, I do note that a colleague, one of the deputy chief nursing officers, did undertake a piece of work with BAME representatives, which was on making sure that there was a proper risk assessment on how to end up with good FFP3 protection when it was necessary. When I was talking about risk assessments, it was more in relation to the environment and the

Health and Safety Executive's hierarchy of controls, and the health equality impact assessment on the guidance did highlight within that the PPE, particularly the FFP3 fit testing for BAME groups and colleagues, so that was highlighted in that document. And as I say, I know that a deputy CNO colleague did take forward some work, which I wasn't involved in, to do with fit testing for ethnic minority groups.
MS BANTON: Thank you.
Thank you, my Lady.
LADY HALLETT: Thank you very much.
Mr Simblet.

Questions from MR SIMBLET KC

MR SIMBLET: Thank you, my Lady.
Dr Ritchie, I'm asking questions on behalf of the Covid Airborne Transmission Alliance in connection with, well, first, some issues in relation to IPC guidance and its applicability.
Now, can I have your witness statement on screen, please.
It's INQ000421939, and internal page 12.
While that's being located, Dr Ritchie, your witness statement for this module, and I think it's your only witness statement, is dated 23 July 2024, so barely seven weeks or so before we began and well after

disclosure of the infection -- of the expert statements and so on in relation to transmission science.
So could I have paragraph 40 put on the screen, please, and zoomed in. It's at the bottom of the page.
What you have told us there is that:
"Effective IPC guidance must be broadly applicable. IPC strategies are not specific to any one pathogen and generally apply to all routes of transmission."
With that in mind, Dr Ritchie, a pathogen is any micro-organism that can cause disease, and some pathogens, this is obvious I would have expected, are more serious and harmful to human health than others, and they are called serious pathogens. Is that right?
A. Correct.
Q. And those include TB, MERS, SARS-1, and even some more common ones such as measles. Is that right?
A. Correct.
Q. With TB, healthcare workers will wear respiratory protective equipment when dealing with cases; is that right?
A. That's recommended.
Q. Yes, and local risk assessments are not required for TB?
A. They are recommended.
Q. Right. Why is Covid-19 any different from TB?
A. Covid-19 is different from TB because the predominant

mode of spread for TB is airborne; for Covid-19 the predominant mode of spread is droplet and contact.
Q. Is that still your position in this Inquiry today, after all the evidence we've heard: that the primary mode of transmission for Covid-19 is droplet and contact?
A. That is my position.
Q. So what you've said at paragraph 40 needs to be looked at in this context as well, doesn't it, that when it comes to respiratory protection for healthcare workers, you think that those who are guarding against Covid-19 require less than is required for TB?
A. It's not just -- what I've tried to explain in the last couple of hours is not just the respiratory protective equipment, it's making sure that the environment and the hierarchy of controls is applied and risk assessment is applied as well. Paragraph 40, saying about effective IPC guidance must be broadly applicable, is because pathogens generally don't just transmit by one route, they generally transmit by many routes and, when it says "IPC strategies are not specific to any one pathogen", that's the approach. IPC is multifaceted, there is no one single thing like hand washing that's going to make a difference for a pathogen; it's multiple interventions that are reliably applied all of the time and the monitoring of that is happening all of the time to

ensure that those things are in place.
Q. Right.
Now, one of the things that you've mentioned at various points in your evidence is risk assessments and you've spoken of local risk assessments and healthcare workers' own risk assessments. Do you accept that with a disease such as Covid-19, where you can't see it, or hear it, or smell it, or anything like that, that it's essentially impossible for a individual healthcare worker to undertake their own individual risk assessment?
A. But that individual may -- there is an assessment done on the individual and the individual may have signs and symptoms, they may be tested, so you would have some idea of someone being suspected or known to have that pathogen. And the high risk assessment is not and should not be new to healthcare systems. In the Health and Social Care Act, the code of practice for infection prevention and control mentions risk assessment many, many times, and it is something that should be put in place across every healthcare facility to make sure that people are looking at ventilating systems and assessing the environment and making the environment as safe as possible for patients and staff and visitors.
Q. No, but in terms of doing their own individuated risk

assessment, to protect themselves, the healthcare worker, it's almost impossible, isn't it?
A. I'm not quite sure I follow your question.
Q. The disease against which they are guarding is one that cannot be seen or smelt or heard, or whatever, so for them to suddenly sit down and start deciding what they ought to do to guard against it, as opposed to being assisted and instructed in what to do by specialist infection prevention and control guidance, is effectively impossible, isn't it?
A. But that could then be said for many pathogens, like MRSA, or C. diff. You do an assessment of the patient, you look for signs and symptoms, you may take some tests, and on the basis of your clinical assessment, which our healthcare workers are doing every single day, they are seeing patients with suspected and known infections in many of the healthcare settings, so they are making that individual risk assessment depending on also the procedure that they're going to undertake. So the patient may not even have an infection, but they might be going to undertake a procedure where there might be some spraying or splashing of blood, for example, and in that situation they would clinically risk assess and wear the appropriate PPE.
LADY HALLETT: Mr Simblet, (a) I don't see where this is

going and (b) I don't see it on the list of questions I authorised.
MR SIMBLET: Right, well, in that case, could I move to something else. My Lady, we have asked, as you know, over the weekend -- there was some material which was highly relevant to the IPC guidance which was disclosed very recently. We have been working very hard over the weekend to try and assist in formulating questions. It may be that we have to ask for this witness to come back, but we've submitted questions this afternoon and had the email back that we're awaiting your determination, but it's now 4.15, so would you like me to ask them or would you like me to pursue this in a different way?
LADY HALLETT: I'm sorry, I haven't got the foggiest what you're saying, Mr Simblet. I will only allow for a witness to be recalled if I think it's absolutely and strictly necessary. I've given permission for you to ask certain questions, you may ask them, but just be warned that if you don't ask them you may not get the opportunity because I may not agree that the witness needs to be recalled.
MR SIMBLET: Thank you.
Then I shall -- can I move on to a different issue, please. It's in relation to the suggestion that --

well, it's in relation to what you thought the guidance should lead to and the confidence that you wanted people to have in it.

Could we have on the screen, please, INQ000398144.

These are an extract from some of the minutes of the IPC cell for 9 September 2020.

LADY HALLETT: Have you warned our wonderful document manager of the document you want up on screen?

MR FIREMAN: Yes, I wonder if the question could be summarised with reference to the relevant passage.

LADY HALLETT: If you could summarise what's in the document.

MR SIMBLET: Okay, if that's easier.

And my Lady, I'm sorry to be doing this on my feet. This is not any fault of me or those instructing me or my clients. This is material that could and should, we would say, have been disclosed --

LADY HALLETT: All right, Mr Simblet, I'm not going down that path now. So could you carry on with the questions. You're running out of time.

MR SIMBLET: Thank you.

It's in those minutes and it's for the people following at box 3, bullet point 3, it was said that, well, somebody in the meeting said:

"If you wanted to change the guidance itself it

would need a very careful narrative as it would be easy to give the impression that we got it wrong the first time when it's something we collectively signed off on and submitted to our chief nursing officers."

Now, that was said in a meeting on 9 September. You weren't there, but the minutes came out subsequently. Would you say that sometimes the IPC cell was more bothered about maintaining face than actually transparently and accurately providing the best and most reliable information?

A. Absolutely not. As a UK IPC cell, it was not about saving face. We were doing our level best to make sure that the guidance that was put out was going to protect our healthcare workers and protect patients.

Had that guidance been incorrect and had we been advised by any of our senior clinicians that the guidance was incorrect, it would have been changed. We were not a rogue cell.

Q. Can I go on to a different topic, please, and, again, this is INQ000398221, and page 6 of that. These are minutes from 27 January 2021 and, taking the approach I've just been asked to do, I'll summarise this.

MR FIREMAN: Sorry, I'm not sure if these minutes have actually been authorised in terms of the particular question that the core participant has been given

permission to ask a question on.

LADY HALLETT: What's the question, Mr Simblet, and I'll reconsider? Apparently I have declined permission.

MR SIMBLET: Oh. Well, if you did so, my Lady, it was something that hadn't happened when we got to the break.

What I wanted to ask is that in the minutes there are various suggestions of people raising concerns that it's "as caused by the minority", ie a minority of healthcare workers, and what I wanted to ask you about is: what did you understand to be the minority and what was the concern about listening to them?

LADY HALLETT: I think you've asked the question now, so you've got permission.

Dr Ritchie?

A. I don't recall the minute. If it's something that I can help with outwith this session, and provide a written response, I'd be happy to do that.

MR SIMBLET: Thank you.

There's one more question I would like to ask, please, and it's this: there are some references in the minutes, including going back as early as March and February 2020, to concerns that, if the guidance on changes to PPE is changed, that that could affect PPE supplies. To what extent were you worried that the guidance needed to reflect what materials you actually

had, what supplies you actually had?

A. So the supply, the purchase, all of the issues round about PPE was not within the remit of the UK IPC cell. We were aware, given the global demand, that that might be something that could happen, that there would be a limit or run out of PPE. The guidance was not based on any supply issues to do with PPE.

MR SIMBLET: Well, I've got the answer to that. Thank you.

LADY HALLETT: Thank you, Mr Simblet.

Further questions from THE CHAIR

LADY HALLETT: One last question, Dr Ritchie, and I promise you it is the last question. It's been a long day for you, I know. Basically, it's a question that's come from the BMA.

You've placed quite a lot of reliance, many people would understand why, some may question why, on the World Health Organisation. Dare I say it, none of us are infallible and the question comes based on a statement made by, forgive my pronunciation if I get it wrong, Dr Soumya Swaminathan, the World Health Organisation's chief scientist, who stated on her retirement in November 2022 that her biggest regret was not acknowledging earlier in the pandemic that SARS-CoV-2 could be spread by aerosols.

I suppose it's really a comment rather than

a question, but given that, haven't you, as somebody exercising an expert capacity, got to be careful about the reliance you place on any one body or one expert, because they may not always be right?

A. Absolutely, I don't disagree with that, and I think a body of evidence is much better than a single view. I think, you know, we've got a long way to go on the research, and I think those clinical medical groups that made a difference was the behavioural scientists and our clinical medical people.

The research currently, and this might be something for the way forward, I think a lot of the research grants go to a lot of the "omics", like genomics and research in that space. It's not easy to do infection prevention and control research, so it feels like we need to have something pre-made, ready to go, to test all of these interventions, because it's really difficult to tease out: well, was it because we put the patient in a single room, was it because they were wearing FFP, the healthcare worker was wearing an FFP3 respirator? So I think bringing the operational arm, like us nurses, IPC nurses, with the scientific arm and really bringing that much closer together in research would be a major step forward.

Thank you.

LADY HALLETT: Thank you very much indeed. As I say, I do realise it's been a long day for you, thank you very much indeed for all your help.

We will finish there and I shall start again at 10 o'clock tomorrow morning.

(The witness withdrew)

(4.27 pm)

(The hearing adjourned until 10 am on Tuesday, 17 September 2024)

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