Witness Name: Rosemary Gallagher

Statement No.3

Dated: 25 April 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ROSEMARY GALLAGHER MBE

I, Rosemary Gallagher MBE, of The Royal College of Nursing ("**the RCN**") of 20 Cavendish Square, London W1G 0RN, will say as follows: -

1. I make this statement, about the RCN's views on the impact of Covid-19 pandemic on healthcare systems in the four nations of the UK, in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 26 May 2023, in relation to Module 3 of the Inquiry. The facts and matters contained within this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

2. I make this statement on behalf of the RCN and confirm that I am duly authorised to do so.

Introduction

3. I am the Professional Lead for Infection Prevention and Control ("**IPC**") and nursing sustainability lead at the RCN. I was appointed to the role substantively in July 2009 and have retained responsibility for IPC and antimicrobial resistance ("**AMR**") since then. In addition to this portfolio, I have also led and supported a number of RCN member communities including forums or networks across a range of nursing practice areas

including, for example, blood transfusion, renal nursing, breast care and cancer nursing, gastroenterology and procurement. I currently sit on a number of external national committees aligned with my RCN work, skills and expertise such as the Royal College of Physicians Patient Safety Committee, NHS England Emergency Planning Resilience and Response ("**EPRR**") Clinical Reference Group, English Surveillance Programme for Antimicrobial Utilisation and Resistance ("**ESPAUR**") group, UK AMR Diagnostics Committee and the New Hospital Programme Oversight Committee. I am also a Trustee for the UK Health Alliance on Climate Change and sit on the Executive Committee.

4. At the RCN, the key elements of my role are to provide visible leadership; representing and supporting the RCN, its members and key stakeholders on IPC, AMR and sustainability and the impact of these on nursing practice. My role is UK-wide, and I respond to the needs of each country as required. As a member of the professional nursing team, I also provide nursing leadership and representation across the RCN's portfolio of professional nursing practice. For example, I attend and support the RCN annual Congress, represent the RCN at events and meetings and undertake presentations and engagements on behalf of the College. I also lead and deliver specific internal projects as part of RCN business planning or delivery of resources and outputs.

5. This statement has been prepared following the collation and review by the RCN of documents relevant to Module 3 and discussions with colleagues. It is in addition to the two witness statements I have provided for Module 1 of the Inquiry. Unavoidably, there are some gaps in the evidence as a result of the routine deletion of documents pursuant to the RCN's document retention policy, which dictates that emails are deleted after four years and other publications, working documents and records are generally deleted after six years.

6. In this statement I cover the following matters:

    a. A summary of RCN's concerns at paragraphs 7 to 19;

    b. Issues raised by RCN members in relation to Personal Protective Equipment ("**PPE**") measures and IPC guidance throughout the currency of the pandemic and subsequent action taken by the RCN (at paragraphs 19 to 138) including:

        a. PPE procurement
        b. PPE stockpiles

c. PPE distribution
d. Availability of PPE and the issues this led to including re-use of single use PPE)
e. Fit testing, fit testing training and difficulties which arose due to physical attributes
f. PPE guidance
g. IPC guidance
h. Health and Safety issues in the workplace
i. RIDDOR reporting

c. A list of the guidance and advice the RCN provided to its members in relation to IPC and PPE and/or respiratory protective equipment ("**RPE**"), such as in relation to the transmission of respiratory infections and the level of PPE/RPE required to protect nurses whilst at work, can be found at paragraphs 139;

d. A summary of the submissions or representations provided by the RCN to the UK Government, Devolved Administrations and other key stakeholders and to any IPC guidance-making body and the response to those submissions or representations at paragraphs 140 to 228;

e. Recommendations in order to improve the provision and quality of nursing care and conditions for nurses and nursing students in the event of a future pandemic at paragraphs 229 to 245;

f. A separate witness statement provided by Pat Cullen addresses the further matters in the Inquiry's Rule 9 request that are not covered here.

Summary of RCN concerns

7. **IPC guidance** – The RCN found that there was a serious lack of engagement with wider stakeholders and representatives of the health and care sector when developing, reviewing and updating IPC guidance, specifically in the early phases of IPC guidance development. This was in contrast to the experience of management of the H1N1 pandemic in 2009 and lessons identified as a result of the investigation into transmission of Ebola Virus Disease ("**EVD**") in Madrid in October 2014. The lack of engagement led to an inability to put forward practical and clinical rationale for amendments to draft

guidance to protect our members and patients during the delivery of care. This action also impacted on the ability of stakeholders such as the RCN to consider the implementation of guidance across different care settings where specific considerations were necessary, such as mental health inpatient settings. Given the extent of its concerns, the RCN commissioned an Independent Review of the UK IPC guidance, written by Professor Dinah Gould, an Honorary Professor of Nursing at London's City University and Dr Edward Purssell, also from City University and published this on 07 March 2021. The report questioned the continuing use of the rapid review of the literature undertaken by Health Protection Scotland to inform UK wide-guidelines for infection prevention and control 12 months into the pandemic when opinions about the way that SARS-CoV-2 was transmitted had changed and it was becoming apparent that airborne transmission beyond the technical process of aerosol generating procedures ("**AGP**s") was possible and likely.

8. The RCN was concerned about the development of IPC guidance based on influenza rather than existing guidance on the management of Middle Eastern Respiratory Syndrome ("**MERS CoV**"), a known coronavirus. By way of example, on 29 January 2020, after an EPRR Clinical Resource Group meeting, I raised my concerns, to Stephen Groves, National Head of EPRR NHS England and NHS Improvement **[RG/001 - INQ000114353**]. I communicated my concerns regarding the lack of clarity on how the Covid-19 incident was being managed between the relevant agencies and how key stakeholders were being engaged with. I noted that the key lessons from pandemic flu and the EVD outbreak highlighted the crucial need to engage with organisations supporting frontline staff to ensure that guidance was both relevant and able to be implemented. In relation to emerging Public Health England ("**PHE**") guidance, it was unclear how the related agencies were being coordinated and what the mechanisms were for communication and escalation of concerns or risks.

9. I asked for further information as to how the incident management teams planned to engage with professional organisations, working alongside each other across the many settings and specialties, to ensure communications were consistent and that the lessons identified from previous outbreaks were utilised. I also stated that it was the RCN's wish to support those managing the Covid-19 incident through proactive advice and the development of guidance, rather than to have to feedback concerns after decisions were made or guidance issued.

10. Again, in a further email exchange with Professor Chris Moran, National Clinical Director for Trauma at NHS England and NHS Improvement, on 29 January 2020 **[RG/002 - INQ000114354]**, I restated the importance of involving key stakeholders early, as part of a multi-professional team, to shape and develop guidance. I explained that guidance must be developed and assessed by those in practice to ensure its ability to be implemented (as we had learnt from the EVD incident), in addition to the consideration of other supplementary factors that may impact on compliance. I further explained that interagency collaboration and engagement of professional organisations needed to extend beyond the development of guidance – it was clear that there were evolving employment questions and wider workforce issues that would need to be addressed through a multi-agency approach.

11. PHE infection prevention and control guidance for MERS CoV was published in 2016 and remains current at the time of my statement. This guidance refers to evidence based on the experience in the Middle East and outbreaks of MERS CoV in Korea regarding the known 'ease of transmission' in healthcare settings and the need for use of RPE by staff in caring for people with known or suspected infection. As a novel coronavirus causing severe respiratory disease, suspicion was maintained that SARS CoV-2 was capable of being spread via the airborne route during activities of daily living and not confined to AGPs as MERS CoV had evidenced. This contrasted with a long-held view that influenza virus transmission occurs predominantly through large droplets considered to travel short distances only from an infected person. This distinction carried significant implications, from a health and safety and infection, prevention and control perspective, for the protection of healthcare workers exposed to SARS-CoV2 in all care settings, in relation to the type and amounts of PPE required, potential for healthcare worker infection and its impact on workforce availability and patient safety.

12. **Respiratory protective equipment (RPE)** - RPE is designed to protect the wearer from inhalation hazards (chemical or biological, for example) and must meet specific standards within the Personal Protective Equipment at Work Regulations 2002 ("**the PPE Regulations**") to ensure the item's effectiveness. This contrasts with 'source protection' where the wearing of a mask, commonly a surgical facemask or equivalent, protects the patient from infection by the wearer (healthcare professional or carer). It is the PPE Regulations and associated standards that ensure, providing the mask or respirator fits appropriately and the user is trained in its use, that hazards and respiratory risks are managed, and healthcare professionals are protected. Surgical face masks such as

Fluid Resistant Surgical Masks ("**FRSM**") or Type 11R masks are classed as medical devices and must meet standards as directed by The Medical Devices Regulations 2002 ("**the Medical Devices Regulations**"). They do not, unless specifically confirmed by manufacturers, meet the standards of the PPE Regulations, and are designed to protect the wearer from physical contamination such as respiratory secretions/large droplets.

13. It is the view of the RCN that a lack of clarity on use of the term "PPE", and confusion over the definition and purpose of source control combined with a culture of assumptions that historical influenza guidance was adequate, and that IPC guidance prevailed over Health and Safety requirements including Control of Substances Hazardous to Health ("**COSHH**"), placed healthcare workers at unacceptable risk in the workplace. The RCN spent a considerable amount of time lobbying for the UK health leaders and government to update and strengthen IPC guidance, including repeatedly calling for RPE for frontline workers to prevent infection due to airborne transmission of SARS-CoV2.

14. **PPE stocks** - Existing stocks of PPE, based on modelling for an influenza pandemic, were insufficient. Without adequate and proper RPE, nursing and midwifery staff put their own lives, and the lives of their families and patients, at risk. These supplies should have been based on Health and Safety Executive ("**HSE**") recommendations such as those made in the HSE's report '*Evaluating the protection afforded by surgical masks against influenza bioaerosols*' ("**the RR619 report**"), concerning the need to comply with Health and Safety legislation, the adoption of a 'precautionary approach' to the protection of healthcare workers and, taking into account infection control guidance which reflected the latest available PHE scientific and clinical evidence, not dictated by cost or opinion. It is our view that pandemic stock levels were vastly underestimated and that global demand, as expected in a pandemic, was not sufficiently considered.

15. **PPE distribution** – Distribution of PPE was slow and not transparent. Public commitments to supplying adequate PPE had not translated into increases in consistently deployed and accessible stocks of suitable and adequate PPE across all health and care settings. The wider health and care system, outside of acute NHS hospitals, continued to provide care to vulnerable people in society yet there had been a disproportionate focus on considering supplies only for NHS hospitals.

16. Due to inadequate supplies of PPE, there were reports that RCN members had been required to reuse equipment, to use equipment previously marked as out of date, to clean old gowns with alcohol wipes and to use alternative equipment which had been

donated and did not provide adequate protection. Whilst public donations of supplies were signals of support to frontline staff, they did not replace the legal responsibility of system leaders and governments to ensure that correct PPE was provided. The RCN received reports of members wearing makeshift gowns out of bin bags, ski-masks or swimming goggles when PPE of the required standard was not available.

17. At no point did the RCN receive communications, from the government or others to the effect that Health and Safety legislative requirements had been paused as a result of the pandemic. Other legal requirements, for example the Environment Protection Act 1990 directing the management of clinical waste and The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 remained enforceable at this time, however the enforcement and visibility of Health and Safety legislation to protect staff within health and care settings was largely absent. The RCN understands that a relatively small number of HSE inspections were carried out between December 2020 to January 2021 in 13 NHS trusts in England and 2 NHS Health Boards in Scotland and Wales, as part of the National HSE Covid-19 spot check inspection programme. A report summarising the results of the inspection was produced by the NHS Trade Unions in March 2021 **[RG/003 - INQ000427463]**.

18. **Availability of PPE** - Our members reported that insufficient supplies of PPE resulted in some equipment made available to them being of an unsatisfactory standard. FFP3 respirator masks offer a high level of protection and require users to undergo fit testing by a person competent to do so in line with health and safety requirements. This ensures the mask fits the individual correctly and a tight-fitting seal is achieved to protect the wearer from inhaled hazards, in this case SARS-CoV-2 virus. Provision of a different brand of mask to the one normally used by an individual necessitated users of FFP3 masks to undergo additional fit testing for each brand of mask provided and used. Where different brands of FFP3 masks are provided in succession, the fit testing of all staff using masks will be repeatedly required. This resulted in staff being withdrawn from clinical care at the height of the pandemic response to undertake the necessary face-fit training, which in turn caused friction between the RCN and employers, including Chief Nurses in NHS Trusts to ensure the safety of their staff. Some members reported that equipment to undertake fit testing was not available to them and that demands to 'fit check' not 'fit test' (as per legal requirements) placed nursing and midwifery staff at risk due to issues with masks not providing an adequate facial seal due to different face sizes/shapes. This created additional pressure and delays for staff and the system at this critical time.

19. Unfortunately, we do not know the full scale of the impact of these failings because of a lack of robust data on health and care worker infections and deaths by hospital in addition to any associated with PPE usage.

Issues raised by RCN members in relation to PPE measures and IPC guidance throughout the currency of the pandemic and subsequent action taken by the RCN

20. The RCN received a notable amount of feedback from members via the RCN's support services, RCN Direct ("**RCND**"), regarding a lack of appropriate PPE and the stress and concern this caused. Health care professionals described feeling like "*lambs to the slaughter*" or "*cannon fodder*" and that they were "*scared*" and were left feeling "*let down and frustrated*". Records of members' concerns were maintained and copies are exhibited to my statement at **[RG/004 - INQ000328870]** and **[RG/005 - INQ000328871]** and are expanded on in detail in the paragraphs that follow.

21. The RCN undertook two extensive surveys of its members working across all health and social care sectors in April and May 2020, specifically about the use and availability of PPE. The first survey, titled 'Personal protective equipment: use and availability during the Covid-19 pandemic' **[RG/006 - INQ000114401]** received responses from 13,605 members, including those working in environments with possible or suspected Covid-19 but who were not themselves undertaking high-risk procedures, and others who were working in environments where high-risk procedures were being undertaken. Findings showed that:

    a. Of those treating possible or confirmed Covid-19 patients in high-risk areas, around half (51%) reported that they were being asked to re-use items of PPE marked 'single use' by manufacturers.
    b. Of those treating Covid-19 patients elsewhere (i.e. non high-risk areas), over a third (39%) said they were being asked to re-use this equipment.
    c. Almost a third of nursing staff treating Covid-19 positive patients not on ventilators reported an immediate lack of face and eye protection.
    d. One in ten nurses were relying on face or eye protection they had bought or was homemade.
    e. 70% of respondents had raised concerns about PPE. Concerns were most likely to be raised with their manager either verbally (91%) and/or in writing (13%).

22. The second survey, titled 'Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the Covid-19 pandemic' **[RG/007a - INQ000328873] [RG/007b - INQ000427462]** received 5,023 responses and found that:
    a. 34% of respondents felt pressure to care for individuals with possible or confirmed Covid-19 without adequate protection.
    b. 56% of respondents from ethnic minorities felt pressure to work without the correct PPE.
    c. 44% of respondents said they were being asked to reuse single-use equipment.
    d. 58% said they had raised PPE concerns, the majority being raised with their employer, but more than a quarter (27%) of this group reported that these concerns had not been addressed.
    e. As efforts were made to manage the pandemic, staff reported difficulties in communicating with patients or colleagues when wearing full PPE and many had been working in unfamiliar clinical environments.

23. These survey findings were shared with a number of relevant stakeholders including the Department of Health and Social Care ("**DHSC**"), the UK Prime Minister **[RG/008 - INQ000328874]** the Scottish Cabinet Secretary for Health and Sport **[RG/009 - INQ000328878]**, members of the Welsh Senedd **[RG/010 - INQ000328820]**, Audit Wales **[RG/011 - INQ000427472]** the HSE **[RG/012 - INQ000417594]** and NHS England and NHS Improvement **[RG/013 - INQ000427471]**. The HSE responded on 17 April 2020 **[RG/014 - INQ000417596]** acknowledging the survey results and noting that HSE was working closely with other Government departments including DHSC, NHS and PHE to facilitate efficient procurement and distribution of suitable and effective PPE. NHS England and Improvement noted that there had never been a shortage of respirator masks or gowns and requested more data which was subsequently provided **[RG/013 -INQ000427471]**. The first RCN PPE survey was reported in an RCN Northern Ireland press release and web story and was subsequently extensively referenced and quoted in a report published in 2022 by the Northern Ireland Audit Office on the supply and procurement of PPE **[RG/014a - INQ000417702]**.

24. There was mounting evidence of the unequal impact of Covid-19 on nursing staff from ethnic minorities as reported by survey respondents. The RCN's first PPE survey, published in April 2020 **[RG/006 - INQ000114401]**, revealed that staff from ethnic minority groups were more likely to report that they did not have access to adequate supplies of PPE compared to their colleagues from white British groups. Staff from

ethnic minorities, working in high-risk areas and requiring the use of PPE such as FFP3 masks were less likely to have been fit tested for their PPE in comparison to their white British colleagues (49% compared to 74%). One member noted how:

> *"I stood my ground and highlighted it was preposterous she expected us to work without adequate PPE. My refusal to work wasn't me being insubordinate, it was merely me looking out for the safety of the other patients on the ward who were negative and my colleagues I was working with. The thing that worries me the most from this incident is how many staff have probably encountered this with said sister and have worked without adequate PPE … As I belong to an ethnic minority group myself this then poses the question that are we losing more BAME healthcare workers because they are being told to work without the adequate PPE."*

25. Staff members from ethnic minority groups reported feeling less confident in their employer's ability to protect them from exposure to Covid-19 in comparison to their white British counterparts: almost a quarter of ethnic minority staff did not feel confident at all, compared to around 1 in 10 white British staff. Although a high proportion of respondents reported that they had raised concerns to their managers, these concerns were reported as not always addressed. Staff from ethnic minorities reported that they were less likely to have their concerns addressed in comparison to their white British counterparts. Very few reported confidential discussions about safe redeployment especially during the peak of the pandemic.

26. What follows, under relevant sub-headings, are illustrative quotes taken from RCND's call logs **[RG/004 - INQ000328870]** and the RCN's social media logs **[RG/005 - INQ000328871]** maintained from March 2020 to June 2022, detailing concerns raised by members. Those in quotation marks are direct quotes from written correspondence from members, whereas those not in quotation marks are the RCND call operator's contemporaneous summaries of concerns raised by members as recorded in the RCND's call logs.

PPE procurement

27. Members raised numerous issues in relation to PPE procurement, such as equipment not being fit-for-purpose, a lack of clinical engagement in procurement decisions, and poor packaging of PPE:

a) *"So far we have had 4 different types [of mask] from 2 different manufacturers, none have been clinically acceptable, they simply do not fit. I am aware that contracts have already been signed to purchase. When I have fed back to cabinet office that they don't fit, I was told any mask was better than nothing. Another company on a call wanted to know how the NHS fit test masks, and when I questioned them on which Trusts were already using their FFP3 masks, or had evaluated, they said none, yet they have also been contracted to supply into the NHS."*

b) *"The clinical engagement is being done AFTER the purchasing decisions have already been made. It is paying lip service to it and is too late once decisions have already been made based on tech specs, NOT clinical specification and evaluations."*

c) *"We have received hand gel that is not fit for purpose, it's like water, and most of it is coming without a pump dispenser, so unable to get accurate dosing or hands-free dispensing. The bottles are either shower gel type with flip top lid, or a tomato sauce type squeezy bottle."*

d) *"Some gel arrived in filthy boxes, and on opening the gel also filthy on top."*

e) *"We also were sent some dust masks which were allegedly FFP3s, but no way would they pass a fit check."*

f) *"Packaging of Type IIRs is shocking, come wrapped inside the box, so you have to open the box, take the whole 50 masks out of the plastic packet and put them back into the box. Some you have to dispense from the side of the box, so you pull and loads come out. Certainly risk contaminating a box of masks."*

28. I raised these concerns during a conference call with the Cabinet Office and NHS England ("**NHSE**") and NHS Improvement ("**NHSI**") on 08 July 2020 **[RG/015 - INQ000328880]**. To the best of my knowledge, the conference call only had England

representatives present. This took place as a result of member concerns raised following the publication of an interim PPE procurement structure **[RG/016 - INQ000417641]**. Members had raised concerns at the apparent lack of clinical presence in the structure, the lack of detail on the links with the 'Clinical and Product Assurance' (**"CAPA"**) function of NHS Supply Chain, and the lack of transparency on the evolution of this work. Whilst the focus remained on procuring PPE that met technical standards, member concerns focused on the equivocal need for clinical acceptability of products to support its safe and effective use. Members also raised concerns on the procurement of sub-standard PPE sent to Trusts in England and highlighted the benefits of implementing clinical evaluation at an earlier stage of the process within the published structure. Meeting attendees acknowledged that local procurement was a challenge. A decision-making committee ("**DMC**") had been established to assess products where questions had been raised about their suitability for health and care settings. I was informed that this DMC was made up of technical assurance individuals and regulatory bodies. I requested a nursing presence via a specialist procurement nurse on the DMC to support decision making. Whilst I understand that there was no specialist procurement nurse, three nurses were present on the DMC.

29. The RCN understands that the Cabinet Office was responsible for purchasing decisions for NHS England and that individual countries had their own procurement processes in place. The RCN understands that Government worked with all four UK countries to support procurement and the mutual aid of PPE. We have no details of how this process worked or when it was implemented. It is assumed that information shared during the conference call on 08 July 2020 would have been disseminated to representatives in the other UK countries who were responsible for procurement of PPE.

30. By way of follow up to the conference call on 08 July 2020, I emailed NHSI/E on 16 July 2020 and forwarded a number of member concerns I had received regarding PPE procurement including photo evidence **[RG/017a - INQ000328900] [RG/017b - INQ000427455] [RG/017c - INQ000427444] [RG/017d - INQ000427445] [RG/017e - INQ000427446]**. I reminded NHSI/E that there were a number of experienced RCN members who would be happy to support evaluation of PPE procurement either via the DMC or as part of various groups looking into different aspects of current and future procurement of PPE. This was based on previous RCN involvement in procurement and clinical evaluation methodologies of consumables used by nurses to deliver patient care. To my knowledge, I don't believe that this offer was ever taken up and I am unable to locate any response.

31. I also took the opportunity in my email to explain that I had been contacted by one Trust who had raised concerns over the complexity of reporting issues with PPE as some items needed to be reported via the Medicines and Healthcare Products Regulatory Agency ("**MHRA**") and others via different routes, and how time consuming this was if there were multiple issues, adding unbearable pressures to specialist procurement nurses supporting NHS Trusts and wider systems at this time **[RG/018 - INQ000328894]**.

32. MHRA is the executive agency of the Department of Health and Social Care that acts on behalf of the Ministers to protect and promote public health and patient safety by ensuring that medicines and medical devices meet appropriate standards of safety, quality, and efficacy. The MHRA ran a dedicated coronavirus Yellow Card scheme which collected and monitored information on suspected safety concerns or incidents involving medicines and medical devices. Where PPE was for patient protection i.e. surgical gloves or masks, it would be classed as a medical device and therefore any issues were reportable via the MHRA yellow card system. Where PPE was for the protection of the individual wearing it, it was not classed as a medical device. Reporting of incidents or faults with PPE that was not a medical device i.e. FFP3 marks, eye protection etc needed to be raised with the HSE. In addition to reporting issues via MHRA and HSE, PPE related incidents should have been reported via local incident reporting mechanisms such as by submitting a Datix and reporting to the NHS PPE dedicated supply channel via procurement teams. I do not know whether local Datix reporting was fed into national PPE coordinating groups in a standardised way or how local Trust data was being used across the wider system. In addition, NHS organisations could raise complaints to suppliers via an online form which would trigger an investigation. My understanding at the time was that where complaints were received via the online form in England, they were reviewed by the DMC which included representatives from regulators in addition to NHS England, DHSC and HSE representatives.

33. On a practical level, the duplication of reporting and the different methods required made the system unworkable for those involved in reporting. A significant proportion of specialist procurement nurse time in England was required and this took them away from their critical roles in securing and accessing supplies for Trusts. Issues with procurement continued throughout the pandemic.

34. RCN members as specialist procurement nurses continued to work to support the reporting and resolution of PPE issues through the evolution of groups established to

address these at pace in real time. Our learning from this situation is that a one stop standardised form should be developed that enables electronic reporting once only to capture issues aligned to the quality of safety of critical supply items, including PPE, in incidents such as a pandemic to enable accurate data, reporting and transparency of the situation and release valuable clinical time for healthcare workers.

PPE stockpiles

35. The PPE stockpile was based on what would be required in an influenza pandemic under a reasonable worst-case scenario as set out nationally. It was not sufficient to manage the reality of the Covid-19 pandemic. The volume of PPE needed was much higher due to the extensive needs of nursing and other healthcare staff in work settings beyond hospitals, particularly for nurses working in community settings including care homes and disruptions to global supply and distribution chains. Shortages of fit test solution to support the use of PPE, specifically RPE by healthcare workers was also problematic. The demand for PPE exceeded availability and this evolved over time and affected all care settings including adult social care. Different elements of PPE were impacted at different times and for a variety of reasons. For example, the provision of FFP3 masks was impacted not only by supply but by a shortage of fit testing solutions to support the safe use of such items. A shortage of PPE items subsequently led to the PHE publication of 'Considerations for Personal Protective Equipment in the Context of Acute Supply Shortages for Coronavirus Disease 2019 (COVID-19) Pandemic.

36. PPE stored in the Pandemic Influenza Preparedness Programme ("**PIPP**") stockpile was insufficient in terms of the type and number of items required over a sustained incident period. This included a reliance based on the assumption that surgical face masks would provide adequate protection for healthcare workers, with RPE such as FFP3 masks only needed in certain circumstances. The PIPP stockpile was based on influenza planning, not coronavirus, and did not appear to have considered learning from other coronavirus incidents. Shortage of fit test solutions also occurred indicating the amount required to support use of FFP3 masks had been underestimated.

37. Some RCN members who had been provided with PPE by their employers were required by their employers to use equipment previously marked as out of date. Use of PPE in this condition posed a risk to health and social care workers and to their patients and had a significant impact on confidence in the system and the ability of employers to protect

employees in the workplace as per expectations of Health and Safety legislation which remained current.

38. When existing stocks began to deplete, PPE was tested and re-labelled and items such as facemasks that had passed their expiry date were provided for staff. RCN members raised their concerns about out-of-date equipment being circulated to health and social care staff:

    a. *"We have been using an expired FFP3 mask in my hospital. The original expiration date was 2015. A yellow sticker was placed on to it with a 2017 expiration and another sticker on top of it showing a February 2020 expiration date. I have a video of the expired FFP3 boxes we been using in intensive care covid unit."*

    b. *"We are a team in endoscopy who have been given out of date masks 8yrs out of date and we are extremely anxious to be using them which we are at the moment. The only assurance we have been given is an email from Occupational Health saying they are fine with no reference to being out of date. Please can you inform us what we should do?"*

    c. *"I noticed yesterday that our FFP3 masks are expired - both boxes - last expiry date was mid 2019 - but both had had expiry dates under these stickers - one being 2014 the other 2016. When I questioned this my line manager went to stores to check and came back to tell me that Procurement had passed them as safe to use. When I questioned her further about the reason for expiry dates I was told they had been tested. Where do I stand?"*

39. The RCN understands that some PPE stored in the PIPP stockpile was managed in such a way as to ensure maximum shelf life and testing was undertaken periodically on some items to ensure they remained at the correct standard to provide the appropriate level of protection to wearers. The RCN was not aware of when the PIPP stockpile was distributed early in the pandemic, or the timescales for periods post expiration. The RCN noted, through discussions with members, the deterioration of some items such as nose bands and ear loops on masks **[RG/019 - INQ000417677].** The RCN was unaware if any processes or systems for testing of PPE included liaison with the HSE who regulate the use of PPE under COSHH. I raised my concerns with the NHS Supply Chain via email on 18 March 2020 **[RG/020 - INQ000328901]** and was informed that a

communication was being drafted by PHE to address matters such as shelf-life testing and labelling. CEM/CMO/2020/018 Considerations for Personal Protective Equipment in the Context of Acute Supply Shortages for Coronavirus Disease 2019 (Covid-19) Pandemic was subsequently produced.

40. The RCN advised members, via its dedicated PPE webpage, to not use PPE which was not fit for purpose, including PPE which:

    - Did not fit correctly (for example, had a failed fit test).
    - Did not meet the correct standard or specification (for example, was not CE marked to indicate that the manufacturer or importer affirms the goods' conformity with European health, safety, and environmental protection standards or did not meet other required standards) which would include items recalled by MHRA or HSE, for example ear looped FFP3 masks. The RCN actively disseminated and communicated MHRA and HSE alerts on how to report RPE and PPE failures as provided by national agencies, to members.
    - Had degraded material present.
    - Was donated by a third party with no assurance that quality standards had been met.
    - Was dirty or unable to be adequately decontaminated.

    Members were encouraged to refer to local level policies (i.e. Trust policies) on the use of PPE and to report any quality issues immediately to managers alongside completing a local incident form.

41. The RCN is aware that there may be local nuances to be considered when implementing guidance, including IPC guidance. Local policies should take into account national IPC guidance and its application to local situations and/or needs. Whilst many aspects of guidance will be able to be applied as principles for best practice on IPC, some content often needs to be considered and amended in light of specific local population and patient/clinical needs.

42. The RCN's view is that IPC policies, as developed by the UK IPC cell from March 2020 (such as Version 1.0 of Guidance for Infection Prevention and Control in Healthcare settings) **[RG/021 - INQ000325350]** used language that influenced the use of PPE as directed by the IPC guidance, which led to a lack of prominence of the need for focused organisational and local decision-making informed by risk assessment under COSHH.

This position was clear in the NHS Staff Council joint statement dated February 2020 of which the RCN is a member.

43. Version 1.0 of the UK IPC guidance (undated) **[RG/021 - INQ000325350]** is described as 'good practice' in the document. The reader is directed to Table 1 (page 24), 'Transmission based precautions: Personal protective equipment for care of patients with pandemic COVID-19' which advises the use of FFP3 masks only for AGPs or when present in an Intensive Treatment Unit or High Dependency Unit setting. It further states that in a general ward setting a surgical mask is sufficient, citing '*PPE for close patient contact (within 1 metre) also applies to the collection of nasal or nasopharyngeal swabs*'. There is no overt reinforcement or reference to the need for risk assessment under COSHH taking into account Table 1 recommendations given close contact with patients who may be coughing or expelling secretions as a result of Naso Gastric tube insertion, pharyngeal swab collection or other interventions. Such scenarios were a cause of concern to members as they clearly identified such situations as posing an increased risk for the transmission of infection in healthcare settings.

44. Some RCN members reported a lack of support when requesting RPE in circumstances when IPC guidance recommended surgical face masks as the IPC guidance was interpreted as unchallengeable. This combined with minimal visibility and alignment of health and safety statutory requirements and wider lack of local expertise in risk assessment of respiratory hazards left RCN members feeling unprotected and unsupported.

PPE distribution

45. The RCN recognise that governments across the UK, health agencies and other bodies worked hard to resolve distribution issues. However, actions to mitigate issues with PPE distribution were regarded by our members as having been too slow and not transparent. Public commitments did not effectively translate into increases in consistently deployed and accessible stocks of adequate PPE. RCN members raised their concerns as follows:

    a. *"I'm an Advanced Nurse Practitioner who visits nursing homes and would like to raise my concern about a lack of PPE/ face masks available to my colleagues who work in the nursing homes. There has been one confirmed case of Covid-19*

in a resident who is now in hospital but there are 15 other residents symptomatic who won't be tested. The staff only have gloves and aprons but no masks and cannot get any anywhere. The situation is extremely unsafe."

b. *"I am an Intensive Care nurse on the front line of the Coronavirus Pandemic. Our trust is unable to provide us with the correct PPE to care for patients with confirmed Coronavirus."*

c. *"I work in a frailty assessment team, currently we see patients in the community i.e. in patients own homes and care homes for admission avoidance. We currently have no PPE and are expected to assess patients that could be suspected [of] Covid-19. I feel [I] would be putting myself and other patients at risk. These concerns have been raised to managers who have insisted we just continue as normal."*

The RCN also received reports of PPE being removed from PPE stations, and of staff being told they would be challenged if "caught" wearing certain types of masks **[RG/022 - INQ000328902]**.

46. The RCN regularly expressed its concerns in correspondence to the Scottish First Minister, Wales First Minister, Northern Ireland First Minister and Deputy First Minister and the UK Prime Minister regarding the difficulties RCN members had in accessing adequate supplies of PPE (see paragraphs 140 to 228 below).

47. The RCN ensured, via its dedicated website page, that PPE supply and distribution processes across the four UK countries were explained for members and links to the relevant third-party websites were included to allow members to liaise directly with suppliers.

48. Local deviation from PPE procurement via NHS Supply Chain (England) led to variation in the quality and type of PPE available with donations of PPE/homemade products complicating oversight of the PPE status. The ability for NHS Trusts and other health and care providers to buy 'off catalogue' as an alternative to routine procurement routes remained in place. By way of example, the RCN received feedback from members that the purchase of gowns in April 2020 via alternative routes led to issues with availability of items via NHS Supply Chain (England). Health and care organisations struggled to receive full orders of PPE as supplied by national procurement agencies and therefore

attempted to secure stock from a variety of sources. RCN members reported this included sourcing items from other industries who did not usually provide to healthcare. This included fit test solutions or coveralls/visors from the fire service or construction industries. The local donation or manufacture of items such as visors for use by staff had the potential for variation in quality.

49. Due to ongoing PPE quality and supply issues, PPE continued to be procured locally, not via central procurement agencies, and therefore lacked governance oversight. As a result, poor quality transactions of PPE happened at the local level. The complexity of reporting these issues through official reporting channels (MRHA and HSE) clouded recognition at the national level.

Availability of PPE and the issues this led to including re-use of single use PPE

50. There were shortages of essential PPE in all settings and health and social care staff were reliant at times on PPE items being donated or home-made in some cases. As the excerpts from RCND call logs (at paragraph 57) demonstrate, many staff members were forced to compromise their safety to provide care to their patients. It is unacceptable for health and social care professionals to be exposed to avoidable risk to their own safety. As was evident from the responses received to the RCN PPE Survey in April 2020 (see paragraphs 20 and 21) there was a stark and deeply worrying contrast in the experience and safety of members from ethnic minority backgrounds compared to their white British counterparts.

51. Care homes were particularly affected by a lack of PPE, with some reporting that they were left with no option but to purchase their own or accept donations which did not meet required standards. In an honourable attempt to help frontline workers, members of the public produced PPE at home to support the overall effort. Whilst well intentioned, the RCN made clear that PPE worn by all health and care staff must, at all times, be of the correct standard as Health and Safety legislation was equally applicable to care homes and NHS settings. The RCN therefore discouraged healthcare workers from accepting any handmade PPE donations so as to ensure that healthcare workers had reliable and effective protection against infection and to ensure PPE was fit for purpose **[RG/023 - INQ000328903]**.

52. Conversely, a lack of PPE led some managers to 'stockpile' and preserve PPE supplies, which in turn led to some RCN members in different settings reporting that they were told they could face disciplinary action for wearing PPE to see 'low risk' patients. Such scenarios represent a lack of understanding of fundamental health and safety responsibilities by managers in conjunction with IPC guidance inadequately reinforcing the need for local COSHH risk assessment as opposed to blanket use of specific items such as surgical face masks as described in IPC guidance. The lack of visibility of the HSE and wider health and safety communications resulted in a dominance of IPC guidance, without a complimentary focus on health and safety requirements and aligned educational needs. This, we believe, led to confusion and an inadvertent prioritisation of IPC guidance content in the minds of managers who lacked experience to objectively interpret its application in the workplace. It is the view of the RCN that IPC guidance should be complementary to, and enable compliance with, Health and Safety legislation, not take precedence. The RCN's view is that the lack of recognition in the UK IPC guidance that SARS CoV2 could be spread via the airborne route, as recognised in MERS CoV and SARS clinical guidance, outside of aerosol generating procedures, was also a major barrier to managers and employers adopting a proportionate and focused approach to the protection of health care workers in line with existing requirements.

53. The RCN was disappointed and concerned at an apparent lack of visibility of HSE/HSENI input in key guidance that affected healthcare workers access to and use of PPE. As a minimum, given the seriousness of the situation and the concerns raised regarding PPE, the RCN would have expected for example, to have relevant health and safety logos or supportive statements on all IPC guidance and for any relevant national communications to be provided to external stakeholders and supported and countersigned by health and safety leaders.

54. The RCN verbally questioned during IPC meetings whether the HSE and Health and Safety Executive for Northern Ireland were members of the UK IPC cell where opportunities to input on guidance existed but we did not receive confirmation. The terms of reference for the UKIPC cell and its associated membership were not available in the public domain for transparency.

55. Early IPC guidance published on infection prevention and control was limited in its reference to health and safety statutory requirements resulting in the RCN's view, in an assumption that NHS Trusts had in place the knowledge/expertise to implement IPC guidance in a pragmatic way that met both IPC and health and safety requirements. For

example, in January 2020 'Wuhan novel coronavirus (WN-CoV) infection prevention and control guidance' makes only one reference to health and safety despite SARS CoV 2 having a High Consequence Infectious Disease' ("**HCID**") classification at that time. It stated, '*The hospital should be mindful of its responsibilities to persons who are not employees, under The Control of Substances Hazardous to Health Regulations 2002 and The Management of Health and Safety at Work Regulations 1999'.*

56. The RCN, as a member of the NHS Staff Council was a signatory to the published guidance on the need for COSHH risk assessments and adherence to health and safety requirements (February 2020) as previously described. This was issued due to concerns that clear communications on the need for risk assessment under COSHH were not present and that this limited opportunities for escalating or reporting of concerns.

57. Below is a summary of members concerns:

    a. *"Basically our PPE is apron, short gloves, fluid repellent theatre masks, and Christmas cracker glasses."*

    b. *"We have bare arms & faces. We are on the front line with these patients. I've had to wear my own protective goggles from home, a shower cap & colleagues have made makeshift protection wear out of bin bags in order to treat COVID-19 patients, we feel we don't have confidence in the issued PPE on the ward. And feel we are at risk of being infected & passing this virus to our families at home."*

    c. *"I work on a 48 bed Respiratory Ward. We are told that wearing a thin disposable apron, hand gloves & a surgical mask is sufficient to nurse a ward full of COVID-19 patients. How can this be a safe working environment when we're doing direct bedside nursing…"*

    d. *Nursing covid positive patients in a bay, other patients attend unit same time who aren't positive. Advised to re-wear gowns at first, now advised to wear bin bags.*

    e. *"My workplace is the Emergency Department and we do not have adequate personal protective equipment. Do I have to agree to put myself or my staff in*

situations caring for patients with Covid-19 without adequate PPE? We are being exposed with Covid-19 in open areas and only have a minimal supply of paper surgical masks. Other areas like ICU have full PPE. They come through the Emergency Department first."

f. *"We have been told that we are expected to attend to patients with Covid-19 symptoms without face masks unless they are diagnosed and confirmed. If they are confirmed cases then we can get face masks as part of our PPE but if not we can only have aprons and gloves even if our patients have temperatures, a new cough or a sore throat."*

g. *"I have been informed that there will be masks delivered to the [nursing] home but staff are not to have these unless there is concern of an outbreak within the [nursing] home. I was not sure if these should be given beforehand to prevent any outbreak as the past week patients have coughed and spat on me."*

h. *Member works in critical care and they have run out of protective goggles. Employer has now provided goggles from B&M and told staff to re-use them*

i. *"We have minimal PPE, only 2 FFP3 masks (for whole Neonatal Unit) and no visors, only 6 pairs of goggles which are meant to be disposable but we have been told to Actichlor [disinfect] and reuse. We do have gowns but only for positive patients otherwise suspected etc. we are to use yellow plastic pinnies. Thrown to the lions."*

j. *"In the recent published guidelines section 8.1, it states that full gown, visor etc. are required if phlegm (cough) is induced with AGP (Aerosol Generating Procedure). What I don't understand is, if coughing is induced by a procedure and full PPE is required why on earth am I caring for up to four positive patients in one bay, who can all be coughing constantly, with just a surgical mask, plastic apron (which does not cover me because I'm overweight), goggles and fully exposed arms and a pair of gloves. Why?"*

58. Given the shortages of PPE experienced particularly during the early stages of the pandemic, PHE produced 'The Public Health England Acute Shortages Guidance' on 17

April 2020 which aimed to highlight the "*sessional use and re-use of PPE when there are severe shortages of supply. The considerations are to ensure that health and care workers are appropriately protected from Covid-19 where items of PPE are unavailable and should be considered as temporary measures until the global supply chain is adequate to meet the UK's needs"*. This followed the decision to downgrade SARS CoV2 as a HCID. This decision by the UK government did not remove the need for nursing staff and other health professionals to have access to and use of PPE, including RPE in line with risk assessment and the classification of SARS CoV2 as a Group 3 biological hazard. A Group 3 hazard is described in the HSE's Approved List of biological agents, as a biological agent that '*can cause severe human disease and may be a serious hazard to employees'*. It remains a group 3 biological agent at the time of my statement.

59. Whilst the RCN cannot comment on the Government's decision and subsequent transparency regarding the decision to downgrade SARS CoV2 as a HCID at this time, this decision did not, in the view of the RCN, justify the blanket application of IPC guidance on use of FRSM when caring for patients with Covid-19 as described in NHSE and NHSI correspondence dated 20 March 2020 **[RG/024 - INQ000252604]**, regarding the supply and use of PPE and associated FAQs guidance of the same date **[RG/025 - INQ000384374]** The FAQs do not refer readers to the need for risk assessment nor do they make reference to health and safety requirements under COSHH. This, together with the IPC guidance, served to override Health and Safety legislation without consultation or transparency on decision making.

60. It is a legal requirement that suitable and sufficient workplace risk assessments are carried out and adequate control measures identified to reduce risk as far as reasonably practicable, in accordance with Regulation 3 of the Management of Health and Safety at Work Regulations 1999 and COSHH. Individual clinicians should have been empowered to decide the correct PPE they required based on their own dynamic risk assessments and informed by their organisation's workplace risk assessment. Anecdotal evidence from members indicated that such workplace risk assessments were absent or, where they did exist, were inadequate. Reference to the hierarchy of controls as described in IPC guidance of March 2020 was, in the view of the RCN confusing as this represented unfamiliar language to many employers and staff (except health and safety professionals employed by the organisation), was not implementable given the airborne route of infection and poor ventilation in many areas and did not emphasise the risk assessment aspects of controls under COSHH.

61. The Public Health England Acute Shortages Guidance April 2020 was developed without full and formal consultation with the RCN. The RCN was not informed that work to develop guidance on reprocessing of PPE had been proposed or commenced and viewed this exclusion as detrimental to discussions and decision making. This situation was another example of failures to consider guidance beyond technical aspects, led by 'experts' to the detriment of open debate and anticipated implementation challenges. The RCN made plain in its correspondence to the HSE on 17 April 2020 (see paragraph 106 below) that it was not acceptable to publish this guidance without appropriate consultation. Only sound scientific evidence and/or detailed discussions with relevant professional, scientific and legislative bodies should have resulted in any changes to existing guidance. Nursing staff needed to have confidence in health and government leaders and wider system working. This is crucial in times of unprecedented challenge where health professionals are at personal risk as a result of their role and work.

62. The reuse of single-use PPE, as suggested by PHE, was deemed unacceptable, and the RCN did not support this guidance which deviated from other UK countries positions (see paragraphs 63 and 64) **[RG/026 - INQ000328904]**. This was a significant risk to health and care workers and to their patients. Given the mounting concerns regarding limited availability of PPE, the RCN published advice to members regarding 'refusal to treat due to lack of adequate PPE' on 09 April 2020 **[RG/027- INQ000328905]**. This advice offers a step-by-step guide to determine whether to refuse to treat. The guidance refers to the UK Infection Prevention and Control government guidelines and, in combination with the RCN's guidance document 'PPE – are you safe?" **[RG/028 - INQ000328947]**, sets out the steps that members should take to determine what they need in order to be safe and how to escalate matters and document these for record keeping purposes if they have not been provided with the necessary equipment, training, information, or if they have any concerns relating to those. The guidance also suggests that the nurse should 'take part in identifying changes to the way that you work that reduce the risk to you short of refusing to provide treatment at all'. It is clear that refusal to treat was a last resort only if all other measures had failed or were unavailable.

63. The RCN were concerned about the approach to PPE shortages in the Devolved Administrations. Scotland and Wales had committed not to implement The Public Health England Acute Shortages Guidance. The RCN urgently requested similar reassurances be given from Northern Ireland and England in correspondence dated 18 and 22 April 2020 respectively **[RG/029 - INQ000328906] [RG/030 - INQ000328912]**. A response

was received on 11 May 2020 from PHE **[RG/031 - INQ000328907]** in which they noted that the guidance for shortages on PPE had been published at the request of DHSC and NHSE, and delivered by PHE and the HSE as severe shortages of face masks and gowns were predicted for the weekend of 18-19 April 2020. PHE acknowledged that due to the urgency of this guidance, it did not believe it had time for wider consultation.

64. Robin Swann, Minister for Health in Northern Ireland, responded on the same day, assuring the RCN that the revised PHE guidance had not been implemented in Northern Ireland **[RG/032 - INQ000328908]**. A letter from Conor Murphy, Minister of Finance was also received on 20 April 2020 in which he endorsed the RCN's stance on PHE's revised guidance on the grounds of staff safety **[RG/033 - INQ000328909]**.

65. These concerns were shared with NHSE and NHSI, Chief Medical Officer ("**CMO**") for England Chris Whitty and Chief Nursing Officer ("**CNO**") for England, Ruth May on 14 April 2020 via email correspondence **[RG/034 - INQ000328910]**. They noted that the implementation of PPE guidance was a matter for local employers who were responsible for adherence and training.

66. Dame Donna Kinnair, RCN Chief Executive and General Secretary at the time, subsequently wrote to the Secretary of State for Health and Social Care on 21 April 2020 **[RG/035 - INQ000328911]** and the Chief Executive of PHE on 22 April 2020 **[RG/030 - INQ000328912]**, raising concerns about the lack of consultation with the RCN and advising that we were unable to endorse the guidance as our view was that members needed to have the necessary PPE required, which was their legal right, in order to be able to safeguard both themselves and their patients. We also demanded the opportunity to be included in future consultations and requested details of the evidence base on which the revised guidance had been issued.

67. A brief response was received from the Chief Executive of PHE on 11 May 2020 **[RG/036 - INQ000328913]**. The letter advised that the guidance had been rapidly issued at the request of the HSE in light of predictions of severe shortages of face masks and gowns. Although the letter indicated that PHE was committed to working with the RCN and wished to hear concerns raised by our members, disappointingly, the letter failed to provide details of the evidence base requested by Donna Kinnair.

68. I contacted PHE on 22 May 2020 **[RG/037 - INQ000328916]** following concerns received from members about the reallocation of half masks (respirators) between staff once cleaned at the end of the shift. I highlighted potential risks with this practice and requested that the current IPC guidance be updated to reference individual allocation of the respirators. I understand that my query was forwarded to the HSE Centre for Workplace Health who provided a brief response on 23 May 2020, advising that the reuse of half masks RPE is a normal procedure for a number of workplaces where there is a pool of RPE in use and that correct cleaning to the manufacturer's protocols is ensured by adequate supervision of staff **[RG/038 - INQ000427443]**.

Fit testing, fit testing training and difficulties which arose due to physical attributes

69. One-size-fits-all protective equipment had been a problem for frontline healthcare workers who had to wear this life saving equipment for up to 12 hours at a time. A number of brands were not producing masks to fit female faces, particularly with the shape and design of masks being too big and causing many female nurses and doctors to fail the fit testing process. An illustrative selection of the concerns raised by members follows.

a. *Member wears a headscarf. Member has been told to remove this. Member is wearing only surgical mask. Employer says that member has to remove scarf as she has failed fit test.*

b. *"When we first started dealing with suspected COVID-19 patients we were told we must change into hospital scrubs, wear full plastic apron, gloves and appropriate fit tested mask and visors. Now that stock is running out we are being encouraged to nurse suspected Covid-19 patients for hours wearing only our own uniform with a disposable pinny on, gloves and a surgical mask (not a fit tested one and not a visor)."*

c. *"None of my team at the moment have been fit tested for an FFP3 mask. We have now been told that there are not enough masks to test everyone so we will not be fit tested. Instead they recommend picking any FFP3 mask and for checking instead. Is this correct and in line with current guidance? Is this not putting us at risk?"*

d. *"The PPE is very poorly produced, is one size, so for example the visors fall off and does not instil confidence."*

e. *"Staff test one mask and then get issued with a different type of mask so have to fit test everyone again. No one has the capacity to keep doing this."*

f. *Member has to wear PPE for every shift but member has been having problems – disposable masks don't fit member. Have previously been told to fit check instead of fit test – but that's now changed couple weeks ago. Need to fit test everything now but masks just don't fit member's face – has to fight to get one that does. Member needs size small and they're just not coming in.*

g. *"I am a nurse of 15 years. I have hearing loss and wear bilateral hearing aids. I am struggling with patients and staff wearing masks as I rely on lipreading and facial expressions. I am at the point of giving up."*

70. As a consequence of these concerns being raised, on 31 March 2020 the RCN wrote an open letter to the Chief Executive of the HSE, calling for their intervention to ensure the adequate availability of fit testing, and to ensure that employers comply with Regulation 4 of the PPE at Work Regulations 1992 which stipulate *'that suitable PPE must be provided to employees who may be exposed to a risk to their health and safety while at work'* **[RG/039 - INQ000328917]**. The RCN received an unsatisfactory response **[RG/040 - INQ000417540]** and had expected the HSE to act given the extreme seriousness of the situation (see paragraph 157 below).

71. FFP3 respirator masks - which are needed for the highest level of respiratory protection to prevent a hazard (SARS CoV-2) from being inhaled - require users to be fit tested to ensure that the masks fit correctly. Each brand of FFP3 mask fits differently and therefore users must undergo subsequent fit testing for each brand. Nursing leaders reported being given up to 17 different types of masks within one Trust which meant that the fit testing of all staff was repeatedly required, and some members reported that equipment needed to undertake the fit testing was an additional procurement and supply issue.

72. The RCN also raised the issue of gender and PPE, specifically how some brands of FFP3 do not appropriately fit female faces, with the British Safety Industry Federation ("**BSIF**") in correspondence dated 28 May 2020 **[RG/041 - INQ000328920]** (see paragraph 170 below).

73. Incidents of concern arose throughout the pandemic whereby a number of healthcare staff, including nurses, were put at risk due to the incorrect fit testing of respiratory masks. On 01 July 2020, Pat Cullen, the then Director of RCN Northern Ireland, wrote to the Public Health Agency, the Department of Health for Northern Ireland ("**DoH Northern Ireland**") and other Health and Social Care Trusts in Northern Ireland to express the RCN's concerns in respect of this issue **[RG/042 - INQ000328921].** Whilst an independent level 2 serious adverse incident review of this issue was announced by the Public Health Agency, the RCN sought reassurances regarding the composition of the review team and the terms of reference to ensure that the same was entirely independent.

74. On 03 July 2020, the DoH Northern Ireland responded **[RG/043 - INQ000328922]** noting how, in response to this issue, the Public Health Agency would also bring forward a regional fit testing assurance framework to ensure all fit testing was standardised across the region. HSENI were informed of this issue. HSENI wrote to all Health and Social Care Trusts seeking a report in respect of the fit testing incident.

75. A further incident arose in at least one NHS trust in England concerning the incorrect fit testing of respiratory masks, whereupon a Portacount machine had been set to US standards of fit testing, rather than UK standards. The RCN wrote to the HSE on 20 July 2020 **[RG/044 - INQ000417660]** raising this issue and asked that they investigate and alert other NHS organisations accordingly. A response was received on 30 July 2020 **[RG/045 - INQ000417582]** in which HSE confirmed they were on notice of the incident and had drafted an alert to send to all NHS Trusts and other health and social care sector providers to ensure all quantitative face fit testing machines were set to UK test protocols.

IPC guidance

Stakeholder engagement

76. The RCN found that there was a serious lack of engagement with wider stakeholders and representatives of the health and care sector when developing, reviewing and updating IPC guidance. The RCN's expectation was that stakeholders would be engaged in the development of guidance as per our previous experience of major incidents of infectious disease. As the pandemic progressed our correspondence was often ignored or offers to meet to provide evidence turned down as detailed in the chronology below (see paragraphs 140 to 228). The RCN would expect that, considering the fundamental role the nursing profession has, as the largest professional workforce in health and care delivery across all sectors, in implementing IPC measures on the ground, the guidance-making bodies would want to particularly engage from the outset with those who have unique and useful expertise and are ultimately responsible from implementing guidance in practice.

77. The RCN's working relationship with government healthcare bodies during the relevant period, was too restricted at times, in that whilst the RCN tried to engage widely as a professional body and Royal College this was not reciprocated. This led to restricted, reactive relationships. Despite multiple attempts made by the RCN, both on its own and in collaboration with other professional stakeholder organisations, to engage with the UK government and its agencies on serious issues largely relating to the IPC guidance, no significant changes to guidance, and therefore the management of risk to our members and patients, had occurred. This included attempts to redress this through letters to the Prime Minister, PHE and CMO and during the IPC guidance stakeholder meeting on 3 June 2021 (see paragraphs 209-210 below). Our attempts to influence meaningful stakeholder inclusion and engagement in guidance development were met by the UK government and its agencies with disinterest. Similarly, our efforts to engage in light of growing international scientific evidence of airborne transmission of Covid-19 were dismissed as NHSE and Health Protection Scotland remained committed to a dogma of droplet transmission despite no evidence supporting this for a novel pathogen and existing/current PHE guidance on MERS CoV management via aerosols (see paragraphs 83 to 94 below). It should be noted that SARS CoV-2 remained a Group 3 biological hazard throughout this period and remains as such.

78. The RCN was excluded from meetings involving the Medical Royal Colleges, which resulted in delays in communication and negatively impacted the RCN's situational awareness and ability to raise questions and/or concerns. This was raised in an email to Alistair Henderson, Chief Executive of Academy of Medical Royal Colleges on 31 January 2020 **[RG/046 - INQ000328928]**. The RCN was not, to the best of my

knowledge, invited to attend any subsequent meetings. Whilst the RCN is not a member of the Academy of Medical Royal Colleges, the two organisations have a close working relationship and, in my experience, the RCN was often included in key meetings that involved the other medical Royal Colleges. The RCN's absence from these key meetings to my mind demonstrates that the UK government did not consider that nursing was an equal partner to the medical Royal Colleges in managing the response to Covid-19, despite the fact that the RCN represents the largest number of healthcare workers of any Royal College. The RCN, instead of being around the table with its medical and clinical counterparts, was forced to receive the information imparted by the CMO second-hand via the Royal College of General Practitioners. Not only was this state of affairs highly disrespectful to the nursing profession, it caused unnecessary delays in the dissemination of vital information and created tensions that absorbed energy that could have been much better used elsewhere.

79. Limiting stakeholder engagement impacts on the ability to review guidance and consider its implementation across care settings. The RCN continuously raised its concerns, as set out in the chronology that follows at paragraphs 140 to 228, that the IPC guidance was inconsistent with the evidence on airborne transmission and was defective in terms of failing to reinforce the need for healthcare employers to consult staff and undertake effective local risk assessments that reflected the needs for flexibility in infection control.

Transparency of decision-making

80. Our concerns regarding the need for multi-professional engagement were raised early in the pandemic in an email to the EPRR Clinical Reference Group dated 29 January 2020 **[RG/002 - INQ000114354]**. The alignment, governance and interconnectedness of multiple cells supporting the pandemic, once the EPRR Clinical Reference Group was stood down in February 2020 and the clinical cell was established, remained a cause of continuous concern with implications for IPC guidance development and implementation. It is not known how decisions were made regarding where guidance development, including IPC was to be structured or supported and how matrix working across cells, for example public health, social care, would be managed. The RCN was also very concerned at the apparent absence of a governance and risk cell such as that established during the EVD incident to support decision making at a time of unprecedented challenge.

81. The lack of transparency around infection control guidance decision making and governance of various teams/cells was a matter of serious concern to the RCN. The minutes of IPC cell meetings, membership and terms of reference were not publicly available. Similarly, many of the decisions made, such as the decision on a change in status of Covid-19 as a HCID in March 2020, and data on healthcare worker infections via the Hospital-Onset COVID-19 Infections ("**HOCI**") study, were not publicly available or underpinned by minutes of any committee or the evidence used in support of these pivotal decisions. This also meant that key decisions were not transparent or open to scrutiny by and constructive debate by others.

The evidence base and updates to guidance to reflect emerging evidence

82. At the beginning of the pandemic, despite early IPC guidance stating the airborne route of transmission, it was subsequently stated that respiratory secretions containing the virus travelled over short distances as droplets and settled quickly under gravity and this was the dominant route of transmission. These droplets can contaminate the close environment of an infected person. Consequently, physical distancing, fluid resistant surgical face masks (Type 11R) to protect workers against exposure to physical droplets, and hand hygiene were regarded as the most important infection prevention measures in clinical guidance. Airborne transmission and the implications of this appear less important, and the role of respiratory protection was disregarded unless under specific situations such as AGPs. The airborne route of transmission in the view of the RCN also had significant implications for patient safety and the risks to patients who could easily acquire Covid-19 in health and care settings. UK infection prevention and control guidelines to prevent the spread of Covid-19 in health care settings and the rapid reviews of the literature undertaken by Health Protection Scotland on which it was based, identified and maintained droplet spread as the major route of infection and promoted hand hygiene as a key infection prevention measure, based on early advice from the World Health Organisation ("**WHO**"). This, as previously stated, is not in line with existing and current IPC advice (in England) on the management of MERS CoV, a member of the Coronavirus family. Evidence indicates that aerosol spread is much more significant and the original advice from the WHO was quite quickly superseded.

83. The RCN raised its concerns with NHS England and NHS Improvement via email on 26 February 2020 regarding the IPC guidance on decontamination of healthcare facilities and the PPE required **[RG/047 – INQ000475215]**. In my email I highlighted how primary care guidance was advising different standards of PPE for decontamination of the

environment. I queried why there were differences in the guidance on the use of PPE given the potential for exposure to the same risk and asked for clarity on the rationale for this difference. In response, NHS England and Improvement confirmed that they were aware of the discrepancies in the wide range of guidance currently available and noted that the IPC cell, with assistance from PHE, HSE and Devolved Administrations were working to align the guidance in all primary care settings. The RCN however remained concerned from a COSHH perspective as to why different levels of PPE protection to staff was being advised regardless of the setting and again sought clarity. In their response dated 28 February 2020, NHS England and Improvement noted that whilst the predominant mode of spread is from droplets, or a contaminated inanimate environment following transfer by hand to mouth, nose of mucous membranes, they acknowledged that there was a perceived risk of airborne spread from aerosol particles. The risk was deemed likely to be proportionate to the length of time the affected patient was present in the room. NHS England and Improvement sought to draw a distinction between an inpatient isolation room versus a primary care setting where a suspected patient "*is not an in-patient and so their time in a room has been much less and cleaning would not be undertaken while the patient was in the room*."

84. The RCN first started to heighten its consideration of the role of aerosol transmission outside of AGPs between March and April 2020. Up to that point we had trusted national agencies to undertake thorough scientific reviews and maintained a position of support in public so as not to be seen to be undermining a national effort at a time of huge public concern. IPC guidelines however continued to be based on outdated evidence on the transmission of SARS CoV-2, in our view. The RCN was so concerned that it took the extraordinary step in February 2021 to commission an Independent Review of Guidelines for the Prevention and Control of COVID-19 in Health Care Settings in the UK **[RG/048 - INQ000114357].**

85. This Independent Review was commissioned by the RCN and conducted by Professor Dinah Gould and Dr Edward Purssell and was published on 28 February 2021. This review focuses on the rapid literature reviews undertaken by ARHAI Scotland and updated approximately every month, which formed the basis of UK IPC guidelines at that time. The Independent Review found that the Scottish Rapid Review of evidence to inform IPC guidance was not conducted in accordance with the accepted procedures even for rapid reviews in emergency situations, and that it had not been appropriately updated in the 11 months since its publication. In particular, the Independent Review

highlights the lack of consideration given to evidence of airborne transmission and ventilation of health care premises despite research being conducted into these matters which was published during the relevant time period. The Independent Review also found that insufficient consideration was given to evidence of aerosols generated by coughing and ordinary speech as it focused on aerosol generating procedures.

86. From these findings, the RCN Independent Review concluded that the UK guidelines that were derived from this rapid review had not been appropriately constructed or updated to address the situation as it had developed, particularly with regards to the use of respiratory protection. The review clearly outlined how UK IPC guidance had not adequately evolved taking into account emerging evidence. It was critical that UK IPC guidance developed and approved jointly by all 4 national IPC teams had not followed existing WHO's guidelines for emergency advice reviews and recommendations arising from them. The WHO guidelines were used as a framework to critically appraise the development of UK IPC guidance and the findings published with recommendations from the authors. The RCN Independent Review recommended that a more thorough interim review should be conducted by a multidisciplinary team with multi-professional stakeholder involvement and peer review, which would continue to be updated monthly to respond to new knowledge.

87. As a key element of IPC guidance designed to protect both health professionals and patients, the RCN is unclear why, in the absence of any evidence regarding the predominant route of transmission of SARS-CoV2 via large droplets, this was changed and amended from statements included in IPC guidance in the early phase of the pandemic. This IPC guidance change directed health professionals to use surgical masks in place of RPE, ignoring the advice contained within existing PHE MERS CoV guidance (2016). SARS CoV2 remained a class 3 biological hazard, as defined by HSE's Advisory Committee on Dangerous Pathogens following downgrading of the virus as a HCID in March 2020. The RCN considered this classification as warranting a different approach to the selection and use of PPE, specifically RPE, taking into account COSHH, than was advised in IPC guidance at that time. At a time when strong evidence of the transmission dynamics of SARS-CoV2 may not have satisfied those developing and approving IPC guidance, the RCN expected a more precautionary approach to be adopted, rather than the position of 'no evidence', to justify no change to IPC guidance.

88. Additionally, the RCN is unclear as to the extent to which PHE scientific advice and existing guidance, such as that for MERS CoV-2, was taken into account by the NHS IPC

team and wider UK IPC Cell. Having worked closely with PHE to support a number of international incidents, it is my understanding that PHE provides scientific evidence and data which other organisations, for example NHSE should incorporate when developing guidance. This is further described in the PHE 2019 Remit Letter published in March 2019.

89. In the early months of the pandemic, national guidance and policy on PPE did not maintain pace with the changing risks and emerging realities of the virus. The RCN considers that the UK IPC guidance was slow to be revised and not standardised, with hospital and non-hospital settings provided with different sets of guidance by different organisations. Leading on from this it is unclear how literature reviews from Health Protection Scotland were commissioned and how information gained was scrutinised given its critical importance in shaping what became UK IPC guidance. The RCN considered it important that the most up to date data and knowledge on emerging variants such as increased transmission dynamics, be reflected in PPE guidance, or where evidence was not available, risk assessment via COSHH is promoted and a precautionary approach to the use of PPE considered.

90. IPC guidance, first published by PHE, failed to robustly acknowledge, and align with Health and Safety requirements from the earliest iterations of guidance based on SARS CoV-2 as a HCID. The RCN notes that in January 2020 Wuhan novel coronavirus ("**WN-CoV**") which preceded the nomenclature of SARS CoV-2, was described as "*an airborne high consequence infectious disease ("HCID") in the UK*". This position supports RCN concerns referenced previously as to why influenza guidance, with a documented predominance of droplet transmission, was later adopted rather than existing guidance on the management of coronavirus such as MERS CoV. The guidance made only one reference to health and safety statutory requirements despite SARS CoV2 being classified as a HCID at the time. It stated "*The hospital should be mindful of its responsibilities to persons who are not employees, under the Control of Substances Hazardous to Health Regulations 2002 and The Management of Health and Safety at Work Regulations 1999*". This trait was continued once UK IPC guidance development was coordinated by NHSE.

91. The RCN is unclear why responsibility for guidance development moved given the role and responsibility of PHE at the time and the ability to consider all care settings within guidance, not just NHS needs. It is the RCN's view that, given the importance of IPC guidance in situations such as a pandemic, the absence of clear alignment to Health and

Safety requirements, including COSHH, confused employers, lowered the profile of Health and Safety legislation and was disruptive to efforts to protect healthcare workers following the downgrading of SARS-CoV-2 as a HCID. This approach continued to the detriment of RCN members who attempted to access RPE outside of scenarios where these were recommended in IPC guidance. Employers must be supported to respond quickly and urgently to best protect their staff and patients in incidents such as this in the future.

The Independent Review

92. The RCN was involved in the work of the AGP Alliance (now the Covid Airborne Protection Alliance) from January 2021. The AGP Alliance was a coalition of organisations formed with the purpose of influencing the governments and health services in all four nations of the UK in relation to recognising the full range of defined AGPs and changing the government's guidance on PPE to better protect health care workers. The RCN supported a request, made by the AGP Alliance in February 2021 **[RG/049 - INQ000114330]**, to meet with the CMO for England to discuss the implications of the Public Accounts Committee Report "*Covid-19: Government procurement and supply of Personal Protective Equipment*" published on 10 February 2021. Professional bodies and unions, including the RCN, were concerned that AGPs had been given over prominence in the IPC guidance because of a single-minded adherence to the dogma of droplet transmission, and, as a result the IPC guidance was inadequate to protect frontline staff when in close proximity to suspected or known people with Covid-19.

93. The disappointing response from PHE dated 17 February 2021 **[RG/050 - INQ000114314]**, noted how the UK-wide IPC cell had undertaken a review of the evidence and had determined that no changes to the current PPE requirements were needed. The issue was of particular concern at that time due to the emergence of a more transmissible variant of SARS CoV-2 and the implications for infection and the increasing absence of health and care professionals either due to infection with Covid-19 or shielding. This response prompted the RCN to commission an Independent Review of the UK IPC guidance (the "**Independent Review**") **[RG/048 - INQ000114357]** published on 07 March 2021. This was not a measure the RCN would have expected ever to have to take, but the organisation felt compelled by the inaction of the UK IPC cell, PHE and the UK government. The Independent Review received significant push back from senior health leaders in the four countries on publication. Despite push back by UK health leaders and IPC specialists, the report was widely shared internationally and

acknowledged as exemplary work with implications for learning and the management of future pandemics. The RCN does not understand how, given feedback that UK IPC aligned with WHO guidance on Covid-19, the UK IPC cell did not follow existing internationally based methodologies which were available from WHO at that time.

94. The Independent Review acknowledged that there was a need for the rapid synthesis of the available infection prevention and control evidence at the beginning of the pandemic when the novel coronavirus first emerged. Twelve months into the pandemic, the continuing use of the same rapid review to inform UK wide-guidelines for infection prevention and control was questioned, opinions about the way that Covid-19 was transmitted had changed, and it was becoming apparent that airborne transmission of SARS-CoV-2 beyond the technical process of aerosol generating procedures was possible. The Independent Review also highlighted that the IPC guidelines omitted detail on the importance of ventilation and advised that higher level PPE must only be provided in certain high-risk settings like intensive care, however as a result of risk assessment it is the responsibility of individual employers whether or not to provide this more widely to other staff.

95. The report was shared with a number of key stakeholders including the four CNOs **[RG/051 - INQ000417619]** and **[RG/052 - INQ000417620]** and was published on the RCN's website. As a consequence of this rapid review, a meeting was held with Deputy CNO, Sue Tranka, on 17 March 2021. I recall that the meeting was very challenging, and the RCN received significant pushback as documented in my notes following the meeting **[RG/053 - INQ000328927]**. In commissioning the rapid review, the RCN reiterated it was responding to concerns raised by members and stakeholders over a period of time and action needed to be taken to listen those concerns and to act on them in the absence of meaningful support and interaction from IPC leaders as members of the UK IPC cell led by NHSE. The report was undertaken after a series of considered steps had already been taken to no avail and the noticeable lack of response to reasonable questions raised by the RCN and assurance sought from senior NHS and Government leaders. The Independent Review was generally very well received by scientists, academics and stakeholders externally. A response to the Independent Review was posted to a blog on NHS National Services Scotland website on behalf of the National IPC Cell on 15 April 2021 although the link no longer remains active **[RG/054 - INQ000427452].**

IPC guidance regarding the selection and use of PPE

96. Members contacted the RCN and raised the following concerns:

a. *"I have concerns re provision of protective equipment specifically face masks in care of suspected and confirmed cases of Covid-19. Contradictory information when health experts advised the masks being worn by public in UK & other countries had limited effect. Now Health Care Workers advised standard masks will provide adequate protection when in close proximity to patients with or suspected at having Covid-19. What has changed where is the evidence these masks will prevent transmission?"*

b. *"As I am sure you are aware, new PPE guidance was produced in the last two weeks by Public Health England, Scotland and Wales. This guidance has been endorsed by WHO (World Health Organisation) however it does differ from their own guidance. My two main concerns are the use of surgical masks and not FFP masks and the use of aprons and not gowns for healthcare professionals nursing suspected and confirmed Covid-19 patients. Nurses and Doctors do not feel protected from this virus and they are terrified that they are going to lose their lives. Colleagues have written letters and cards to their children because they are scared that this virus will kill them."*

c. *"Nurses and Doctors are looking after suspected and confirmed Covid-19 cases on wards where they are advised as stated in the guidance that a plastic apron is enough to protect their uniform. The official line on the absence of gowns released with the new guidance states that gowns are not required because there is a bare below the elbow policy. This does nothing to address the fact that health care professionals are in close proximity to patients with suspected or confirmed Covid-19 with their uniforms exposed. The Centres for Disease Control and Prevention & WHO have noted that the virus may remain viable for hours to days on surfaces made from a variety of materials including clothing. When a patient is confirmed with Covid-19 the drug chart is rewritten and the old one is quarantined. The medications are taken out of the room and kept separately. The trial documentation that the patient signs is put straight into an envelope and then sealed. Yet there is a real disparity between these type of actions and the use of aprons and not gowns because if this virus is so contagious why are our uniforms exposed? The uniforms*

that we sit in to eat our food, the uniforms that we need to take off over our heads at the end of every shift…"

d. *"Health care professionals are also frightened of wearing just a surgical mask with suspected and confirmed Covid-19 patients. We know that an FFP mask offers more protection than a surgical mask…It is only those who work in acute areas such as A & E and Intensive Care that get to access FFP masks but those that work on the wards are also at risk of exposure as they care for Covid-19 patients with potentially high viral loads."*

e. *"We were sent new PHE guidance today through our employer outlining their new guidance on PPE including community practice. Very little has changed. I keep seeing the same message when it comes to PPE outside of ICU, wear a plastic apron, paper mask & gloves, & if the patient is coughing, goggles or a visor. However at the same time I hear countless concerned voices (including my own) from GPs and community nurses asking, are we REALLY safe with just this? The WHO recommends that along with a surgical mask & gloves staff should wear gowns when carrying out care on confirmed Covid19 patients in their homes. This makes sense given the fact we drive from patient to patient & so potentially spread the virus at each visit if droplets land on our uniform. We can wash our arms but cannot protect our uniform & hair with a small plastic apron. Everything I read in the UK tells me gowns are only necessary for when carrying out aerosol generating procedures. But when caring for patients dying at home, as we will be doing a lot of soon, who are coughing, the PPE we are being provided with & assured is safe, feels woefully inadequate…Why is it that Public Health England are recommending less than the WHO? Could it be simply a matter of supply? As a nurse concerned for my safety, my family's safety & my patients' safety, I feel my concerns are shut out by a system that tells me my fears are unjustified because the protection I have been provided with (that leaves me feeling exposed) is entirely adequate."*

f. *"The PPE recommendation of the government for staff who work in COVID wards without aerosol treatment is not enough to protect us. The management will not supply us long gown or FP3 despite of numbers of patient are persistently coughing or on high amount of oxygen because they are not considered as aerosol generating treatment. We are risking our life and the ethical obligation of our employer is to keep us safe."*

g. *"Latest information from BAPEN states that NG feeding should be classed as an aerosol generating procedure. The government advice however is that NG feeding is not an aerosol generating procedure. Does the NMC or RCN have a stance on this as we are struggling to get the PPE including FFP3 masks for this procedure."*

97. Throughout this pandemic, clarity on when or how PPE should be used effectively to keep staff and patients safe, had been missing. Initial UK IPC guidance (version 1, March 2020), published after SARS CoV2 was downgraded as a HCID failed to reflect the standardised adoption of a precautionary approach to the protection of healthcare workers. The guidance was confusing and contradictory as evidenced by the following: 2.1 Routes of transmission states "*Infection control advice is based on the reasonable assumption that the transmission characteristics of COVID-19 are similar to those of the 2003 SARS-CoV outbreak*". SARS remained classified as an airborne HCID, and although a decision had been made to downgrade SARS CoV2 the route of transmission remained as airborne.

98. The reference to predominance of droplet and contact spread via the rapid review of evidence (Scotland) did not concur with existing PHE guidance on MERS CoV and an absence of hard scientific evidence or proof of droplet /contact spread as the predominant mode of spread between people.

99. The RCN also considered the introduction of language into pandemic guidance such as the 'hierarchy of controls' on the use of PPE, to be both confusing and inappropriate in a situation where evidence and views on transmission routes was divided and many employers were unfamiliar with the language.

100. The RCN views the limited reference within IPC guidance to Health and Safety legislation and risk assessment process insufficient. Combined with no implementation plan, this guidance was of limited value to managers and employers with no experience of applying the hierarchy of controls in a situation where staff were exposed to a respiratory hazard of this magnitude.

101. The RCN had further concerns relating to a widely accepted view that ventilation, with the exception of specialist areas such as ITU and operating theatres, was poor in most in-patient areas as a result of an inability to open widows and a lack of mechanical ventilation. This in reality diminishes the value of the hierarchy of controls, with an emphasis of responsibility on managing the unmanageable, before use of respiratory

PPE was considered appropriate by IPC guidance. In my view as a specialist advisor to the RCN, stronger visibility and detail on Health and Safety requirements and how to manage the selection of PPE in situations where ventilation was known or suspected to be limited should have been developed or, as a minimum, embedded in IPC guidance. There was no indication at this time that members of the HSE were involved in or supported the development of IPC guidance.

102. The lack of clarity around PPE guidance left our members feeling unsafe and resulted in a confused situation for RCN staff advising members on this topic. The RCN was clear that it would not issue separate RCN guidance but seek to influence via the NHS IPC team. A full understanding of the transmission dynamics of Covid-19 and published international literature continued to emerge in March/April 2020 and the RCN sought to influence IPC and PPE guidance through stakeholder engagement routes with the expectation that these would be developed as per the experience of EVD and H1N1 pandemic.

103. As the pandemic progressed, members raised concerns at apparent differences in standards of protection to those provided in some European countries following the downgrading of SARS CoV2 as a HCID on 19 March 2020.

104. The increase in staff healthcare acquired Covid-19, alongside increased staff absence in April 2020, resulted in the RCN being asked to respond at very short notice to revised IPC guidance aligned to a nosocomial 'Transmission of Covid-19: 4 Nation CNO (IPC) Response' briefing on 20 April 2020 **[RG/055 - INQ000328929]**. The governance and responsibility for leading this work was unclear. This resulted in increased confusion regarding how PPE guidance was being developed, the approach to a standardised whole system policy (covering the NHS, community care and adult social care) for the protection of healthcare workers and accountability for decisions on guidance content and sign off.

105. Activity on PPE and IPC guidance escalated significantly in April 2020. On 16 April 2020, a number of gov.uk webpages associated with IPC and PPE referred to the UK as experiencing 'sustained transmission'. This had consequences for nursing and midwifery staff on the type of PPE to be worn in accordance with the four PPE tables, of which table 4 related to 'sustained transmission'. It was not therefore clear why PPE tables 1-3 remained in situ on the gov.uk webpages. I flagged this discrepancy to PHE along with a

request for clarity given that this was causing confusion with employers using a variety of tables to allocate PPE in care settings.

106. On 17 April 2020, PHE published 'Considerations for acute personal protective equipment shortages guidance' (also known as The Public Health England Acute Shortages Guidance) without consultation with the RCN. In order to circumvent a lack of disposable gowns, and despite IPC guidance from WHO and HSE to the contrary, the use of coveralls was being promoted as a suitable alternative. On 16 April 2020, I emailed HSE to clarify which type of coveralls met the requirements of the UK PPE guidance (updated 12 April 2020) in light of the queries raised by members **[RG/056 - INQ000328930]**.

107. On 17 April 2020, the RCN wrote an open letter to HSE regarding the government's continued failure to provide sufficient and suitable PPE in all health care settings. The RCN formally requested HSE's intervention to ensure the timely support of sufficient and suitable PPE **[RG/057 - INQ000328931]**. We are unable to locate a similar letter to HSENI although we believe that one would have been sent at the same time.

108. Guidance for PPE for all health and care workers supporting the pandemic response was predominantly focused on hospital settings at the expense of health and care staff working in community and social care settings. By way of example, draft revisions to the PPE guidance in secondary care produced by PHE were circulated by the Academy of Medical Royal Colleges to the RCN on 28 March 2020. The RCN was astonished at the limited nature of the draft revisions of PPE guidance in that it continued to apply to acute hospitals only. The RCN highlighted the absence of consideration for those nurses and health care assistants working in the community to the CNO for England via email on 28 March 2020 **[RG/058 - INQ000328932]**.

109. In addition, guidance on PPE focussed on the frontline, such as acute hospitals, and did not fully apply across the sector; in particular, it was not easily implemented for mental health settings as it did not reflect the realities of staff being scratched, pulled, spat on, punched etc during restraint situations. We believe this is down to a lack of consultation in development of the guidance as relevant staff who would need to implement the guidance were not consulted on the implications of IPC guidance in common situations experienced in this example. Similar situations were experienced by nurses working in criminal justice settings, for example prisons and police custody. Had this consultation been undertaken at the start of development of the guidance, these

issues would have been highlighted and addressed earlier. I therefore contacted Sue Tranka, Deputy CNO at NHSE on 27 May 2020 regarding the applicability of PPE guidance in mental health settings and in particular when restraining patients. She confirmed that the IPC Cell at PHE were reviewing the guidance and would keep the RCN updated. Unfortunately, a prompt review did not occur **[RG/059 - INQ000328933]**.

110. The RCN recognised very early on that a dedicated RCN webpage needed to be established and continuously updated to give RCN members working in all health and care settings information about the virus including its symptoms and how nursing staff could protect themselves and their patients. This was based on RCN experience of implementing similar webpages during H1N1 pandemic and EVD outbreak which were valued by members. The dedicated webpage was created on 03 February 2020. It also hosted the latest guidance and updates from the DHSC, the Foreign and Commonwealth Office and public health bodies across the UK **[RG/060 - INQ000328934]**.

111. The RCN sought to address uniform provision and the lack of adequate changing facilities across the four nations by calling on employers, via RCN published position statements on 14 April 2020 (and updated on 06 May 2020), to provide guidance which detailed the requirements for workwear within each respective organisation **[RG/061 - INQ000328935] [RG/062 - INQ000328936]**. The RCN highlighted how, under the Workplace (Health, Safety and Welfare) Regulations 1992, where the work being undertaken requires employees to change into and wear specialist clothing, the employer must have adequate changing facilities which should be of sufficient size to allow for social distancing measures to be adopted and cleaned appropriately.

Chest compressions, Aerosol Generating Procedures and IPC guidance

112. There was a divergence of opinion with regard to whether, and to what extent, chest compressions should be classified as AGPs and this impacted the advice given on the level of PPE to be worn. The RCN and Resuscitation Council UK were in communication regarding this issue in April 2020 **[RG/063 - INQ000328938]** in addition to the British Medical Association ("**BMA**") and Hospital Consultants and Specialists Association ("**HCSA**"). The Resuscitation Council UK took a precautionary approach, in alignment with WHO guidance, and formed the view that chest compressions were AGPs: effective chest compressions will inevitably lead to excretions of both aerosol and droplets, from the nose and mouth. As such, Level 3 PPE was needed. However, PHE published

revised guidance on 02 April 2020 in which chest compressions were designated non-AGPs.

113. RCN members voiced their confusion regarding the conflicting positions of PHE and the Resuscitation Council:

a) *"The resus council [Resuscitation Council UK] issued a statement to say ffp3 should be used for any staff member attending / intervening in a cardiac or respiratory arrest. This poses a challenge for trusts but if this the official statement should there be any give in this guidance?"*

b) *"There is conflicting opinions from PHE and the RCUK [Resuscitation Council UK], about CPR. PHE say it isn't an AGP, whereas RCUK argue it is. Is it wise 1. To take full precautions therefore in FFP3 and 2. Should we always be fit tested for any type of FFP3 disposable respirator?"*

114. A joint letter from the RCN, Resuscitation Council UK, BMA and HCSA was therefore sent to PHE on 23 April 2020 **[RG/064 - INQ000328939]** addressing our respective concerns that healthcare professionals were being asked to resuscitate patients without adequate protection due to a lack of national consensus on this issue. The guidance from Resuscitation Council UK provided a clear process for both protecting patients and healthcare workers – treating Cardiopulmonary Resuscitation ("**CPR**") as a potential AGP. This involves one staff member shocking the patient up to three times with a defibrillator, whilst wearing fluid resistant surgical mask, apron, gloves and eye protection, giving others – if they are not already wearing it – time to put on full protective PPE: namely FFP3 mask, gown, gloves and eye protection. The letter urged PHE to therefore take a precautionary approach and classify CPR including chest compressions as an AGP. This was a defining moment for RCN activity and challenge to the traditional dogma of droplet/aerosols to define the use of respiratory PPE. It led to more detailed activity on risks associated with close physical care delivery (within one metre of patients known or suspected to have Covid-19) and formed the basis for escalated lobbying for the protection of healthcare workers.

115. A response was received the following day from PHE **[RG/065 - INQ000117861]** in which they noted that it was "*biologically plausible that chest compressions could generate an aerosol, but only in the same way that an exhalation breath would do. No other mechanism exists to generate an aerosol other than compressing the chest, and*

an expiration breath, much like a cough, is not currently recognised as a high-risk event or an AGP". The New and Emerging Respiratory Virus Threats Advisory Group ("**NERVTAG**") also stated that it "*does not consider that the evidence supports chest compressions or defibrillation being procedures that are associated with a significantly increased risk of transmission of acute respiratory infections*". They would not therefore add chest compressions to the list of AGPs. It was clear that NERVTAG had relied on evidence from the literature review undertaken by Health Protection Scotland in October 2019 **[RG/066 - INQ000417687]** rather than the more recent review from the International Liaison Committee on Resuscitation ('**ILCOR**') from April 2020 **[RG/067 - INQ000417665].** The RCN was also aware that NERVTAG continued to advise against using existing PHE guidance on the management of MERS CoV, a known coronavirus capable of infecting healthcare workers and resulting in outbreaks within healthcare facilities. Whilst these reviews drew on similar literature, the ILCOR review allowed the evidence base to be interpreted by experts in resuscitation science from around the world to develop consensus on science and treatment recommendations. It further benefited from the opportunity for public comment and feedback prior to being finalised.

116. The RCN sought clarification from the Scottish Government as to their view on this issue. David Caesar, the then Deputy Director, Head of Health Leadership and Talent for the Scottish Government Management confirmed, via email on 27 April 2020 **[RG/068 - INQ000328942]**, that this matter fell under a four-nation approach and the guidance from NERVTAG remained the same: chest compressions and defibrillation were not considered AGPs. Fiona McQueen, CNO for Scotland, confirmed that a letter would be published shortly on behalf of the CNO and CMO in Scotland to clarify the position as it applied to Scotland. The letter was shared with the RCN on 30 April 2020 **[RG/069 - INQ000427459]** and feedback was provided on the following day **[RG/070 - INQ000427436]**. A revised version was shared on 6 May 2020 **[RG/071a - INQ000427474] [RG/071b - INQ000427475],** and the RCN understands that the letter was then published shortly thereafter.

117. From a UK perspective, the RCN and others sent a follow-up joint letter to PHE on 01 May 2020 **[RG/072 - INQ000328943]** pointing out how PHE published guidance was out of step with international clinical guidance. The letter expressed continuing concerns about the decision-making process PHE was adopting in considering whether chest compressions were an AGP. PHE had failed to take into consideration the clinical realities of conducting repeated chest compressions as part of a resuscitation attempt. They had also failed to take account of the European Resuscitation Council guidance,

published on 29 April 2020, which corresponded with Resuscitation Council UK's position. PHE additionally failed to reinforce the need for risk assessment when clinicians were faced with such situations in order to select the level of PPE required to support them, as per each individual situation. The RCN is not able to confirm if HSE were consulted on this issue and any advice provided by them on the selection of PPE based on risk assessment under COSHH.

118. The First Minister for Wales confirmed, in correspondence dated 22 June 2020, the NHS Wales guidance on this point: chest compressions and defibrillation were not to be considered AGPs and first responders, in any setting, could commence chest compressions and defibrillation without the need for AGP PPE whilst awaiting the arrival of other clinicians to undertake airway manoeuvres **[RG/073 - INQ000328945]**.

119. It also became clear that there was a divergence of opinion between a number of professional organisations, including the RCN, and PHE with regard to the designation of nasogastric tube insertion ("**NGT**") as a non-aerosol generating procedure ("**AGP**"). The RCN and others formed the view that NGT insertion is an AGP contrary to the position of PHE and WHO. RCN members were clear that in their clinical experience in such procedures a high probability existed that the close proximity to patients and expulsion of saliva/respiratory particles as a result of gagging posed a risk of aerosol generation. It was inclusive of a precautionary approach to the protection of healthcare workers and of great importance when considering the appropriate PPE to protect all of those involved in caring for Covid-19 patients. NGT insertion was common practice in patients suffering from Covid-19 in critical care. I understand that these concerns were captured in correspondence authored by the British Association of Parenteral and Enteral Nutrition ("**BAPEN**") in April and May 2020 to Matt Hancock, Secretary of State for Health and Social Care. The RCN was very disappointed at the singular approach of PHE and others responsible for defining AGP's that due consideration of health professionals' views were overridden in the absence of 'science or evidence' and a precautionary approach, in line with health and safety assessment, was not advised at that time.

Requirement for healthcare staff to wear face masks

120. Type 11R masks have historically been worn by patients with suspected or confirmed open pulmonary tuberculosis or in operating theatre settings to protect the wearer during procedures and the patient from potential infection (usually a wound infection). Prior to

the pandemic the use of Type 11R masks was very limited in care settings. They must, in line with the Medical Devices Regulations, meet standards on splash/spray resistance for the exterior of the mask and bacterial filtration designed to reduce transmission of bacterial pathogens from the wearer to other individuals. Viral pathogens are not included within this criterion. Type11R masks do not routinely protect wearers from aerosol/airborne hazards including SARS CoV2 in the workplace. Additionally, the HSE RR619 report confirmed that:

- Surgical masks provide the lowest level of protection compared to FFP3 respirators.
- If a residual airborne risk of harm to health remains, respiratory protection may be required.
- Surgical masks may reduce any residual aerosol risk, but it remains unclear whether this level of protection sufficiently reduces the likelihood of transmission via this route, so as to minimize the risk of infection to as low as reasonably practicable.
- In the study, live viruses were detected in the air behind all surgical masks tested.

121. It is the RCN's understanding that FRSM's supplied during the pandemic were designed by manufacturers to have a medical purpose only, intended to limit the transmission of infective agents from staff to patients, not for a protective (PPE) purpose. The RCN is unclear how the decision was made to approve the routine use of Type11R masks in IPC guidance given confusion over the predominant mode of transmission of a novel coronavirus. This confusion arose from multiple sources including:

- A clear statement from PHE in January 2020 that Wuhan novel coronavirus was an airborne infection.
- Existing guidance on the management of patients with MERS CoV.
- The RR619 report by HSE demonstrating the limitations of surgical masks.
- The absence of evidence that SARS CoV2 was spread via the droplet route unless an AGP was being performed.

122. Another issue surrounding PPE guidance was the requirement for staff to wear surgical face masks which was mandated by the Secretary of State for Health and Social Care on 05 June 2020 and introduced on 15 June 2020 **[RG/072a - INQ000427451]** Many organisations incorrectly interpreted this as a requirement to wear masks if a

distance of two metres could not be maintained and there was confusion regarding what constituted a 'Covid secure' area at a time when PPE shortages were being experienced. There had clearly been misunderstanding regarding implementation of the original advice which was issued at a time of high cross-infection rates between staff driving healthcare associated Covid-19 acquisition. The RCN received general feedback from members that guidance had been issued without sufficient consideration and no implementation plan.

123. As a consequence, on 10 September 2020, NHSE/I via Paul Reeves (Head of Nursing: Education and New Roles) approached Yinglen Butt, then Associate Director of Nursing at the RCN, for input into developing a national professional approach to ensuring nurses and midwives wear face masks whilst at work **[RG/074 - INQ000328946]**. I offered to discuss this directly with Sue Tranka, Deputy CNO, as I had spoken directly to members about confusion over the guidance **[RG/074 - INQ000328946].** Yinglen Butt confirmed that she would communicate my willingness to liaise with Sue Tranka about this matter when she met with Paul Reeves. I contacted Yinglen Butt for an update on 21 September 2020 and was informed that there had been no further response from Paul regarding my offer **[RG/075 - INQ000417678]**. To the best of my recollection, no meeting took place between Sue Tranka and I on this issue.

<u>Health and Safety issues in the workplace</u>

124. Many RCN members worked in close proximity to patients who had or were suspected of having Covid-19, often in enclosed spaces with poor ventilation. This occurred in both hospital and non-hospital settings, including patient's own homes. Some members were recognised as being at an increased risk of contracting or developing more severe complications, from exposure to Covid-19. The RCN expected all employers to follow their legal duties under Health and Safety legislation in ensuring the health, safety and welfare of all their employees when they are at work including the carrying out of suitable and sufficient risk assessments, identifying who can be harmed and how, by a person with the competency to do so. However, RCN members raised concerns that risk assessments were not being undertaken:

   a. *If my workplace aren't offering the appropriate PPE for looking after suspected or confirmed cases of Coronavirus can I refuse to stay at work and leave? I want advice on where I stand if I walked out?*

b. *"I work in Hemodialysis Outpatients. No risk assessment is being done. I've Crohn's disease with ileostomy, breast ca tamoxifen. Lymph removal. Am I high risk category?"*

c. *Member works in ICU. She is 20 weeks pregnant and has had 2 risk assessments. She cannot wear full PPE as wearing a mask makes her vomit. She has had the second risk assessment. The outcome is that she is high risk and as there is no alternative work for her to do she will continue to work in ICU, with an adjustment to allow her to reduce her hours. Member has been assessed by OH [Occupational Health] – they advised her that her employer is best placed to decide on adjustments for her and therefore no recommendation/s were made.*

125. To help members understand their employer's obligations in respect of PPE and to assist them in raising concerns with reference to Health and Safety legislation, the RCN produced a Personal Protective Equipment – Are you safe? Flyer in April 2020 **[RG/028 - INQ000328947]**. In addition, the RCN encouraged members to contact RCND with their concerns to enable RCN to support their cause and advise on escalation to external bodies. Further guidance was issued throughout the currency of the pandemic including 'Uniform and Workwear Guidance' **[RG/076 - INQ000328948]** 'Risk of Exposure' **[RG/077 - INQ000328949]** and 'use of PPE' poster **[RG/078 - INQ000328950].** A full list of published PPE guidance can be found at paragraph 139 below.

126. Given the influx of concerns the RCN was receiving from its members regarding the insufficient supply of appropriate PPE, the RCN took the unprecedented step of issuing last resort advice to members of 'refusal to treat due to lack of adequate PPE' in April 2020 **[RG/027 - INQ000328905]**. In short, the advice explained how, should members not have sufficient PPE for the setting in which they were working and, if they had raised concerns with their employers pressing for PPE to be immediately provided in order to treat patients and this had not been supplied, members were encouraged to think of their own safety and to consider refusing to provide treatment. It was not expected of members to inform the RCN if they had followed this advice.

127. In May 2020, NHS Leadership Academy asked the RCN to comment on a draft Risk Reduction Framework for NHS Staff at risk of Covid-19 infection **[RG/079a - INQ000417692] [RG/079b - INQ000050360] [RG/079c - INQ000050361] [RG/079d - INQ000050362].** While the RCN welcomed the opportunity to provide feedback on the tool and recognised the need to work at pace in terms of a collective response to Covid-19, the staff side trade unions took the view that it was vital for NHS Employers to develop separate guidance on risk assessments in consultation with staff side trade unions. We were deeply concerned that there was insufficient time to properly consider, consult or test the proposals with our members. The emergent evidence highlighted the range and complexity of factors that accumulate to shape risk levels for staff and we indicated that full consultation with trade unions, via the Social Partnership Forum ("**SPF**") in ways that enabled meaningful co-production with those most impacted by decisions, was necessary.

128. We also raised a number of questions about the draft tool, for example co-morbidity was not defined and obesity was omitted as a risk factor. We also stressed a need for access to an Occupational Health practitioner for staff for advice. Furthermore, we highlighted receiving a number of calls from members who were pregnant or in black and ethnic minority groups who were not being treated appropriately by their manager or were being bullied into working in areas they felt put them at risk. The draft document, however, did not touch on cultural issues and how managers could approach this sensitively so that the tool could work in practice and in a reliable way, nor did it confirm that organisations needed to conduct comprehensive and continuing equality impact assessments (including assessing the impact on black and ethnic minority groups and disabled staff) relating to the deployment of staff and allocation of shifts in high risk areas and on access to PPE and testing **[RG/080 - INQ000328954]**.

129. The RCN subsequently worked on developing its own Covid-19 risk assessment resource for its members to align IPC and Health and Safety requirements and provide clarity of the position of Health and Safety legislation which remained current throughout the pandemic. It did not represent new guidance and was developed as a practical informative tool. Developed with a range of stakeholder organisations, the RCN's Covid-19 workplace risk assessment toolkit was launched on 23 December 2021 to members and non-members **[RG/081 - INQ000114284] [RG/082 - INQ000114307] [RG/083 - INQ000328953]**. The toolkit highlighted the legal duties of employers to protect their staff and reflected UK legislation on risk assessment, such as the Management of Health and Safety at Work Regulations and COSHH. It allowed health

care staff and employers to make evidence-based decisions about the correct level of PPE, including RPE, needed to keep staff safe. The toolkit underwent extensive review by specialists prior to launch and was well-received by stakeholders.

Reporting deaths and publication of data

130. Members contacted the RCN with concerns about collection of data on healthcare worker deaths **[RG/004 - INQ000328870]** and **[RG/005 - INQ000328871]**, for example:

a. *In response to Matt Hancock's statement that the only front-line staff whose deaths will be monitored is doctors, member feels that ALL healthcare workers deaths in relation to Covid-19 need to be monitored and recorded - feels that the opinion and view of Matt Hancock undermines what nurses do and their position within the Covid-19 crisis.*

b. *"Is anyone counting nursing deaths? I see deceased doctor figures frequently mentioned in the press."*

c. *"Can I ask to be put in touch with somebody for further advice about my mum - she was a nurse and member who passed away from COVID working in a care home. We are facing difficulties with the home who are denying there was COVID in the workplace."*

d. *"How many NHS staff including nurses have died from covid? What is being done to raise awareness about these figures?"*

e. *Member is aware that his employer did not follow correct guidelines and notify RIDDOR.*

131. There was no visible systematic data collection or reporting on deaths, infection rates and self-isolation amongst the health and care workforce. It is unacceptable that we did not know, at any given time, how many health and care staff were unwell or had died because of Covid-19. Infection and self-isolation rates amongst health and care staff would have been a key indicator of what impact the government's approach was having, and this information was therefore a key piece of scrutiny which was missing.

132. Any death in service is significant, and it was important that the government, public and our profession knew the full extent that this pandemic was having upon staff working within health and care settings. There was already some reporting into central organisations, such as in the NHS, but we called for this information to be collected and publicly reported on more frequently, and for a system to be rapidly devised to collate the same information for non-NHS organisations **[RG/084 - INQ000328956]**.

133. HSE collected data where a worker had been diagnosed as having Covid-19 or had died from the infection and there was reasonable evidence to suggest that it was caused by occupational exposure, under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 ("**RIDDOR**"). Determining occupational exposure was dependent on specific criteria being met. This data covered England, Wales and Scotland and was split by industry. Nursing professionals were covered under "Human health and social work activities". However, revised guidance produced by the HSE on 17 April 2020 had the effect of requiring definitive evidence that Covid-19 was contracted as a result of exposure in the workplace **[RG/085 - INQ000427476]**. This now called for employers to make a judgment on the available information as to whether or not there was reasonable evidence that a work-related exposure was the likely cause of a confirmed diagnosis, with the employer only reporting under RIDDOR if they were satisfied that Covid-19 was caused by or contracted at work. This revised guidance stipulated that it was most likely, even in a healthcare setting, that a case of Covid-19 would have been contracted in the community rather than the workplace.

134. In addition, where a healthcare worker received a positive diagnosis of Covid-19 from a laboratory, consideration should be given to an occupational causation and, where a healthcare worker worked within a Covid-19 area it would be reasonable to assume a community infection unless there has been a failure in the supply of PPE, with the failure needing to be confirmed by a manager in conjunction with Occupational Health and, Health and Safety Specialists. This resulted in the reluctance of many healthcare employers to report incidences of Covid-19 in their workforce as it was difficult to pin down specific evidence, i.e., a Covid-19 positive patient deliberately removing the mask of a healthcare worker. In contrast, other employers reported every case of Covid-19 amongst their workers. Employers were focussing on the wearing of PPE, in line with the HSE's new guidance on reasonable evidence and making a decision to report based on whether or not the healthcare worker was wearing PPE. In essence, if PPE was worn, no report was summitted. However, we know that PPE is not 100% effective in

protecting the wearer from exposures, even if worn properly and fit tested, hence it being low down in the hierarchy of controls. It is the view of the RCN that, a lack of standardised UK data on healthcare acquired infection among healthcare workers, resulted in an inaccurate picture and lost opportunities for learning throughout the evolution of the pandemic as a result.

135. A joint union letter was sent to the HSE on 1 July 2020, asking them to reconsider their guidance on RIDDOR and return to the requirement for "reasonable evidence" of occupational exposure for the health care sector so that there would be consistency in reporting **[RG/086 - INQ000328957]**.

136. Employers and government had been slow to respond with coherent strategies and actions designed to mitigate and manage the disproportionate risks to healthcare workers from ethnic minority groups and this was compounded by a lack of data on death rates which impacted their ability to understand the true picture. The letter to the HSE also raised concerns about the disproportionate impact of Covid-19 on people from ethnic minority groups and asked for the HSE to record ethnicity and gender data within RIDDOR reporting. To date, this data is still not recorded.

137. It was the RCN's view that several challenges existed in relation to the RIDDOR requirement **[RG/087 - INQ000328958]**. These included:

a. Few employers were likely to admit to not following national guidance on infection control or providing suitable and adequate PPE;
b. Some employers undertaking assessments for workplace acquired infection stated this was too complex to assess due to high levels of community transmission of Covid-19; and
c. Few employers had access to whole genome sequencing to monitor transmission of Covid-19 between in the workplace associated with clusters or outbreaks of Covid-19.

138. The fact the rate of death amongst nursing staff was significantly higher than the general population of a similar age group highlighted the absolute need to properly investigate why and to give them the protection they needed. The RCN believes that the HSE failed to hold employers to account for making proper judgements as to whether a confirmed diagnosis of Covid-19 was likely to have been caused by occupational

exposure. All frontline staff deaths related to Covid-19 should have been reported as occupational fatalities as a precaution.

139. Apart from the reporting of incidents of disease to the HSE, under RIDDOR, there was no central data collection system in place to collate the number of healthcare workers who had or may have acquired Covid-19 in the workplace. This lack of data was a fundamental concern to the RCN, who were repeatedly referred to the HOCI data (England) that the numbers of healthcare workers affected was very low, however the data set informing the HOCI study was never provided to the RCN. I wrote to the Secretariat for the Hospital Onset COVID-19 Working Group (HOCI) – a sub-group of SAGE on 21st April 2021 to request the minutes and location of information to enable review and consideration **[RG/088 - INQ000427456]**. To the best of my knowledge, I never received a reply. The effect, therefore, of the constantly changing IPC guidance was unknown. This prohibited learning and planning for future events.

A list of the guidance and advice the RCN provided to its members in relation to IPC and personal protective equipment ("PPE") and/or respiratory protective equipment ("RPE")

140. The RCN provided guidance to support members on topics including raising concerns about insufficient PPE and advice on withdrawing care and refusing to treat where this was necessary as a last resort due to the lack of inappropriate or insufficient PPE. A list of the published guidance can be found below. All guidance was applicable UK-wide, unless specifically stated:

a. FAQ on how to protect myself at work published 18 March 2020;
b. Uniform and workwear guidance published 01 April 2020;
c. PPE poster published 01 April 2020;
d. FAQ on risk of exposure published 08 April 2020;
e. Refusal to treat guidance to members published 09 April 2020;
f. PPE – Are you safe? Published 09 April 2020 – providing a flow chart of steps to take to escalate concerns surrounding the provision of PPE;
g. Joint guidance on verification of death during Covid-19 published 09 April 2020;

h. Personal Protective Equipment: Use and availability during the Covid-19 pandemic published 18 April 2020 – findings from the RCN's online survey of nursing staff on issues relating to PPE during the pandemic;
i. FAQs on reporting health and safety breaches and personal injury published 28 April 2020;
j. FAQ on PPE published 28 April 2020 and updated on 07 May 2020, 12 June 2020, 30 June 2020, 03 July 2020, 20 July 2020, 24 August 2020 and 25 September 2020;
k. FAQ on PPE guidance published 30 April 2020;
l. RCN Wales briefing on PPE published 18 May 2020;
m. RCN FAQs on re-using PPE published 27 May 2020;
n. RCN FAQs on death verification, laying out and last offices published 27 May 2020;
o. Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the Covid-19 pandemic published 28 May 2020;
p. RCN FAQ on negative tests before returning to work published 03 June 2020;
q. RCN Independent Review of Guidelines for the Prevention and Control of Covid-19 in Health Care Settings in the UK published 07 March 2021;
r. Raising the Bar published 14 April 2022 – an independent review to identify and compare international definitions and guidance used to describe standard and transmission-based IPC precautions.

A summary of submissions or representations the RCN made to any IPC guidance-making body and the response to those submissions or representations.

141. The information that follows is a chronological overview of the concerns raised by the RCN in written correspondence, meetings and telephone calls with the UK Government, Devolved Administrations, IPC guidance making bodies and other key stakeholders. I have sought to indicate those documents and/or discussions which were had by my colleagues and so the detail of which is not within my direct knowledge.

January 2020-2021

142. By the end of January 2020, there was a lack of clarity on the governance and risk management of the emergence of Covid-19, particularly around preparedness and

escalation. I raised concerns in this regard on 28 January 2020 with Mark Sewell NHS Preparedness and Response Senior Manager, at NHSE and NHSI **[RG/001 - INQ000114353]** prior to a meeting of the EPRR Clinical Reference Group later that day. I reiterated my concerns to Stephen Groves, National Head of EPRR NHSE and NHSI in an email exchange on 29 January 2020, **[RG/001 - INQ000114353]**. I noted that the key lessons from pandemic flu and the EVD outbreak highlighted the crucial need to engage with organisations supporting frontline staff to ensure that guidance was both relevant and capable of being implemented. Again, in a further email exchange with Professor Chris Moran, National Clinical Director for Trauma at NHSE NHSI, on 29 January 2020 **[RG/002 - INQ000114354]**, I explained that interagency collaboration and engagement of professional organisations needed to extend beyond the development of guidance – it was clear that there were evolving employment questions and wider workforce issues that would need to be addressed through a multi-agency approach.

143. On 23 March 2020, Donna Kinnair wrote to the UK Prime Minister setting out the serious concerns of RCN members regarding the lack of PPE available for frontline staff **[RG/089 - INQ000417657]**. The RCN also highlighted the confusion over guidance on what PPE to use and in what circumstances. To the best of our knowledge, no response was received to this correspondence. Similar concerns were raised by Theresa Fyffe, the then Director RCN Scotland, to the First Minister of Scotland **[RG/090 - INQ000417556]**.

144. On 24 March 2020, First Minister of Scotland, Nicola Sturgeon, responded to Theresa Fyffe's correspondence and noted National Services Scotland's attempts to acquire additional supplies of PPE equipment, including FFP3 masks, hand sanitiser and other items **[RG/091 - INQ000417683]**.

145. Helen Whyley, RCN Director for Wales spoke with the Minister for Health and Social Services in Wales, Vaughan Gething on 27 March 2020 and informed him of the issues RCN members were having in accessing adequate supplies of PPE **[RG/092 - INQ000417538]**. Vaughan Gething responded via letter dated 14 April 2020 **[RG/093 - INQ000417537]**. He noted that the Welsh Government were working hard to have extra supplies of PPE sent out to all frontline staff.

146. The RCN responded to PHE's consultation: 'Covid-19 – guidance on personal protective equipment in secondary care' on 29 March 2020 **[RG/094 - INQ000478111]**.

The RCN voiced its concern that the plethora of guidance issued by different organisations was causing members considerable confusion. In addition, the use of FFP2 respirators were now being advocated instead of FPP3 respirators. This was of significant concern in that it appeared PPE was being downgraded due to the non-availability of stock, with a lack of transparency as to why this step was being taken.

147. The RCN responded to the 'Covid-19 – guidance on personal protective equipment in primary and community care' consultation on 30 March 2020 **[RG/095 - INQ000417700].** Amongst other concerns, the RCN highlighted the absence of reference to those working in the independent sector, requested further clarity on the minimum PPE required in all direct care areas including eye protection, and raised concerns about the use of FFP3 masks and the need to replace surgical/fluid repellent surgical masks once moist.

148. On 30 March 2020, the RCN and Irish Nurses and Midwives Organisation wrote a letter to the First Minister and Deputy First Minister of Northern Ireland **[RG/096 - INQ000417543]**. The RCN requested that the government mandate that PPE be to the appropriate standard for category A infections, as specified by the European Centre for Diseases Protection and Control ("**ECDC**"). In the same correspondence, the RCN urged the government to ensure that all staff and patients were mandated to wear surgical masks in clinical and non-clinical areas including in home and community settings, pointing to one of the key lessons from Italy, which was that transmission to staff was happening at a higher rate in non-Covid-19 treatment areas.

149. On the same day, Pat Cullen, then RCN Director for Northern Ireland, requested an urgent meeting with the First Minister and Deputy First Minister of Northern Ireland to discuss RCN's pressing concerns regarding the lack and availability of PPE and the varying approaches in applying relevant guidance throughout the health and social care sector and independent providers **[RG/097 - INQ000417544]**. An email response acknowledging receipt was received from the Executive Office on 31 March 2020 **[RG/098 - INQ000417598]**. A further email was received on the same day from the Private Secretary to the Minister of Health **[RG/099 - INQ000417600]** advising that due to the current volume of work, the Department was not in a position to respond in full but that the correspondence had been redirected to the lead policy official within the Department who would consider and take appropriate action. On 1 April 2020, a teleconference was held with the Executive Office, Minister Swann and CNO to discuss the matter. On the same day and subsequent to the teleconference, Pat Cullen contacted Andrew Dawson director of workforce policy at the Department of Health by

email, raising members serious concerns about the lack of FFP3 respirator masks and associated fit testing requirements, which had not been identified by the Health Minister at the teleconference. Pat Cullen informed Andrew Dawson that members would be advised not to participate in direct patient care requiring an FFP3 mask should this not be available. Andrew Dawson acknowledged the email on the same day **[RG/100 - INQ000417680]**, indicating that the issue had been passed to the Department's PPE leads for advice. The RCN's refusal to treat guidance was published shortly thereafter.

150. A joint letter was sent to Jeane Freeman, Cabinet Secretary for Health and Sport in Scotland, on 30 March 2020 on behalf of the RCN, the Royal College of General Practitioners ("**RCGP**") and Scottish Care **[RG/101 - INQ000417696]**. Whilst updated PPE guidance was underway, the joint signatories highlighted how it was imperative that the updated guidance recommended a consistent approach to the level of PPE required across both acute and community settings, in particular in terms of what constitutes an 'aerosol generating procedure' (for example, taking throat swabs from symptomatic patients).

151. Jeane Freeman responded on 1 April 2020 **[RG/102 - INQ000417663]** setting out the steps the Scottish government had taken and were taking to distribute and supply PPE to health and social care workers across the country. Reference was also made to further information and infographics which were due to be produced later that week and provides no further detail on PPE guidance in her letter.

152. The RCN wrote to both HSE **[RG/039 - INQ000328917]** and HSE NI **[RG/103 - INQ000400948]** on 31 March 2020 raising members' concerns that a number of health and social care organisations were in breach of their obligations under Health and Safety legislation. The letter highlighted the reports received from members regarding fit testing of FFP3 masks not being widely available. In the absence of fit testing, healthcare workers were being asked to wear FFP3 masks which they had not been trained to use, resulting in the wearing of ill-fitting equipment and placing them at risk of infection. Concerns had also been raised that the IPC guidance was being interpreted by employers in response to what PPE they had available rather than what would best protect staff. The RCN also highlighted the emergence of evidence suggesting Covid-19 was being transmitted by asymptomatic carriers. A response from HSE was received on 01 April 2020 **[RG/104 - INQ000328918]** in which they noted they were working closely with the Government and reiterated how an employer must not carry out work which is

liable to expose their employees to a substance hazardous to health, such as the Covid-19 virus, unless a risk assessment had shown it was not reasonably practicable for that employer to prevent exposure. In those cases, it was the employer's legal duty to ensure that measures were put in place to adequately control exposure to the virus.

153. Responses were received from HSE on 01 April 2020 **[RG/104 - INQ000328918]** and 02 April 2020 **[RG/040 - INQ000417540]** which noted that HSE had been engaging with PHE and NHSE about fit testing and regulatory requirements. This did little to reassure RCN members that fit testing would be routinely undertaken.

154. On 02 April 2020, RCN NI wrote to the First Minister, Deputy Minister and Minister for Health in Northern Ireland in strong terms, highlighting how Northern Ireland were being treated as an afterthought, particularly in relation to testing kits which were produced in Northern Ireland by Randox Laboratories as part of a UK-wide contract **[RG/105 - INQ000417519]**. Despite being manufactured in Northern Ireland, the kits were then shipped out of Ireland until such time as they made their way back to Northern Ireland under the UK supply chain. Of significant concern was that the Chief Executive of Belfast Health and Social Care Trust had been informed that a consignment of PPE destined for Northern Ireland had been "turned back". To the best of our knowledge, RCN Northern Ireland did not receive a response to this letter.

155. RCN Wales encouraged the First Minister of Wales, Mark Drakeford by way of letter dated 09 April 2020 **[RG/106 - INQ000417552]**, to ensure more effective partnership working with the RCN given its policy expertise and to ensure that the Welsh Government's messages were swiftly reaching nursing staff on the frontline**).** A response was received from the First Minister on 22 May 2020 **[RG/107 - INQ000417534]**, accepting that some of the detailed partnership working had been curtailed due to the necessary response in the early stages of the pandemic, although refuting the assertion that there had been a lack of effective partnership with the RCN.

156. In Scotland, in response to concerns around PPE supply, expressed by the RCN and others, a social care triage hub was established in or around 25 March 2020 and new supply routes for primary care and hospitals were set up from 30 March 2020. PPE guidance for health and social care staff was repeatedly updated, with input from the RCN and other stakeholders, including a PPE Clinical Oversight Group established by the Scottish Government. A dedicated phone number was also set up for staff to report problems with PPE distribution, following requests from the RCN for an additional

mechanism for staff to raise concerns. The RCN queried, via then RCN Scotland Director Theresa Fyffe, how nursing was represented in the development of clinical guidance via the clinical cell. Fiona McQueen, CNO for Scotland, acknowledged in her email correspondence **[RG/108 - INQ000417597]** that she was fighting a medical dominance and agreed that the Royal Colleges should be involved in the development of clinical guidance although this did not come to fruition. The RCN took this to mean that there was an absence of nursing expertise in shaping the guidance, which was instead being driven by representation from other medical professionals.

157. On 01 April 2020, Donna Kinnair and I joined a telephone conference call with representatives from the Academy of Medical Colleges and CNO for England to discuss PHE revisions to PPE tables **[RG/109 - INQ000417689]**. The RCN's comments were considered, and PHE confirmed they would be discussed with the IPC four nations group **[RG/110 - INQ000417679]**.

158. On 31 March 2020 and 1 April 2020 respectively, Donna Kinnair **[RG/039 - INQ000328917]** and Helen Whyley **[RG/111 - INQ000417623]** wrote to HSE urging them to take action over inadequate supplies of PPE. Helen Whyley expressed her concern that some NHS and social care employers in Wales were failing to follow their statutory obligations in relation to the provision of PPE. Similar correspondence was sent to all Health Boards in Wales **[RG/112 - INQ000417546]**, in which the RCN requested details be shared of the plans in place for the distribution of and access to PPE for nurses and healthcare support workers in each Health Board including those in community and care homes. A response from the HSE was received on 02 April 2020 **[RG/040 - INQ000417540]** and responses from individual Health Boards in Wales were received throughout April 2020 **[RG/113 - INQ000417547] [RG/114 - INQ000417548] [RG/115 - INQ000417549] [RG/116 - INQ000417550]** in which they sought to reassure the RCN that all reasonable steps were being taken but RCN concerns remained.

159. Similar correspondence was sent to the HSE on 09 April 2020 by Theresa Fyffe on behalf of RCN Scotland **[RG/117 - INQ000417681]**, regarding the provision of PPE to healthcare workers. In their response, dated 15 April 2020 **[RG/118 - INQ000417682]**, HSE confirmed that they had been meeting with PHE and NHSE about fit testing and regulatory requirements for FFP3 respirators, as well as the management of FFP3 products in the stockpile.

160. Helen Whyley raised concerns regarding a lack of plans to install adequate changing facilities by the Welsh Government and NHS Wales directly with the Chief Executive for NHS Wales in correspondence dated 14 April 2020 **[RG/119 - INQ000417553]**. Given UK government advice for PPE and IPC suggested reducing the risk of transmission of Covid-19 by healthcare workers changing into and out of their respective uniforms at work and not wearing the uniform whilst travelling, the RCN wanted to ensure that there were appropriate measures in place to allow this guidance to be followed. A response was provided on 16 April **[RG/120 - INQ000417554]** and the following advice from the CNO for Wales was included: "*Uniforms in general pose a low risk of transmission of any HCAI including Covid-19. Uniforms do become contaminated by micro-organism, but they are mainly those of the staff wearer. The virus degrades within hours and is unlikely to pose a risk in taking off even over the head as any droplet dry quickly, if the staff member is doing an aerosol generating procedure then they will be gowned*". Similar concerns were raised with NERVTAG via email correspondence on 21 April 2020 **[RG/121 - INQ000417624]** particularly regarding uniforms which needed to be removed over the head. The RCN requested on a number of occasions, that a study evaluating the level of risk that this posed for contamination of conjunctiva, similar to that conducted by Anne Tunbridge at HSL for the EVD PPE evaluation, be commissioned.

161. On 16 April 2020, Donna Kinnair wrote to Jon Ashworth, Shadow Health and Social Care Secretary **[RG/122 - INQ000417664]**, about continued issues with access to adequate PPE as well as the lack of availability of Covid-19 testing for both staff with symptoms, and the antibody testing required to give staff confidence that they no longer pose a potential risk.

162. A 'Management of the Coronavirus Outbreak Inquiry' was heard by the Health and Social Care Select Committee in April 2020 and chaired by Jeremy Hunt MP. Donna Kinnair gave evidence to the Committee on 17 April 2020 **[RG/123 - INQ000203951]**.

163. On 17 April 2020 an urgent PPE guidance meeting was convened at short notice between Donna Kinnair and representatives from PHE **[RG/124 - INQ000417666]**. I do not recall attending this meeting and do not have copies of the minutes from the call.

164. A response to RCN's open letter to HSE dated 17 April 2020 (at paragraph 61 and 106 above) was received on 24 April 2020 **[RG/014 - INQ000417596]** in which HSE confirmed that, working in collaboration with other relevant agencies, they would be

undertaking investigations into reportable deaths of workers associated with Covid-19. Acknowledgment was made of the disproportionate number of workers from ethnic minority groups succumbing to the virus and noted that this would be considered appropriately.

165. On 21 April 2020, the RCN submitted a consultation response to NHSE/I on their 'Guidance for infection prevention and control in health and care settings 2020' **[RG/125 - INQ000417602]**. A response was received on 22 April 2020 from NHSE/I, attaching the revised guidance and thanking RCN for its feedback **[RG/126 - INQ000417902]**.

166. On 29 April 2020, Donna Kinnair wrote to the HSE regarding the investigation of reportable deaths associated with Covid-19 **[RG/127 - INQ000417650] [RG/128 - INQ000417576]**. A response was received on 03 June 2020 in which HSE noted that the reuse of PPE had been agreed in discussion with PHE in times of emergency **[RG/129a - INQ000417575] [RG/129b - INQ000417577]**.

167. On 18 May 2020, Helen Whyley wrote to the First Minister of Wales **[RG/130 - INQ000417532]** and provided a number of comments on the draft paper 'Covid-19 Taking all reasonable measures to maintain physical distancing in the workplace'. The RCN welcomed the opportunity to be able to provide such feedback. Our comments included highlighting the absence of specific reference to at risk/shielding for staff from ethnic minorities and how best to utilise a workforce who were not able to return to work. A response was received on 22 June 2020 **[RG/073 - INQ000328945]** in which the First Minister noted that an advisory group, established by Judge Ray Singh and Dr Heather Payne, were examining the disproportionate impact of Covid-19 on ethnic minority groups.

168. The RCN also reviewed the Adult Social Care Risk Reduction Framework and provided feedback to the DHSC on 22 May 2020 **[RG/132 - INQ000417632]**. In particular, the RCN highlighted how it would like to see a strengthened focus on significantly improving wider control measures which included issues such as: working conditions, employment policies and systems that provide for greater safety, first-line protection and resilience. The RCN noted how these matters were fundamental for the health and safety of all and would significantly reduce the vulnerability of any worker to illness and infection if carefully and effectively implemented.

169. The RCN sent an email to the HSE on 04 May 2020 highlighting member concerns regarding fit testing **[RG/133 - INQ000427437].** In particular, members had reported that employers were deviating from published guidance when receiving masks from multiple different manufacturers. The RCN understood from anecdotal evidence that employers had submitted action plans and risk assessments to the HSE to mitigate the issue and move to a process of checking rather than fit testing PPE in the short term. In their response dated 07 May 2020 **[RG/133 - INQ000427437]**, HSE confirmed that there was no derogation from the requirement to fit test and employers must discharge their duty by having arrangements in place to manage the risks that their employees and others are exposed to. The RCN received significant push back from senior nurse leaders on the practical implications of compliance with the need for fit testing indicating a lack of awareness and communication on this issue by HSE aligned to IPC guidance.

170. Further correspondence was sent to HSE on 27 May 2020 regarding RIDDOR reporting and the RCN's expectation that all health and care worker deaths related to Covid-19 are reported to the HSE as occupational fatalities **[RG/134a - INQ000417578] [RG/134b - INQ000417579]** . The HSE responded on 03 June 2020 and noted that diagnosed cases of Covid-19 were not reportable under RIDDOR unless there was reasonable evidence that work-related exposure caused the worker's death **[RG/134c - INQ000417580]**.

171. On 28 May 2020, the RCN and BMA sent a joint letter to the BSIF on PPE for male and female users highlighting how nurses and doctors' safety was being fundamentally compromised by the lack of adequate and correct supplies of PPE **[RG/135 - INQ000097948]**. Members of both organisations were reporting that specialist FFP3 masks did not securely fit smaller, often female face shapes. This was despite 89% of the UK nursing workforce and 48% of doctors being female. Both the RCN and BMA urged the BSIF to future proof FFP3 provision to ensure that it fits both male and female users. A response was received on 18 June 2020 **[RG/136a - INQ000417569] [RG/136b - INQ000417570]** which acknowledged that one size does not fit all and several RPE manufacturers had the size range which they believed accommodated smaller face sizes but they had struggled to get these established as mainstream products within the NHS and healthcare.

172. Following the publication of new 'Clinical guidance for healthcare professionals on maintaining immunisation programmes during Covid-19' on 1 July 2020 the RCN wrote a

letter to Susan Hopkins at PHE **[RG/137 - INQ000417523]** expressing disappointment at not having had the opportunity to shape the guidance, which provided specific detail on PPE requirements rather than referencing UK IPC guidance and promoting local risk assessment. PHE's response, dated 9 July 2020 **[RG/138 - INQ000417611]**, confirmed that NHSE/I had made a unilateral decision to consult only with RCGP and the Royal College of Paediatrics and Child Health on the guidance.

173. In Wales, NHS Wales Chief Executive Dr Andrew Goodall, afforded the RCN the opportunity to comment on the document 'NHS Wales Covid-19 Operating Framework – Quarter 2 (20/21)'. In its response dated 03 July 2020 **[RG/139 - INQ000417551]**, RCN Wales was pleased to note that RCN's concerns regarding workforce and well-being remained a priority, especially in regard to availability of PPE for both NHS and the Independent Sector, and risk assessments for our colleagues from ethnic minorities and older colleagues. This was especially important to the nursing workforce in light of the number of Covid-19 deaths in both colleagues from ethnic minorities and older colleagues. However, the RCN were concerned that the risk assessment for ethnic minorities was not tailored to the evident disparities of the risks and outcomes of Covid-19 that were known at that time. In particular, the Bangladeshi community had twice the risk of death compared to those of white British ethnicity and the risk was considerably higher than any other ethnicity.

174. On 16 July 2020, I emailed NHSE/I **[RG/140 - INQ000417630]** following their meeting the previous week, to share member experiences of faulty and unfit PPE anonymously and with their permission. I chased for a response on 10 August and 15 September 2020, but none was forthcoming.

175. On 08 October 2020, Helen Whyley, met with the Minster for Health and Social Services (Wales) and discussed a number of the ongoing issues including the risk of nosocomial transmission between healthcare workers. A follow up letter dated 03 November 2020 **[RG/141 - INQ000328819]** recorded the discussion had during this meeting including an update on testing and PPE partnership meetings.

176. On 23 November 2020, the RCN wrote to NHS England and NHS Improvement **[RG/142 - INQ000417625]**, asking for clarification about the IPC guidance. We reiterated our concerns that while the recent publication of guidance for domestic settings implied airborne transmission, IPC guidance and policy did not seem to align

with this in a clinical setting. This had caused confusion and questions had been asked about the risk of infection in health and care environments where ventilation could not be controlled, unlike in domestic settings.

177. On 24 November 2020, following the publication of the government video on ventilation in homes, I emailed a contact at PHE seeking clarity on the use of language and apparent conflict in advice **[RG/143 - INQ000417639]**. The video talked of infective particles remaining in the air for long periods. This inferred airborne transmission based on the Centres for Disease Control and Prevention ("**CDC**") website, which said *'Airborne transmission is infection spread through exposure to those virus-containing respiratory droplets comprised of smaller droplets and particles that can remain suspended in the air over long distances (usually greater than 6 feet) and time (typically hours)'*. This aligned with gov.uk language on 'particles'. The UK IPC guidance and policy still did not support any mention of airborne transmission: there seemed to be conflicting and contradictory language and advice. My concern was that this was advice for the public in their own homes. Healthcare workers would quite rightly ask how, if this is the advice for homes, they could be protected in clinical settings where there was a greater concentration of virus particles, but windows could not be opened. The RCN recognised that Health and Safety legislation did not apply to the public in their own homes but did apply to healthcare workers in their place of work – this further confused the language and advice in IPC guidance.

178. In response to the emergence of the new alpha variant, Sue Tranka, scheduled a call with the CNO for England and representatives from the RCN, the Royal College of Midwives and NHSE, amongst others, for 22 December 2020 to engage on the topic of PPE and IPC concerns. I represented the RCN on this call **[RG/144 - INQ000417637]**. The enormous pressures on the limited IPC staff resources were discussed and there were calls to make IPC staff available at the frontline and less tied-up with contact tracing and central reporting, as their expert knowledge was needed to drive better adherence to IPC among clinical staff. Non-adherence to IPC guidance for Covid-19 was agreed to be a major problem, contributing to nosocomial transmission, but many IPC leads felt they were lacking the necessary support at Board level to ensure that their expert advice was followed and guidance implemented by all NHS staff. There were calls for more innovative ways of ensuring that the key messages reached those delivering care and for more proactive monitoring of IPC practice by IPC practitioners with the knowledge and authority to challenge clinicians. There was, however, a shortage of trained IPC staff and

the ageing workforce was recognised in this meeting. I offered training on the existing RCN IPC education programme to help resolve some of these issues. NHSE undertook to consider establishing an expert IPC group that could provide this expert input to NHSE in a more timely and appropriate way, particularly during this critical phase of the pandemic.

179. On 23 December 2020, Donna Kinnair, sent a joint letter along with Dr Chaand Nagpaul, Chair of the BMA, to Sir Patrick Vallance, the UK government's Chief Scientific Adviser **[RG/145 – INQ000417588]**. This was in response to the identification and communication of the new variant of SARS-Cov-2 at the Prime Minister's press briefing on 19 December 2020. In the letter, the RCN and the BMA expressed their concerns, and the concerns of their members, about the implications of the increased risk of transmission of the new variants to patients and staff through exposure at work in health care settings. We asked that the precautionary principle be applied in terms of increased PPE, including a higher level of RPE for those working with patients suspected or confirmed as having Covid-19. This was to ensure not only compliance with Health and Safety legislation but to protect the workforce to reduce as far as possible sickness absence due to work acquired Covid-19. We also called for more emphasis and tailored guidance on effective ventilation within health care environments, which was acknowledged to be poor for the purpose of diluting risks of respiratory infection and asked for the UK government to initiate a review of the effectiveness of ventilation in the health and care estate. On 13 January 2021, the RCN and BMA followed up on this letter directly with Professor Chris Whitty, inviting a more detailed discussion of the issues highlighted **[RG/146a - INQ000417648] [RG/146b - INQ000417643] [RG/147 - INQ000417627].** Chris Whitty's office confirmed receipt on 13 January 2021 **[RG/148 - INQ000417690]**. We do not believe that a substantive written response was forthcoming.

From January 2021 to 2022

180. Following a Health Services Safety Investigations Body report, 'Investigation report: COVID-19 transmission in hospitals – Management of the risk (a prospective safety investigation) published on 29 October 2020, it was recommended that the DHSC, working with NHS England and NHS Improvement, PHE and other partners as appropriate, develops a transparent process to co-ordinate the development, dissemination and implementation of national guidance across the healthcare system to minimise the risk of nosocomial transmission of Covid-19. On 13 January 2021, the

RCN was asked by DHSC to provide their views on how this recommendation could be achieved. On 15 January 2021, the RCN provided a response **[RG/149a - INQ000417615] [RG/149b - INQ000417640]** which recognised that a transparent process to support and implement national IPC guidance would benefit from enhanced professional stakeholder engagement to support both content and avoidance of concerns raised following publication. Where there was previously an absence of evidence, a structured engagement process would support consensus and allow implementation changes to be raised proactively.

181. On 15 January 2021, Donna Kinnair wrote to Michal Brodie, Interim Chief Executive of PHE, highlighting members' concerns relating to the risk of aerosol/airborne infection and requesting that PHE urgently commission a review of the evidence-base supporting the UK IPC guidance independent of the UK IPC cell **[RG/150 - INQ000114315]**. The rationale for this request was to seek assurance through an independent source that the review of available evidence, and consideration of lack of evidence, was informing advice in IPC guidance in a proportionate and objective way. The RCN was very concerned at this point that group think among senior health leaders and IPC experts was resulting in poor decision making and impeding the development of IPC guidance which was critical for the protection of patients and staff.

182. PHE responded, on 17 February 2021, to explain that the UK IPC Cell had recently reviewed the evidence in relation to the transmission route and the IPC precautions required and that updated IPC guidance had been published on 21 January 2021 **[RG/050 - INQ000114314]**. In response to the RCN's request for PHE to commission a review of the evidence-base, Mr Brodie simply said that the IPC cell had undertaken a review and that no changes to the current PPE requirements were needed.

183. Similarly, on 19 January 2021, the SPF which is made up of representatives from the DHSC, NHSEI, HEE, NHS Employers and the NHS trade unions including the RCN, wrote to Dr Susan Hopkins, Test and Trace and PHE Joint Medical Advisor and Ruth May, CNO for England, seeking to understand whether IPC guidance had been reviewed, or was due to be reviewed, in light of the Omicron variant. In their joint response of 29 January 2021, PHE and NHS Employers confirmed that "*Following extensive clinical and scientific review, no changes to the recommendations, including PPE, have been made in response to the new variant strains at this stage*" **[RG/151a - INQ000417606] [RG/151b - INQ000118278] [RG/151c - INQ000059618]**. The RCN remained very concerned, particularly given there was no scientific evidence as new

variants had only just emerged, that a review of PPE requirements and adoption of a precautionary approach to the use of RPE was not forthcoming.

184. Concerns were therefore escalated to the DHSC by way of letter dated 21 January 2021 **[RG/152 - INQ000417653]**. This correspondence asked the government to:

a. Assure professional organisations that the current UK IPC guidance was sufficiently robust in light of new variants;
b. Ensure nursing staff were supported to use PPE as a precautionary approach; and
c. Review the effectiveness of ventilation across the health care estate.

185. A similar joint letter with the BMA was sent on 21 January 2021 to the HSENI **[RG/153 - INQ000400935]** and to the Cabinet Secretary for Health and Sport in Scotland on 27 January 2021 **[R/154 - INQ000417571]**.

186. We received a response from HSENI on 9 February 2021 **[RG/155 - INQ000400944]**, indicating that IPC guidance fell within the remit of healthcare experts rather than the HSE, but that the IPC guidance would be the minimum standard of care that HSENI expected Trusts to adhere to, as part of their legal duty to protect staff. HSENI, in their response noted a review of IPC guidance, published on 21 January 2021, to take account of Covid-19 variants, but that no changes to the guidance had been recommended as a result of the review.

187. A response was not sent by DHSC to our letter dated 21 January 2021 **[RG/152 - INQ000417653]** until 16 May 2021 **[RG/156 - INQ000417528]** when it said "*The UK-wide IPC Cell, a team within NHSE that looks at the updating of the IPC guidance, recently reviewed evidence in relation to the transmission route of Covid-19 and the IPC precautions required, and agreed that no changes to the current PPE requirements were needed. There is also consensus among the Chief Medical Officers in the four nations of the UK that existing guidance regarding the use of face masks and FFP3 masks by healthcare workers is correct…There is no requirement to increase the level of PPE worn by the clinicians unless the level of care or clinical intervention indicate that a different level of PPE is required. This should be based upon the individual's dynamic risk assessment, with consideration of the transmission route and PPE guidance*".

188. Our concerns about ventilation were also raised with NHS Estates directly, in correspondence dated 28 January 2021 **[RG/157 - INQ000417656]**, where the RCN

asked what review had been carried out on ventilation systems and whether guidance had been developed for estates teams to risk assess their efficacy.

189. The RCN also asked to address the precautionary approach and the issue of ventilation during a meeting with the WHO on 10 February 2021 **[RG/158 - INQ000417670]**. This meeting followed my attendance at a WHO Transmission dynamics event held on 28 January 2021. The meeting on 10 February was arranged through the RCN Policy team as an opportunity to discuss directly with WHO representatives the impact of WHO positions and guidance within the UK context at that time. It was not intended that a specific discussion on UK IPC guidance be undertaken as this is outside the remit of WHO. I was surprised that representatives of the UK IPC team, Mark Wilcox and Lisa Ritchie were invited to the meeting by WHO. This hampered our ability to have a full and frank discussion about the outcomes of the event on 28 January, to seek clarity on some issues and inform WHO of the impact of their guidance within the context of the UK health and care delivery. Topics for discussion were provided in advance as agreed with WHO due to the short meeting duration.

190. I raised the issue of attendance of NHSE/I representatives at the RCN/WHO meeting on 10 February 2021 in writing to Mark Wilcox and Lisa Ritchie on 11 February 2021 to clarify the purpose for a request to meet with WHO **[RG/159 - INQ000417618] [RG/160 - INQ000417701]**. The meeting, as I recall, discussed the agreed topics following on from the 28 January WHO transmission dynamics event. No new information or WHO positions were forthcoming. I was however very surprised at the end of the meeting when WHO representatives offered to support the RCN to re-phrase content on the RCN website relating to the use of PPE aligned to our position at that time. WHO felt a 'more judicious use of PPE' should be promoted. I declined this request, stating that we were unable to do this as this contradicted UK health and safety law pertaining to risk assessment by individual practitioners on the need for PPE. I restated that only the individual practitioners themselves could determine what level of PPE was needed at any given moment in time and that the RCN would not, and could not, be seen to influence this by altering its website content. No further contact with WHO was forthcoming.

191. The Joint Trade Unions wrote to the HSENI on 04 January 2021 **[RG/161 - INQ000417520]** requesting details of healthcare workers who had been reported under the RIDDOR regulations as testing positive for Covid-19. Rita Devlin, the now Director of RCN Northern Ireland was a signatory to this letter in her role as Interim Joint Secretary. To the best of our knowledge a response was not provided to this letter.

192. On 21 January 2021, the RCN and BMA wrote to the HSE with concerns about the ongoing threat posed to health and care staff following the identification of the SARS-Co-V2 variant (VOC 2020/2101) **[RG/162 - INQ000417626]**. Both the RCN and BMA were concerned by data from NHSE which showed that the average number of health and care staff off with Covid-19 related absence in the first week of January 2021 had increased by 22% when compared to the last week of December 2020. Members of both organisations were also concerned that fluid repellent surgical face masks and face coverings, as advised at the time in most general healthcare settings, did not protect against more infective aerosols. The letter sought assurance that employers were carrying out suitable and sufficient risk assessments and called for a precautionary approach to be adopted. A similar letter was also sent to the Scottish Cabinet Secretary on 27 January 2021 **[RG/154 - INQ000417571]** and a response received on 12 February 2021 **[RG/163 - INQ000417684]**.

193. The HSE's response, dated 29 January 2021 **[RG/164 - INQ000417574]**, repeated that "*no changes to the recommendations, including PPE, have been made in response to the new variant strains at this stage, however this position will remain under constant review…Whilst HSE will not be undertaking a review, as this has already been done by those responsible for the guidance, we will continue working closely with DHSC and other government departments*". It provided links to ventilation guidance and pointed to its inspection of NHS trusts and four health boards across England, Scotland and Wales for managing risks arising from Covid -19.

194. On 28 January 2021, Donna Kinnair followed up on this letter and wrote to the HSE and raised concerns regarding the adequacy of PPE **[RG/165 - INQ000417654]**. In particular, the RCN noted how the HSE guidance, published in 2008 regarding investigating the protection afforded by surgical masks against influenza bioaerosols, was predicated on influenza pandemic planning. The design and specification of fluid repellent surgical face masks would have since evolved and therefore the RCN asked for this research to be revisited and repeated utilising SARS-CoV2 as the live virus in place of influenza. The RCN believed a review of this research in the context of the Covid-19 pandemic would fill the existing evidential gap and support the development of guidance on PPE that was suitable and sufficient and offered the right level of protection to enable employers to meet their duties under COSHH.

195. On 18 February 2021, the RCN coordinated a letter to the Prime Minister highlighting concerns about the measures in place to protect health care workers, specifically around better ventilation, PPE and awareness and research in relation to the IPC guidance **[RG/166 - INQ000114283]**. The letter was also sent to the devolved administrations. In the letter, we called for the IPC guidance to be amended to reflect and increase the level of respiratory protection as a precautionary principle for all health care workers and update all guidance to reflect the evidence on airborne transmission ensuring representation from a truly multidisciplinary range of experts. We also called on the UK government to collect and publish consistent data on health care workers who had contracted Covid-19 from likely occupational exposure. The letter was co-signed by a significant number of other organisations (representing professional bodies, unions and other Royal Colleges) that had come together in an informal alliance to seek to influence the UK government on these issues. In the letter we highlighted the fact that we felt it necessary to escalate our concerns to the Prime Minister because of a lack of sufficient engagement from UK government departments and agencies in addressing our concerns. We also reiterated our previous calls to adopt a more collaborative multidisciplinary approach to producing and coordinating IPC guidance. A response to this letter was not received until 7 May 2021 **[RG/167 - INQ000114417]**.

196. IPC guidance for Wales was issued jointly and published by the UK Health Security Agency ("**UKHSA**"). The Welsh Government group feeding into this issue was the Nosocomial Transmission Group, on which RCN Wales was represented. Through this group, Nicola Davis, RCN Wales Acute Care and Leadership Adviser had raised the issues of hospital ventilation and respiratory protection in meetings, including on 11 February 2021.

197. On 24 February 2021, Baroness Masham of Ilton tabled a parliamentary question on behalf of the RCN "*To ask Her Majesty's Government what research they have commissioned to determine the potential risks to patients and healthcare workers of (1) short-range, and (2) long-range, aerosol transmission of Covid-19 in health and care premises*". The answer from Lord Bethell, received on 4 March 2021 **[RG/168 - INQ000176048]**, confirmed that "*the National Institute for Health Research and UK Research and Innovation have jointly commissioned research studies to determine the potential risk to patients and staff from aerosol transmission of Covid-19 and investigate how to mitigate those risks. This includes funding of £433,000 to the AERATOR study at the University of Bristol to investigate aerosolization of Covid-19 and transmission risk at short range from medical procedures. Additionally, Public Health England have been*

awarded £337,000 to investigate environmental and airborne transmission routes of Covid-19 including in healthcare settings."

198. On 12 March 2021, the RCN co-signed a letter (with Royal Colleges, professional bodies and trade unions) to the CMOs in each of the four nations calling for an urgent review of PPE and ventilation guidelines **[RG/169 - INQ000114297]**. In that letter, we requested a meeting due to the length of delay and, in some cases, entire absence in communications with senior leaders. We pointed out that the lack of response to many of our letters asking for changes to current guidance was not only professionally discourteous but also unacceptable. We received a very dissatisfactory response to this letter from Dr Gregor Smith (CMO for Scotland) on 25 March 2021 **[RG/170 - INQ000114412]** – the response was no more than a brief acknowledgement of receipt. Further to our letter, Chris Whitty (CMO for England) agreed to a meeting to take place on 22 April 2021, but this was postponed by the DHSC on 20 April 2021 **[RG/171 - INQ000114426]**. RCN Wales did not receive a separate response from the CMO Wales, which was not unexpected as the letter sent on 12 March was signed and sent by the RCN Chief Executive and General Secretary rather than the Director of RCN Wales. To the best of our knowledge, RCN Northern Ireland did not receive a response form the CMO in Northern Ireland.

199. On 26 April 2021, the RCN reported, via press release **[RG/172 - INQ000417525]** on a document released by SAGE, which said healthcare workers may need a higher standard of RPE when caring for patients with Covid-19 outside of intensive care units. The RCN's position was that this was a step in the right direction, but that guidance needed to reflect this change, so that health and care organisations felt confident applying it, as we had heard many reports from members that employers did not feel able to deviate from the letter of national IPC guidance for fear of being criticised.

200. On 27 April 2021, I attended a meeting with the then Deputy Branch Head PPE Policy at DHSC, along with Tom Embury (from the British Dietetic Association), Ms Kamini Gadhok (from the Royal College of Speech and Language Therapists ("**RCSLT**")) and Robert Wilson from the BMA. This meeting was arranged in lieu of the original stakeholder meeting, due to take place on 22 April, which was postponed at very short notice. In advance of the meeting, Kamini Gadhok of the RCSLT and Alastair Hardisty of DHSC shared talking points that they wanted to cover at the meeting **[108] [RG/173 - INQ000417688]**. I recall that we spoke about the evidence-based approach we wanted the government to take to IPC guidance. We reinforced the centrality of the protection of

health care workers, and how our respective organisations could support the UK government in amending the IPC guidance.

201. By way of follow-up to this meeting, on 4 May 2021, the RCN emailed the DHSC as summarised in an internal email **[RG/174 - INQ000417591] [RG/175 - INQ000417635]**. The email highlighted changes to SAGE and WHO's positions and called for PPE guidance to be consistent with other known and managed high-risk infections. UK IPC guidance was not aligned with guidance from the CDC in the US or the ECDC and the RCN was concerned that it had not been consulted on guidance that affected our members so significantly.

202. On 4 May 2021, the Welsh Minister for Health and Social Services, replied to RCN Wales's letter of 24 December 2020 **[RG/176 - INQ000328861]** about PPE and protection of vulnerable individuals in the context of the new variant **[RG/177 - INQ000417558]**. The reply said "*Following recognition of increased transmissions due to the new virus variant in December 2020, the UK IP&C group met several times to determine whether guidance needed modification. As there is no evidence of any change in the mode of transmission of the new variant, it was determined there was insufficient evidence to support a change to current guidance. This subject has also been discussed at the UK Senior Clinicians' Group, which includes the Chief Medical Officers (CMOs). It was agreed the UK IP&C guidance should not change and that it should be adhered to with consistency across the UK*".

203. On 5 May 2021, Ms Gadhok and I wrote to the then Deputy Branch Head PPE Policy at DHSC on behalf of the same alliance of organisations that had written to the Prime Minister on 18 February **[RG/178 - INQ000114258]**. In this email, we raised our concerns in relation to PPE guidance, drawing attention to the fact that the current UK IPC guidance did not align with guidance from the ECDC or the CDC in the United States.

204. We received a letter from 10 Downing Street on 7 May 2021 **RG/167 - INQ000114417]**, in response to our letter of 18 February **[RG/166 - INQ000114283]**. The letter was dismissive of our calls for the IPC guidance to be amended and for a multidisciplinary approach to developing, reviewing and updating guidance for health care workers. The letter stated that the IPC Cell within NHSE had "*recently reviewed evidence in relation to the transmission route of Covid-19 and the precautions required,*

and agreed that no changes to the current PPE requirements were needed" and that "*there is also a consensus among the Chief Medical Officers in the four nations of the UK that existing guidance regarding the use of face masks and FFP3 masks by health care workers is correct*".

205. In light of this very disappointing response, I coordinated a press release that was published by members of the informal alliance on 14 May 2021 **[RG/179 - INQ000114427] [RG/180 - INQ000114429]**. As mentioned in the press release, the response from the Prime Minister's office failed to recognise the growing evidence that Covid-19 could be spread by aerosols aligned to airborne transmission despite the publication of the government video on ventilation in homes on 24 November 2020.

206. This message was reiterated in June 2021, when the RCN, as co-author with other professional bodies and Unite the Union, submitted written evidence to the Public Accounts Committee **[RG/181 - INQ000130586]**. The submission focused on the concerns of the authors that the relevant UK government departments and advisory committees had refused to update infection control guidance or implement better protections, including higher quality PPE, although the ever-growing scientific evidence of airborne transmission of Covid-19 had been acknowledged by the WHO, SAGE, CDC and others. Indeed, senior political figures, including Health Select Committee Chair Jeremy Hunt and former Chief Advisor to the Prime Minister Dominic Cummings had recently highlighted the lack of action on airborne spread. This had resulted in the UK lagging behind other parts of the world and placed both healthcare professionals and patients at greater risk.

207. The submission highlighted that existing guidance failed to take an appropriately precautionary approach for the protection of healthcare workers. Furthermore, the requirement for a local risk assessment, contained in the guidance, was impractical for unpredictable or time pressured situations. Additionally, national guidance only offered one possible choice for PPE irrespective of outcome of assessment and favoured surgical masks for non–AGP situations which was unacceptable.

208. The submission also emphasised the lack of transparency around infection control guidance decision making as a matter of serious concern. An example of this was the inability to publicly access minutes of IPC Cell meetings, where decisions, such as the

change in status of Covid-19 as a HCID in March 2020 should have been documented, as well as a lack of membership details.

209. Given our members' increasing anxiety levels around the lack of traction we were getting with the key decision-makers around clarifying IPC guidance, and because the meeting with the CMO had been delayed, I, along with Kamini Gadhok of the RCSLT, emailed the DHSC asking that several points be raised at the next IPC Cell meeting **[RG/182 - INQ000417612]**.

210. On 3 June 2021, the DHSC held a PPE IPC guidance Stakeholder Engagement meeting (which was in place of the meeting with the CMO which was initially scheduled for 22 April 2021, but which now had a much larger cast of invitees). I attended this meeting with my colleague Matthew Barker, Deputy Director of Nursing **[RG/183 - INQ000114332] [RG/184 - INQ000114333]**. The alliance prepared a presentation on protective solutions for airborne Covid-19 **[RG/185 - INQ000114414]** that they delivered at the beginning of the meeting and, in the spirit of transparency and collaboration, the RCN also sent in a number of questions prior to the meeting to be addressed in the scheduled Q&A session **[RG/186 - INQ000114261]**.

211. The meeting on 3 June 2021 was widely attended, including the National Clinical Director Infection Prevention & Control, NHSE, Deputy Director, PPE Policy, Briefing & Engagement, Chair of IPC Cell, Medical Director (interim), Public Health Wales, and Head of Healthcare Associated Infections and Antimicrobial Resistance Programme (HARP), DHSC, CNO for England, the CNO (interim) for Wales and Associate Nursing Officer Scotland.

212. The RCN internal briefing paper, following the meeting, documents that the meeting was a professional exchange acknowledging the differences in opinion and interpretation of evidence on both sides **[RG/187 - INQ000417668]**. The alliance openly challenged interpretation of DHSE representatives' evidence and rationale for the current status quo in IPC guidance and lack of alignment with CDC and ECDC guidance. There was a consensus among alliance members that active listening had not occurred, the meeting offer had been tokenistic and answers to questions posed by the alliance required further written clarification. There was no resolution that occurred as a result of this meeting.

213. On 23 June 2021, Michael Dynan-Oakley (Deputy Director, PPE Policy, Briefing and Engagement at DHSC) wrote to the attendees of the IPC guidance stakeholder meeting **[RG/188 - INQ000114267]**. The letter purported to answer the questions that we posed in the Q&A section of the meeting but was again rather dismissive of our key concerns and did not provide any tangible means by which a wider range of stakeholders could support the revision of future guidance and resources.

214. On 8 July 2021, the RCN wrote to Mr Dynan-Oakley **[RG/189 - INQ000114265]** expressing disappointment with regards to his letter of 23 June **[RG/188 - INQ000114267]**. The questions the RCN and the broader alliance had posed were not answered adequately at the meeting or in the follow-up. We felt that the DHSE had failed to recognise the critical issue of short-range aerosol transmission of Covid-19. The RCN's letter stated that "*our members continue to report a loss of confidence in the UK IPC guidance, dissatisfied with a lack of consultation with stakeholders, in particular those represented at the meeting on 3 June*". The RCN was disappointed and surprised not to be offered a follow-up meeting as requested by the alliance.

215. On the same day (8 July 2021), the RCN wrote a joint letter with the AGP Alliance to Dr Jenny Harries **[RG/190 - INQ000300383]**, Chief Executive of the UKHSA highlighting the ongoing concerns regarding the need to recognise airborne transmission of Covid-19 outside of AIGP's and the increasing evidence supporting this as a primary mode of transmission in all settings.

216. On 12 July 2021, the RCN received a letter from Simon Corben, Director of NHS Estates and Facilities **[RG/191 - INQ000417652]** in response to an email from the RCN on 14 April 2021 regarding ventilation in the health and care estate. The letter included links to a recently revised version of Health Technical Memorandum (HTM) 03-01 Heating and ventilation of health sector buildings. Mr Corben advised that the purpose of the guidance was to ensure that Trusts had access to the most up-to-date information and that the guidance continued to be reviewed against known evidence of airborne transmission available at the time of publication.

217. On 14 July 2021, the RCN co-signed a further letter to the Prime Minister **[RG/192 - INQ000114256]**. This called for the continued use of RPE for staff in health and care settings, alongside improvements in ventilation, in the context of continuing concerns around health care staff becoming infected with Covid-19 in the workplace.

218. On 19 July 2021, I raised concerns with the National Covid-19 Response Centre in relation to inconsistencies between PHE's guidance document '*COVID-19: management of staff and exposed patients and residents in health and social care settings*' and the PHE Briefing Note 2021/050 issued on 19 July 2021 **[RG/193 - INQ000114274] [RG/194 - INQ000114275] [RG/195 - INQ000114276]**.

219. On 30 July 2021, Jude Diggins (Director of Nursing, RCN) and I met with CNO for England, and the Deputy CNO **[RG/196 - INQ000114273]**. We proactively reached out to arrange this meeting in order to offer support for a review of the IPC guidance, to explain the work the RCN were planning on doing to support frontline health care workers with risk assessments, and to raise concerns about health care worker infection data and the need for greater detail on inequalities. I came away from that meeting feeling like we had not been successful in influencing the CNO and Deputy CNO on the important issues we raised. Whilst we appreciated the opportunity to liaise with the CNO and Deputy CNO and to share our willingness to offer support, we felt that our concerns would not translate into action. No changes were made post this meeting, for example, to the quality and extent of collation of health care worker infection data despite our concerns. The RCN wanted accurate, collection, recording and reporting of health and care worker deaths in all settings to be made publicly available.

220. On 05 August 2021, the RCN wrote to HSE expressing concerns at the reporting of occupational health and care worker deaths from Covid-19 **[RG/197 - INQ000417669].** The RCN expected all health and care employers to RIDDOR report all cases of health and care workers contracting Covid-19 as disease incidents where they have been exposed to patients with suspected or confirmed Covid-19. The RCN expressed concern that HSE did not have higher numbers of reports considering the emerging evidence suggesting that more than 200 health and care workers had died. In their response dated 17 August 2021, HSE noted that diagnosed cases of Covid-19 are not reportable under RIDDOR unless there was reasonable evidence suggesting that a work-related exposure was the likely cause of the disease **[RG/198 - INQ000417581].** HSE noted how it was for the employer to consider whether or not a confirmed diagnosis of Covid-19 was likely to have been caused by an occupational exposure and to make a decision on whether a report is required.

221. Whilst we do not have a finalised copy, we understand that in November 2021 the RCN was a joint signatory, with the Covid Airborne Protection Alliance- CAPA (formerly

the AGP Alliance) to a letter to Dr Jenny Harries. The letter had been prompted partly by the fact that we had had no response to our previous letter (8 July 2021) **[RG/190 - INQ000300383]**, and by the publication of guidance from DHSC 'Stop COVID-19 hanging around' on improving ventilation by opening windows, together with graphics which left no doubt as to the importance of airborne transmission - albeit without a single mention of the term "aerosol". The letter stressed that the discordance between the latest public health guidance and IPC guidance for healthcare workers was inexplicable and dangerous. Furthermore, it placed healthcare workers at continuing risk of exposure to Sars-Cov-2 which could have been avoided by implementing RPE such as FFP3 or the equivalent for close contact care. The letter requested consideration of these matters and urged that the imminent iteration of IPC guidance took due note of our comments and should be altered in favour of protecting healthcare workers from close range aerosol transmission, irrespective of AGP and in concordance with the latest public health guidance.

222. Information about the RCN Risk Assessment toolkit was disseminated widely by RCN Wales in December 2021 **[RG/083 - INQ000328953]**, including to the CNO Wales, Directors of Nursing in Wales, Heads of Schools of Health in Welsh Universities, Health Education and Improvement Wales, Healthcare Inspectorate Wales and the Care Inspectorate Wales.

223. Similarly, the Risk Assessment toolkit was disseminated widely by RCN Northern Ireland, to the CNO, Directors of Nursing (HSC Trusts), Chief Executive NIPEC, Head of Clinical Education Centre, Head of School of Nursing (QUB & UUJ) and to the Staff Tutor of Nursing at the Open University.

224. On 31 December 2021, following a letter written by the RCN on 22 December 2021 **[RG/199 - INQ000417535]**, Carol Popplestone, Chair of the RCN Council and Pat Cullen, now RCN General Secretary and Chief Executive, wrote to the Secretary of State for Health and Social Care, expressing concern and dismay that the voice of the nursing profession did not appear to have been heard by the Westminster Government and, in particular, by the Secretary of State **[RG/200 - INQ000328841]**. Amongst other topics, the RCN requested that that current operating guidance covering PPE be added to, thus ensuring the highest levels of workplace safety for our members and preventing a postcode lottery from developing. This letter set out a list of concerns raised by members and to call for a more cautious approach to, and greater assurances of, patient

and professional safety. The RCN asked for appropriate RPE for its members as part of maximum workplace protection.

From January 2022 to June 2022

225. The RCN acknowledged emerging evidence on the transmission of SARS-CoV-2 via the air and called for this to be embedded in the UK government's campaign through broader risk assessments and access to PPE in our 'RCN position on Covid-19', dated 5 January 2022 **[RG/201 - INQ000417529]**, and 'RCN position on personal protective equipment (PPE) for Covid-19', dated 07 January 2022. **[RG/202 - INQ000417530]**

226. The emergence of the Omicron variant meant the risk to maintaining staffing levels and patient services was greater than ever before and so, on 27 January 2022, RCN Wales and BMA Wales wrote jointly to the Welsh Minister for Health and Social Services to reiterate the call of the BMA and the RCN for PPE, including FFP3 and FFP2 masks, to be made readily available to protect all colleagues from Covid-19 infection **[RG/203 - INQ000118731]**.

227. In her reply of 7 February 2022 **[RG/204 - INQ000417559]**, the Minister, Eluned Morgan, pointed to the continuous review of IPC guidance. The letter maintained, to the RCN's surprise, that Welsh Government had ensured a supply of PPE which was appropriate for need throughout the pandemic.

228. In March 2022, the Welsh Government announced £4.5million to investigate and learn from hospital-acquired Covid-19 infections in Wales. RCN Wales welcomed this important step in supporting families and patients understand their experiences but was concerned about the lack of process and scope of the investigation and particularly about whether it would explicitly reference the impact of adequate PPE and quality ventilation and wrote to the Welsh Minister for Health and Social Services and Chair of the Health and Social Care Committee about these concerns on 3 March 2022 **[RG/205 - INQ000417539]**.

229. In March 2022, RCN Scotland responded to the Scottish Government consultation 'Future Pandemic PPE Supplies in Scotland' **[RG/206 - INQ000417697]**, highlighting how the provision of FFP3 masks in future pandemics is absolutely paramount as is the provision of a proper programme of face fitting.

Recommendations

230. As a profession, nursing and midwifery professionals deliver the vast majority of physical and psychological care to patients in all care settings. They have led the way in reducing the transmission of infection by prioritising infection prevention and control measures in their practice. These measures are fundamental to our profession which is uniquely well-placed to understand the importance and methods to reduce the spread of infection. In the context of the pandemic, the RCN's key focus was the protection of healthcare workers and patients from infection acquired as a result of work or receiving care. The protection of healthcare workers is critical not only to protect them from occupationally acquired disease, but also to ensure that staffing levels are maximised to avoid harm to patients through an under-resourced service. The Covid-19 pandemic taught us that the experiences of those on the frontline of health and social care was often dangerously overlooked. There were inadequate opportunities for those representing frontline workers to feed into the development and delivery of guidance, particularly IPC guidance, despite learning from previous incidents on the need for this; this resulted in guidance that was not fit for purpose and did not address issues that clinicians and health care workers were facing on the ground. In turn this had a detrimental, sometimes fatal, impact on those who were on the frontline of care. The RCN invites the Chair to make the following recommendations for the future:

Nursing input

231. Full and proper engagement through partnership working with the nursing profession on infection prevention and control national guidance, from the formative stages through to implementation and monitoring, to ensure guidance is robust, fully informed, evidence based and effectively implemented.

232. A strengthened role for professional nursing (as opposed to specialists in IPC) in the design, development and implementation of national IPC protocols, implementation plans, policy decisions and guidance at the local and national level.

233. Professional nursing representation equivalent to medical representation at briefings/meetings etc regardless of whether these are led by the CMO or other health leaders. The emergency response to incidents like pandemics requires multi-professional support and engagement where all professional disciplines are considered equal.

Other advice and support

234. An independent review of pandemic support structures should be commissioned and a reinstatement of the Pandemic Influenza Clinical and Operational Advisory Group or similar, as experienced in the H1N1 pandemic, should be reinstated for clinical guidance development to ensure multi-professional engagement and support outside of IPC.

235. Transparent governance and visibility of all cells and response teams to enable a full understanding of incident response mechanisms and risk management as situations evolve. This should apply to UK wide and devolved cells.

236. Input from non-IPC specialists when producing future IPC guidance, including health and safety experts, occupational hygienists, aerosol scientists, occupational health, and wider professional stakeholders such as paramedics, speech and language therapists, etc, whose roles align with nursing care. A holistic approach avoids group think, ensures that IPC guidance is workable and provides an opportunity for specialisms to raise concerns at an early stage in the process before IPC guidance is finalised and published. This is a key lesson which should be implemented in the development and production of future IPC guidance. Had this been in place during the pandemic, concerns over the applicability of IPC guidance and AGPs could have been addressed prior to publication.

237. Taking forward the recommendation of the Independent Review **[RG/048 - INQ000114357]** that the team responsible for issuing and updating the interim IPC guidance should form a post-pandemic group to undertake a wide stakeholder debrief on lessons identified and implement recommendations based on this.

PPE

238. The government must adopt a longer-term approach to sustainably procuring and maintaining stockpiles of PPE as well as other medical equipment essential for staff and patient safety. Procurement should be harmonised between government departments, and additional resource should be factored in to enable the expertise of clinical procurement staff to be central to decision-making processes.

239. All governments and employers in the UK must ensure that all nursing staff, regardless of practice setting, geographical location, role, employer or finances, have access to the necessary PPE of the required standard, to use when required. The quality and quantity of PPE that an essential health and care worker receives should not be left to chance.

240. The needs and perceptions of ethnic minority nursing staff should be fully explored and addressed within pandemic learning. As a result of inadequate supplies, our members reported examples of clearly unsafe practice including using equipment previously marked as out of date; re-using single use PPE, cleaning down old gowns with alcohol wipes, and even having to use donated equipment. Our ethnic minority members reported more difficulty in accessing PPE throughout the first wave of the pandemic.

241. Health and care services' PPE supply and stockpiles should be prioritized in circumstances where PPE is in demand from all sectors including retail and education. PPE is essential to protect front line staff and effectively reduce virus transmission rates.

242. The government must firmly reinforce the position that re-use of single use PPE is not acceptable under any circumstances. Should this situation ever be predicted again it is essential that broad stakeholder involvement is present in any discussions on mitigations strategies.

243. There should be funding for the urgent development of reusable RPE that is acceptable to staff and patients.

244. There must be greater transparency and governance of the procurement process for PPE at government level during incidents where demand increases.

245. There needs to be comprehensive data collection and systematic reporting on deaths, infection rates and self-isolation rates for nursing staff (capturing ethnicity and gender data) in order to accurately scrutinise the impact of infection, prevention and control measures in real time. This should apply to all care sectors not just hospitals.

Isolation facilities

246. The UK government and its relevant agencies need to review and carefully consider how to build better isolation facilities now so that they will be fit for the future. The UK government needs to learn from the Covid-19 pandemic and specifically consider the role of cohort facilities as well as ventilation and its practical application where possible in the transmission of infection and how care can be delivered safely to large numbers of people whilst also focusing on staff safety in all care settings.

Summary

247. We expect the Government and relevant agencies to:

a. Capture, in collaboration with professional stakeholders, and act on lessons learned during previous and current pandemic/incidents in relation to staff raising concerns about PPE/RPE, equipment and staffing.
b. Ensure there are clear and accountable mechanisms in place for staff to raise any concerns safely, in the knowledge that they will be dealt with fairly and without fear of redress. Staff must not be required or pressurised into working without the correct PPE for their environment.
c. Ensure that nursing is meaningfully and professionally engaged at all levels of incident management and the development of policies/guidance.

Closing remarks

I would like to thank the Inquiry Chair, on behalf of the RCN, for the opportunity to provide evidence in relation to Module 3 of the UK Covid-19 Inquiry. We recognise that this Inquiry presents a unique opportunity to identify and put in place actions to ensure that learning from the UKs experiences of the Covid-19 pandemic is implemented. This is crucial to ensure that the UK is properly prepared, as well as it can be, for future pandemics (where the only question is when, not if, the next pandemic will hit). Nurses and healthcare workers will be once again on the frontline of the next pandemic and the RCN has a responsibility to ensure anything that went wrong or things that could be improved are reported on and acted upon in the interests of nurses, our wider health care colleagues, and the patients to whom they provide care.

The RCN is committed to working with the Inquiry throughout its investigations and we are happy to assist with any further requests.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed Personal Data

Dated 25 April 2024